PATIENT RELIEF FROM COLLAPSING HEALTH MARKETS

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
FIRST SESSION
FEBRUARY 2, 2017
Serial No. 115–4

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov
U.S. GOVERNMENT PUBLISHING OFFICE
WASHINGTON : 2018
COMMITTEE ON ENERGY AND COMMERCE

GREG WALDEN, Oregon

Chairman

JOE BARTON, Texas

FRED UPTON, Michigan

TIM MURPHY, Pennsylvania

MICHAEL C. BURGESS, Texas

MARSHA BLACKBURN, Tennessee

STEVE SCALISE, Louisiana

ROBERT E. LATTA, Ohio

CATHY McMORRIS RODGERS, Washington

GREGG HARPER, Mississippi

LEONARD LANCE, New Jersey

BRETT GUTHRIE, Kentucky

PETE OLSON, Texas

ADAM KINZINGER, Illinois

H. MORGAN GRIFFITH, Virginia

GUS M. BILIRAKIS, Florida

BILL JOHNSON, Ohio

BILLY LONG, Missouri

LARRY BUCSHON, Indiana

BILL FLORES, Texas

SUSAN W. BROOKS, Indiana

RICHARD HUDSON, North Carolina

CHRIS COLLINS, New York

KEVIN Cramer, North Dakota

TIM WALBERG, Michigan

MIMI WALTERS, California

RYAN A. COSTELLO, Pennsylvania

EARL L. “BUDDY” CARTER, Georgia

SUBCOMMITTEE ON HEALTH

MICHAEL C. BURGESS, Texas

Chairman

BRETT GUTHRIE, Kentucky

Vice Chairman

JOE BARTON, Texas

FRED UPTON, Michigan

TIM MURPHY, Pennsylvania

MARSHA BLACKBURN, Tennessee

LEONARD LANCE, New Jersey

H. MORGAN GRIFFITH, Virginia

GUS M. BILIRAKIS, Florida

LARRY BUCSHON, Indiana

SUSAN W. BROOKS, Indiana

MARKWAYNE MULLIN, Oklahoma

RICHARD HUDSON, North Carolina

CHRIS COLLINS, New York

EARL L. “BUDDY” CARTER, Georgia

GENE GREEN, Texas

Vice Chairman

JOE BARTON, Texas

FRED UPTON, Michigan

TIM MURPHY, Pennsylvania

MARSHA BLACKBURN, Tennessee

LEONARD LANCE, New Jersey

H. MORGAN GRIFFITH, Virginia

GUS M. BILIRAKIS, Florida

LARRY BUCSHON, Indiana

SUSAN W. BROOKS, Indiana

MARKWAYNE MULLIN, Oklahoma

RICHARD HUDSON, North Carolina

CHRIS COLLINS, New York

EARL L. “BUDDY” CARTER, Georgia

-ranking Member

Frank Pallone, Jr., New Jersey

BOBBY L. RUSH, Illinois

ANNA G. ESHTO, California

ELIOT L. ENGEL, New York

Diana DeGETTE, Colorado

MICHAEL F. DOYLE, Pennsylvania

Janice D. SCHAKOWSKY, Illinois

G. K. BUTTERFIELD, North Carolina

DORIS O. MATSUI, California

KATHY CASTOR, Florida

JOHN P. SARANES, Maryland

JERRY McNEREY, California

PETER WELCH, Vermont

PAUL TONKO, New York

YVETTE D. CLARKE, New York

DAVID LOEBACK, Iowa

JOSEPH P. KENNEDY, III, Massachusetts

RAUL RUIZ, California

SCOTT H. PETERS, California

DEBBIE DINGELL, Michigan

BEN RAY LULAN, New Mexico

TONY CARDENAS, California

JOHN P. SARANES, Maryland

BEN RAY LULAN, New Mexico

KURT SCHRADER, Oregon

JOSEPH P. KENNEDY, III, Massachusetts

ANNA G. ESHTO, California

(ex officio)
## CONTENTS

<table>
<thead>
<tr>
<th>Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared statement</td>
<td>3</td>
</tr>
<tr>
<td>Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement</td>
<td>4</td>
</tr>
<tr>
<td>Hon. Greg Walden, a Representative in Congress from the State of Oregon, opening statement</td>
<td>6</td>
</tr>
<tr>
<td>Prepared statement</td>
<td>7</td>
</tr>
<tr>
<td>Hon. Susan W. Brooks, a Representative in Congress from the State of Indiana, prepared statement</td>
<td>9</td>
</tr>
<tr>
<td>Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement</td>
<td>10</td>
</tr>
<tr>
<td>Prepared statement</td>
<td>11</td>
</tr>
<tr>
<td>Hon. Anna G. Eshoo, a Representative in Congress from the State of California, prepared statement</td>
<td>108</td>
</tr>
</tbody>
</table>

### WITNESSES

<table>
<thead>
<tr>
<th>Douglas Holtz-Eakin, Ph.D., President, American Action Forum</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared statement</td>
<td>17</td>
</tr>
<tr>
<td>Answers to submitted questions 1</td>
<td>188</td>
</tr>
<tr>
<td>J.P. Wieske, Deputy Commissioner, Wisconsin Office of the Commissioner of Insurance</td>
<td>23</td>
</tr>
<tr>
<td>Prepared statement</td>
<td>25</td>
</tr>
<tr>
<td>J. Leonard Lichtenfeld, M.D., Deputy Chief Medical Officer, American Cancer Society</td>
<td>39</td>
</tr>
<tr>
<td>Prepared statement</td>
<td>40</td>
</tr>
<tr>
<td>Answers to submitted questions</td>
<td>190</td>
</tr>
</tbody>
</table>

### SUBMITTED MATERIAL

| Discussion Draft, H.R. I, the Preexisting Conditions Protection and Continuous Coverage Incentive Act of 2017, submitted by Mr. Burgess | 109 |
| Discussion Draft, H.R. II, the State Age Rating Flexibility Act of 2017, submitted by Mr. Burgess | 116 |
| Discussion Draft, H.R. III, the Plan Verification and Fairness Act of 2017, submitted by Mr. Burgess | 118 |
| Discussion Draft, H.R. IV, the Health Coverage State Flexibility Act of 2017, submitted by Mr. Burgess | 123 |
| Letter of February 1, 2017, from Joyce A. Rogers, Senior Vice President, Government Affairs, AARP, to Mr. Burgess and Mr. Green, submitted by Mr. Butterfield | 128 |

---

1 Dr. Holtz-Eakin did not answer submitted questions for the record by the time of printing.
<table>
<thead>
<tr>
<th>Report/Statement/Document</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of the Asian &amp; Pacific Islander American Health Forum, February 2, 2017, submitted by Mr. Green</td>
<td>148</td>
</tr>
<tr>
<td>Statement of the American Heart Association, February 2, 2017, submitted by Mr. Green</td>
<td>152</td>
</tr>
<tr>
<td>Letter of February 2, 2017, from Rob Restuccia, Executive Director, Community Catalyst, to Mr. Walden and Mr. Pallone, submitted by Mr. Green</td>
<td>156</td>
</tr>
<tr>
<td>Letter of February 2, 2017, from Debra L. Ness, President, National Partnership for Women &amp; Families, to Mr. Walden and Mr. Pallone, submitted by Mr. Green</td>
<td>158</td>
</tr>
<tr>
<td>Statement of the National Women’s Law Center, February 2, 2017, submitted by Mr. Green</td>
<td>160</td>
</tr>
<tr>
<td>State of Wisconsin Report, “Fact Sheet on Mandated Benefits in Health Insurance Policies,” submitted by Mr. Tonko</td>
<td>163</td>
</tr>
<tr>
<td>Statement of Bill Flores, a Representative in Congress from the State of Texas, submitted by Mr. Burgess</td>
<td>171</td>
</tr>
<tr>
<td>Statement of the Blue Cross and Blue Shield Association, February 1, 2017, submitted by Mr. Burgess</td>
<td>172</td>
</tr>
<tr>
<td>Statement of the American Congress of Obstetricians and Gynecologists, February 2, 2017, submitted by Mr. Burgess</td>
<td>175</td>
</tr>
<tr>
<td>Letter of January 2, 2017, from Richard I. Fiesta, Executive Director, Alliance for Retired Americans, to Mr. Burgess and Mr. Green, submitted by Mr. Burgess</td>
<td>180</td>
</tr>
<tr>
<td>Letter of February 2, 2017, from Mary Grealy, President, Healthcare Leadership Council, to Mr. Burgess, submitted by Mr. Burgess</td>
<td>182</td>
</tr>
<tr>
<td>Statement of America’s Health Insurance Plans, February 2, 2017, submitted by Mr. Burgess</td>
<td>184</td>
</tr>
</tbody>
</table>
PATIENT RELIEF FROM COLLAPSING HEALTH MARKETS

THURSDAY, FEBRUARY 2, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:39 a.m., in Room 2123, Rayburn House Office Building, Hon. Michael C. Burgess (chairman of the subcommittee) presiding.


Staff present: Michael D. Bloomquist, Deputy Staff Director; Adam Buckalew, Professional Staff Member, Health; Karen Christian, General Counsel; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Paul Edattel, Chief Counsel, Health; Blair Ellis, Press Secretary/Digital Coordinator; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Communications Director; Peter Kiely, Deputy General Counsel; Katie McKeough, Press Assistant; Carly McWilliams, Professional Staff Member, Health; James Paluskiewicz, Professional Staff Member, Health; Kristen Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Counsel, Health; Hamlin Wade, Special Advisor for External Affairs; Luke Wallwork, Staff Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Jessica Martinez, Minority Outreach and Member Services Coordinator; Dan Miller, Minority Staff Assistant; Samantha Satchell, Minority Policy Analyst; Matt Schumacher, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Member Services, and Outreach; and Arielle Woronoff, Minority Health Counsel.

Mr. BURGESS. I want to thank our guests for being with us this morning. I thank everyone for their indulgence. The Subcommittee on Health will now come to order. I will recognize myself for 5 minutes.
OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

We are all here to help Americans, all Americans, insured, uninsured and functionally uninsured. We want people to get access to quality affordable health care. Our system is plagued with problems that impose the highest burden on individuals and consumers who have fewer choices, sometimes burdensome mandates, costs that continue to spike and—Americans who remain uninsured.

Leading up to the 2016 elections, promises were made to voters that the healthcare system would get back on track. We laid out a step-by-step plan to prioritize access to quality affordable health care not just insurance. The new administration has taken steps to reduce the regulatory burden, and this hearing marks another step in that journey to stabilize and rebuild our healthcare system.

I will be the first to admit we do not agree on everything, but members of this subcommittee, both sides of the dais, have a strong track record of advancing bipartisan legislation. I am confident we can continue to advance bills through an open and through an inclusive process to protect and empower patients.

In today’s hearing we will consider policies that bolster the health markets and reassure Americans that help is on the way. To start, we all agree that individuals should have the comfort of knowing that they will not be denied a health plan from an insurer based upon their health status.

Chairman Walden has offered a bill that will maintain safeguards for patients with preexisting conditions following the repeal of the Affordable Care Act. In addition, Representative Brooks is working on a bill that will go beyond protections for preexisting conditions by creating incentives for continuous coverage.

Currently, individuals moving from one job to another are protected from rate increases by existing law. Extending these protections to the individual market is a simple but important reform that will encourage Americans to enroll in coverage and to stay enrolled. Rather than forcing people to buy insurance that fails to meet their needs, this policy will reward people for making responsible decisions.

Young, healthy adults have faced the highest rate hikes in premiums to account for the higher costs of covering older, less healthy individuals. Today we will discuss legislation offered by Representative Bucshon to modify age rating restrictions and bring younger, healthier individuals into the insurance market.

Regulations have allowed individuals to keep coverage for a full 3 months without paying premiums. Dozens of statutory and regulatory instances allow individuals to enroll in a plan through a special enrollment period. To stabilize the market, Representative Flores and Representative Blackburn have offered legislation intended to end manipulation of health insurance rules.

I look forward to hearing from our witnesses on the merits of setting the grace period to 30 days for nonpayment of premiums and requiring verification of eligibility for those special enrollment periods. I think it is important to note that all of these bills, all of these bills would allow States the flexibility to modify the requirements. After all, States understand what their residents need better than Washington.
Good policy that will stand the test of time requires hard work. It requires compromise. It requires the scrutiny of the American people. As we learned with the Affordable Care Act, policy hastily built by folks behind closed doors results in devastating consequences. We are committed to large-scale reform. Real people are struggling as we speak, and we are not waiting to take action.

These bills are an important example of the work we are doing right now, right now to advance Member-driven solutions that will improve health care for Americans. I am hopeful, hopeful that we can work together to reform our health system for the benefit of the American people.

[The statement of Mr. Burgess follows:]

**Prepared Statement of Hon. Michael C. Burgess**

We are here to help all Americans—insured, uninsured, and functionally uninsured—to get access to quality, affordable health care. Our healthcare system is plagued with problems that impose the highest burden on individuals—consumers have fewer choices and burdensome mandates, costs continue to spike, and as many as 30 million Americans remain uninsured.

Leading up to the 2016 elections, we promised voters that we would get health care back on track. We laid out a step-by-step plan to prioritize access to quality affordable health care, not just insurance. The new administration has taken steps to reduce regulatory burden, and this hearing marks another step in our journey to stabilize and rebuild our healthcare system.

While we do not agree on everything, members of this subcommittee have a strong track-record of advancing bipartisan legislation. I am confident that we can continue to advance bills through an open and inclusive process to protect and empower patients.

In today’s hearing, we will consider policies to bolster our collapsing health markets and reassure Americans that help is on the way. To start, we all agree that individuals should have the comfort of knowing they will not be denied a plan from a health insurer based on their health status. Chairman Walden has offered a bill that will maintain safeguards for patients with preexisting conditions following repeal of the ACA.

In addition, Representative Brooks is working on a bill that will go beyond protections for preexisting conditions by creating incentives for continuous coverage.

Currently, individuals moving from one job to another are protected from rate increases by existing law. Extending these protections to the individual market is a simple but important reform that will encourage Americans to enroll in coverage and stay enrolled. Rather than forcing people to buy insurance that fails to meet their needs, this policy will reward people for making responsible decisions.

Young, healthy adults have faced the highest rate hikes in premiums, to account for the higher costs of covering older, less healthy individuals. Today we will discuss legislation authored by Representative Bucshon to modify age rating restrictions and bring younger healthier individuals into the insurance market.

Regulations have allowed individuals to keep coverage for three full months without paying premiums. Dozens of statutory and regulatory instances allow individuals to enroll in a plan through a special enrollment period. To stabilize the market, Representative Flores and Representative Blackburn have authored legislation intended to end gaming of health insurance rules.

I look forward to hearing from our witnesses on the merits of setting the grace period to 30 days for nonpayment of premiums, and requiring verification of eligibility for special enrollment periods. I think it is important to note that all of these bills would allow States the flexibility to modify these requirements. After all, States understand what their residents want and need better than Washington.

Good policy that will stand the test of time requires hard work, compromise, and the scrutiny of the American people. As we learned during the ACA, policy hastily crafted by Government bureaucrats behind closed doors results in devastating consequences.

While we are committed to large-scale reform, real people are struggling as we speak and we are not waiting to take action. These bills are an important example of the work we are doing right now to advance Member-driven solutions that will improve health care for all Americans. I am hopeful that we can work together to reform our healthcare system for the benefit of the American people.
Mr. BURGESS. And I would now like to yield the remainder of my time to Dr. Larry Bucshon of Indiana.

Mr. BUCSHON. Thank you, Mr. Chairman. Currently the Affordable Care Act requires that the most generous plan costs no more than three times the least generous plan according to age. As a consequence, younger healthier individuals have been priced out of the health insurance market, destabilizing risk pools and driving premiums higher for everyone.

H.R. 708, the State Age Rating Flexibility Act of 2017 would set this ratio at 5:1 or also allow States to set their own age rating based on their unique patient population. For example, Indiana had no age rating prior to the ACA. This solution encourages more actuarially sound plans to enter the marketplace, providing more affordable options for younger, healthier individuals and bringing them back into the insurance market to more adequately balance the risk pools and drive down the premiums for almost everyone.

I yield back.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman, and the Chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for the purpose of an opening statement, please.

Mr. GREEN. Thank you, Mr. Chairman. Before I start, we have a member of our Energy and Commerce Committee but not a member of the subcommittee. I would like to ask to waive on Jerry McNerney, who will be here shortly, and I just wanted to give notice that——

Mr. BURGESS. Is the gentleman making a unanimous consent request?

Mr. GREEN. Yes.

Mr. BURGESS. Without objection, so ordered.

Mr. GREEN. OK, and Congressman Paul Tonko, also unanimous consent.

Mr. BURGESS. Again, without objection, so ordered.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman. Thanks to the Affordable Care Act, 20 million previously uninsured Americans now have health coverage. For the first time ever, less than nine percent of Americans are uninsured with the uninsured rate currently at 8.6 percent. Since the enactment of the ACA, for roughly 150,000 million Americans who have coverage through their employer, premium growth remains much lower than in the past and everyone benefits from consumer protections and provisions that improve and expand coverage.

Unfortunately, my colleagues want to undo the progress we have made. There should be no repeal of healthcare reform without an immediate adequate replacement that achieves the same historical gains in coverage, ensures people with preexisting conditions aren’t blocked or priced out of the market, and that health plans cover a basic set of benefits and consumer protections.

Repealing the Affordable Care Act in whole or in part without an adequate replacement in place would cause chaos and is downright irresponsible. It has been 7 years, and, despite claims to have a
better way, the bills we are considering today will only further sabotage the existing system and offer only unfinished, inadequate proposals that as written would leave Americans worse off and put insurance companies back in charge.

It is truly fitting that today is Groundhog Day, except unlike Bill Murray it is not a comedy. For 7 years we have asked Republicans to work with us to strengthen the ACA and make health care more affordable and accessible, and for 7 years they told us they would not. This is real and not an abstract intellectual debate, and the discussion draft my colleagues have put forward today is just indefensible.

Thirty million people would stand to lose their health insurance if the ACA is repealed. The emergency room should not be the point of entry for our healthcare system. It is bad for patients, budgets and the healthcare system as a whole. Repeal and replace is a slogan not a meaningful policy and would likely put us on a path to catastrophe.

The gravity of the situation is hard to overstate. There are real people with real concerns who deserve more than a half written bill and inadequate talking points. Proceeding with repeal with half-baked ideas for replacement is offensive and confusing and alarming. My colleagues across the aisle control the Congress and the White House. Millions of people are relying on them and looking to them for what they are going to do to protect them. We are well past talking points and the American people deserve answers.

As always, I stand to work with my colleagues, with anyone, to amend and improve the Affordable Care Act. And thank you, Mr. Chairman. I yield the remaining balance of time to Congresswoman Schakowsky.

Ms. SCHAKOWSKY. Thank you. It has been reported that some of our Republican colleagues have recently voiced important and specific concerns about repealing the ACA. And, for example, Congressman Tom McClintock of California, quote, said, “We had better be sure that we are prepared to live with the market being created ... that’s going to be called ‘Trumpcare.’ Republicans will own it lock, stock, and barrel.” And then Congressman Tom MacArthur of New Jersey said, quote, “We’re telling those people that we’re not going to pull the rug out from under them, and if we do this too fast, we are, in fact, going to pull the rug out from under them.”

Mr. Cassidy pointed out that their plan to tax employer-sponsored insurance will increase taxes on the middle class, and these serious concerns and unanswered questions show that Republicans are finally starting to realize what Democrats have known all along, that their plan to sabotage the ACA will leave millions of Americans without coverage, will reduce the quality of insurance, and will raise costs for everyone.

And regardless of the rhetoric that we may hear today, we know that this half-written, half-baked bill put forth by Chairman Walden will allow insurance companies to charge people with pre-existing conditions whatever they want and charge them whatever they want for their coverage. That is what the bill actually does.

Now that Republicans have started to recognize the consequences of their plan to take away coverage from 30 million Americans, I hope that they will finally actually work with us to make health
care more affordable and more accessible. We are ready to sit down. We have been ready for 7, 8 years to do exactly that. Let’s do it.

I do agree with the chairman of the subcommittee that we all agree that we want to provide quality, affordable health care. Those Republicans who have misgivings are right to have that. So let’s sit down and do it together instead of these continual proposals that will hurt all of our constituents. And I yield back to the gentleman from Texas.

Mr. BURGESS. The gentlechair thanks the gentlelady. The gentlelady yields back. The Chair would like to recount the number of times it was rebuffed by the Obama administration on those very points, but I will reserve that until later. The Chair now recognizes the chairman of the full committee, Mr. Walden, 5 minutes for questions, please, for an opening statement, please.

OPENING STATEMENT OF HON. GREG WALDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. WALDEN. Yes, thank you. Thank you, Mr. Chairman, I appreciate it and I appreciate the concerns of my colleagues. I would note from the record there have been multiple pieces of legislation since Obamacare was enacted that have received Democrat and Republican votes and actually signed by the President to repeal problems in Obamacare. Those became law.

So to argue that nothing has ever been done to try and straighten it out is false. I think Democrats combined cast 4,775 votes to repeal, to reform, to change Obamacare, so check the facts. We are here today, we know on our side we are going to repeal Obamacare. It is not working. It has left a lot of wreckage around. We are here to clean it up. And in fact we are wide open to hearing from our colleagues on policy. That is what we are about.

We know Obamacare has, what it has done to the healthcare system. It is why we are hard at work crafting reconciliation language to repeal it, and today we begin the important work of laying the foundation to rebuild America’s healthcare markets as we dismantle Obamacare. We have to save this individual healthcare insurance market. It is collapsing. And if you want to walk away and just let it collapse, a pox on your side. That is not what I am about. I have always been a problem solver.

You will hear us in a minute talk about bipartisan legislation, go after those who try and corner certain markets, drive up costs—things like EpiPen. I am happy to work with you, but it has to be something that can move this forward and take care of people. There is no shortage of evidence that patients and families are hurting under the overwhelming weight of Obamacare. Patients in 21 States have seen average premium increases of 25 percent or more this year. People in seven States will experience premium increases of 50 percent or more. That is not sustainable.

In 2016 there were 225 counties across America that had just one insurance choice in the market, just one on the exchange. This year that number has climbed to a 1,022, 1,022 counties with just one insurer. That is a third of the entire number of counties in the country, a third. Five entire States now, patients there have just one choice.
And if you focus on what those plans are saying, they are evaluating right now whether they can even stay in these markets in the outlying years because of what is coming in existing law passed in a partisan manner by Democrats. Over five of the original 23 insurance co-ops remain in business, five of 23. They tried it, it didn't work. Two of those failed co-ops are sadly in my own State of Oregon and we are pretty progressive about trying new things and a lot of it has worked. These did not.

We have the responsibility to prevent a real train wreck for millions of Americans. Not only can we solve this problem but we must solve this problem. It is time to end the partisan rhetoric and actually come to the table and solve these problems and I commend my colleagues on both sides of the aisle who are willing to do that.

The proposals before us today close enrollment gaps, protect taxpayers and give patients cost relief. The first three bills should come as no surprise. They were introduced last Congress and were the topic of two hearings in this subcommittee. The other proposal is equally important to all of us. We will ensure patients with pre-existing conditions will always have access to coverage and care, period.

To take this a step further, we have included a placeholder as all of you have sort of referenced in your testimony, and I appreciate your testimony. Everybody has a different view of this. We want to get it right. That is why there is placeholder language. Our Better Way agenda envisions a new patient protection in the individual market for helping patients keep health coverage. HIPAA, Medicare Part B, Medicare Part D can serve as guidance for the Congress as we consider how best to achieve the goals of protecting America’s sickest patients and maintaining market stability. We can do both without Obamacare’s unpopular individual mandate where all these carve-outs have occurred.

We have got the best minds focused on helping us, including our witnesses today. We are going to get this right. We are going to take the time to get this right. That is why you see a placeholder language in the draft. And my colleague Susan Brooks is championing these efforts and I would actually like to yield her a few minutes for remarks at this time, and then I will conclude with one other announcement.

[The statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

We all know the damage Obamacare has wrought on our healthcare system, which is why this committee is hard at work crafting reconciliation language to repeal it. But today, we begin the important work of laying the foundation to rebuild America’s healthcare markets as we dismantle Obamacare; especially, saving the individual market from total collapse—which is where it is headed absent our intervention.

Look, there’s no shortage of evidence that patients and families are hurting under the overwhelming weight of Obamacare.

- Patients in 21 States have seen average premium increases of 25 percent or more this year.
- Folks in seven States will experience premium increases of 50 percent or more.
- In 2016, 225 counties had one insurer. This year, there are 1,022 counties with just one insurer—that’s a third of the entire country.
- Five entire States just have one insurer offering coverage on the exchange.
- Only five of the original 23 health insurance co-ops remain in business. In my home State of Oregon, we had not one, but two co-ops fail!
We have the responsibility to prevent a real train wreck for millions of Americans. Not only can we solve this problem, but we must solve this problem.

The proposals before us today close enrollment gaps, protect taxpayers, and give patients cost relief. The first three bills should come as no surprise—they were introduced last Congress, and were the topic of two hearings in this subcommittee. The other proposal is equally important to all of us. We will ensure patients with preexisting conditions will always have access to coverage and care. Period.

To take this a step further, we’ve included a placeholder for a continuous coverage incentive. Our Better Way agenda envisions a new patient protection in the individual market for helping patients keep health coverage. HIPAA, Medicare Part B and Medicare Part D can serve as guidance for the Congress as we consider how to best achieve the goals of protecting America’s sickest patients and maintaining market stability. We can do both without Obamacare’s unpopular individual mandate.

We’ve got the best minds focused on helping us, including our witnesses today. We are going to take time to get it right. That’s why you see placeholder language in the draft, today. My colleague, Susan Brooks is championing these efforts, and I’d like to yield to her for a few remarks. Mrs. Brooks. ...

Thank you, Susan.

While I know our focus today is on insurance reforms, we are also working in other areas of health care to bring relief to patients. Next week, we will take up legislation sponsored by Rep. Gus Bilirakis and Rep. Kurt Schrader that would incentivize generic drug development and increase competition in the market. And for those in industry who think it’s OK to corner a market, drive up prices and rip off consumers, know that your days are numbered.

President Trump made it clear in the White House meeting I attended with him and Vice President Pence: He wants competition that will bring lower drug prices and that is precisely what this measure will accomplish. Patients are tired of waiting for relief. We are going to move forward in a bipartisan way to give them help. It’s an important step forward. And it needs to happen now.

Specifically, the bill would require FDA to prioritize and expedite the review of generic applications for drug products that are currently in shortage or where there are few manufacturers on the market, if any. We all remember recent situations where bad actors jacked up the price of older, off-patent drugs because there was no competition. We want to make sure that doesn’t happen again.

This bill would also increase transparency around the current generic backlog at FDA. While progress has been made, there are still an unacceptably high number of generic drug applications sitting at FDA that, if and when approved, could bring additional lower cost alternatives to patients. Whether it’s examples like Daraprim or EpiPen, patients need solutions and this bipartisan bill gives us all a new tool to fight back on their behalf.

Mrs. BROOKS. Thank you, Mr. Chairman. Yes, I agree. We all agree we have to save the individual market, yet we all know current law requires individuals to buy Government-dictated insurance. Instead, we propose giving people freedom from this mandate, it is only fair. Continuous coverage isn’t a new idea. It has been discussed by reputable public policy organizations like the economic and political freedom center at Hoover Institution, free enterprise-focused American Enterprise Institute and others.

We don’t pretend that this is the only solution, but we are confident that continuous coverage provides promise. That is why it is part of our Better Way Plan, a fairness agenda for helping patients get relief. And today this placeholder provides the clearest signal yet that we are working with patients and healthcare groups to draft language that balances important health status protections with necessary risk mitigation tools.

I look forward to the panelists’ expert feedback today on the value of how this idea might help patients get and keep health coverage, and with that I yield back.

[The statement of Mrs. Brooks follows:]
Thank you, Mr. Chairman. As we all know, current law requires individuals to buy Government-dictated insurance. Instead, we propose giving people freedom from this mandate—it’s only fair.

Continuous coverage isn’t a new idea. It’s been discussed by reputable public policy organizations like the economic and political freedom-centered Hoover Institution and the free enterprise-focused American Enterprise Institute. This coverage incentive has also been contemplated in publications by Rand Corporation, Urban Institute, and others.

We don’t pretend that this is the only solution. But we’re confident that continuous coverage provides promise. This is why it’s part of our Better Way plan—our fairness agenda for helping patients get relief. And today, this placeholder provides the clearest signal yet that we’re working with patients and healthcare groups to draft language that balances important health status protections with necessary risk mitigation tools.

I look forward to the panelists’ expert feedback on the value of how this idea may help patients get—and keep—health coverage.

Mr. WALDEN. Mr. Chairman, if I could just conclude. While I know our focus today is on insurance reforms, we are also working in other areas of health care to bring relief to patients. Next week we will take up legislation sponsored by Representatives Bilirakis and Schrader, bipartisan bill that would incentivize generic drug development and increased competition in the market.

And for those in the industry who think it is OK to corner a market and drive up prices and rip off consumers, know that your days are numbered. President Trump made it clear in the White House meeting I attended with him and Vice President Pence, he wants competition that will bring lower drug prices and that is precisely what this measure will help accomplish.

Patients are tired of waiting for relief. We are going to move forward in a bipartisan way to give them help. It is an important first step. It needs to happen now. Specifically, the bill would require FDA to prioritize and expedite the review of generic applications for drug products that are currently in shortage or where there are few manufacturers on the market.

We all remember recent situations where bad actors jacked up the price of older, off-patent drugs because there was no competition. We want to make sure that does not happen again. This bill would also increase transparency around the current generic backlog at FDA, and while progress has been made there are still an unacceptably high number of generic drug applications sitting at the Food and Drug Administration that if and when approved could bring additional lower cost alternatives to patients.

Whether it is examples like Daraprim or EpiPen, patients need solutions. I believe this bipartisan bill gives us a new tool to fight back on their behalf. I thank you for the indulgence of the committee and I yield back the balance of my time.

Mr. BURGESS. The Chair thanks the gentleman. The Chair recognizes the gentleman from New Jersey, Mr. Pallone, 5 minutes for an opening statement, please.
OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. Pallone. Thank you, Mr. Chairman. I am trying not to blow up here today because I like Chairman Walden, he is a nice guy. I like the gentlewoman from Indiana, she is a lovely woman. But I just, the statements that are coming out from the two of you about what you think you are doing versus what is really happening here are very disturbing to me.

No one has a problem with making improvements to the ACA, but you are not seeking to make improvements. You are seeking to repeal it without saying how you are going to replace it. And, you know, you can do a little, you know, if you really wanted to make some changes and do some things without repealing it, you know, we would be fine to work together, but there is no suggestion of that. And the idea that this is collapsing of its own weight is simply not true.

The reason that the ACA is going to have problems here is because you and the President are purposely, in my opinion, making it collapse because of the policies that you are espousing. You know, the best example of that was when the White House last week announced that they weren't going to do anymore promotion. They were going to pull the ads, so that people wouldn't even be able to sign up or wouldn't even know what they were signing up for.

So, you know, don't suggest to me that somehow this is going to collapse because of the bill, because of the ACA. It is going to collapse because of purposeful Republican policies. And, you know, the gentleman from Indiana mentioned the individual mandate. You know that without the individual mandate that the younger and healthier people are not going to sign up, and then the insurance pool becomes broken and then the insurance companies pull out and gradually the ACA collapses, again if you eliminate the individual mandate.

So I just have to say, you know, Republicans have been rooting for the demise of the Affordable Care Act for 7 years, actively trying to sabotage the law. They have done this under the guise of having a better way, but today it is clear that this was never the case. Now that the time has come for them to actually show the public this better way they are in complete disarray and today it is clear that Republicans have no plan to replace the ACA. Every day their timeline changes and all they have successfully done so far is create chaos and uncertainty among patients and insurance companies. Chaos here with the ACA, chaos with immigration, chaos with foreign policy, the list goes on from this badly motivated person, in my opinion, who is in the White House.

The bills we are discussing today are supposedly the first pieces of the Republicans' elusive plan, so essentially, after a 7-year smear campaign on the ACA, they intend to move forward three bills from last Congress that help insurance companies instead of people.

And another bill, the only so-called replacement, is literally half-written. You know, I had to laugh—again I love you, Dr. Burgess, but I had to laugh when you said that the ACA was hastily built
upon. I mean, the chairman's bill literally runs off the page. I mean, I took it this morning and I started to read it, and then I got to “Title II 09 Continuous Coverage,” it says, “incentive [placeholder].” Talk about hasty built, what is this, half-built? I mean, I just, I don't even know where to begin.

[The statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Since 1965, the Medicaid program has been an invaluable resource to poor families, pregnant women, children, seniors, and now, thanks to the Affordable Care Act, low-income working adults. It is also the program that individuals with disabilities depend on to maintain independence in the community.

In 2016, over 97 million Americans depended on Medicaid at some point during the year. Together, Medicaid and CHIP cover 1 in 3 children in this country, and nearly half of all births. It is undeniable that Medicaid coverage pays us back as a society tenfold—that's why improving and strengthening Medicaid for generations to come continues to be one of my primary goals.

Last Congress, this committee worked together on targeted policies that genuinely strengthened and improved the Medicaid program for beneficiaries. Unfortunately, the bills before us today do not share these priorities. In fact, one piece of legislation continues the Trump administration's assault against our legal permanent resident population and naturalized citizens.

The Republican strategy to strengthen Medicaid is to remove or exclude certain people from the program and then apply those resources to another person. This is a meaningless approach to resource management. There is no evidence to suggest that some beneficiaries take away resources from others, or that excluding some beneficiaries will benefit others.

In today's hearing we will discuss three bills that are based on this very falsehood, bills that target specific beneficiaries for exclusion. Bills that ultimately incentivize and reward those States that choose to operate waiting lists for Home and Community Based Services.

In order to truly strengthen the Medicaid program, we should expand coverage, protect against fraud, and implement advanced delivery system reform. The Affordable Care Act did just that. Thanks to the Affordable Care Act, 31 States and the District of Columbia have adopted expansion and dramatically lowered the uninsured rate. All 50 States are testing innovative models of care, and Medicaid eligibility and data collection systems have been modernized.

Medicaid has always been under attack by Republicans, but the threat to this program and to its beneficiaries is more dangerous than ever before. Republican policies to cap or turn the program into a block grant would result in the rug being pulled out from under millions of children, elderly, individuals with disabilities and low-income working adults. These policies are nothing but bad for our providers and our State economies. In fact, one analysis by the Kaiser Family Foundation found that block granting Medicaid would lead States to drop between 14.3 million and 20.5 million people from Medicaid, an enrollment decline of 25 to 35 percent, and would lead States to cut provider reimbursements by more than 30 percent.

Republicans keep saying that they have a plan—and that Americans will not lose their health coverage. It's clear today, that the Republicans only game plan right now is to sabotage health coverage for tens of millions of Americans.

I yield back.

Mr. PALLONE. I am going to stop, because I have to give some time to Congressman Kennedy and then, if there is also time, to Representative Castor, so I will yield to the gentleman from Massachusetts initially.

Mr. KENNEDY. Thank you, and I thank the ranking member. I want to thank Chairman Burgess and Ranking Member Green for their leadership as we confront one of the most contentious debates this body will address in the coming year. All of us in the subcommittee can agree that there is room for improvement in our healthcare system from premium deductibles that should be lower,
insurance options in rural and underserved areas that must be increased.

But there are also areas where the law is working well. In Massachusetts we have a 2.8 percent unemployment rate and a 2.8 percent uninsured rate. On this side of the dais we are happy to have the debate about fixing the Affordable Care Act, but repealing the ACA without a replacement, and the four half measures today before us are not a replacement, will only exacerbate those problems. More than that it will erode the very minor progress that we have made to reform our mental healthcare system in this very room last year with 21st Century Cures.

For the roughly 43 million Americans suffering from mental illness, parity laws that currently guarantee coverage will crumble. For the 30 percent of patients with a mental health issue that is covered by the Medicaid expansion treatment will no longer be within reach. For constituents in all of our districts, red or blue, rural and urban, preventive screenings for behavioral health that can save lives will be unaffordable and inaccessible. Simply put, no matter where you live if you have coverage or you are uninsured, you are on an uncertain path that will lead to seismic, tragic shifts in our behavioral healthcare system. Today is an opportunity for all of our colleagues to commit to changing course. I yield back.

Mr. Pallone. Mr. Chairman, Mr. Walden had like an extra minute and a half, and I would like Ms. Castor to have a minute if possible. I would ask unanimous consent.

Mr. Burgess. Are you asking a unanimous consent request? So ordered.

Ms. Castor. Well, thank you very much. Members, the fear across America is widespread about the Republican plan to withdraw this lifeline that is the Affordable Care Act. I wanted to tell you about a woman who approached me recently back in Tampa. Sixty-year-old Kathy Palmer is a single parent with a student in high school. She is doing everything right. She is working part-time at a small company. She is working towards her bachelor's degree in accounting. She is paying her fair share in taxes.

She took personal responsibility—because her company is so small and doesn't provide health insurance—she took personal responsibility and went shopping out on healthcare.gov, and in our very robust market, far from collapsing in the Tampa Bay area, where we have 61 plans to choose from, she chose a plan and she has been paying her premiums.

And thank goodness for that, because in December she wound up in the hospital with what she thought was a heart attack. When she got out of the hospital that bill for all the care she received was $70,000. Without the Affordable Care Act, she would be bankrupt. Her future and probably her child's future would have been very bleak.

So I ask my Republican colleagues to listen to our constituents all across this country. Before you go and do the damage of repealing the Affordable Care Act, understand what it will mean for the families that we represent and their economic futures. I yield back.

Mr. Burgess. Does the gentleman from New Jersey yield back? Mr. Pallone. Yes, Mr. Chairman.
Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. We now conclude with Member opening statements. The Chair would remind Members that, pursuant to committee rules, all Members’ opening statements will be made part of the record. We want to thank our witnesses for being here today, for taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement followed by questions from our Members.

We are pleased today to welcome Dr. Doug Holtz-Eakin, no stranger to this committee room, president of the American Action Forum; Mr. J.P. Wieske, deputy commissioner for insurance for the State of Wisconsin; and Dr. Leonard Lichtenfeld, deputy chief medical officer for the American Cancer Society.

We appreciate each of you being here today. We will begin our panel with Dr. Holtz-Eakin, and you are recognized 5 minutes for the purpose of an opening statement.

Mr. KENNEDY. Mr. Chairman, just before we begin the statements, I would like to raise a parliamentary inquiry.

Mr. BURGESS. The gentleman from Massachusetts, for what purpose does the gentleman from Massachusetts seek recognition?

Mr. KENNEDY. Mr. Chairman, I ask a parliamentary inquiry to try to understand from you, sir, given what we have learned in the past several days about coordination between various House staffers and the administration and transition team and the signing of nondisclosure agreements——

Mr. BURGESS. The gentleman——

Mr. KENNEDY. Mr. Chairman, I ask a parliamentary inquiry to try to understand from you, sir, given some of the hearing——

Mr. BURGESS. The gentleman will state his parliamentary inquiry.

Mr. KENNEDY. I would like assurance, Mr. Chairman, given what we have learned in the past several days about coordination between various House staffers and the administration and transition team and the signing of nondisclosure agreements——

Mr. BURGESS. The gentleman——

Mr. KENNEDY. Would like to understand if such agreements——

Mr. BURGESS. The gentleman has actually not stated a parliamentary inquiry, but I do want to accommodate your request. We are here of course to take testimony on bills before the committee. I think that can proceed, and I will defer to the chairman of the full committee for a discussion with you on your parliamentary inquiry.

The gentleman, Dr. Holtz-Eakin, is recognized for 5 minutes for an opening statement, please.

Mr. KENNEDY. So Mr. Chairman, when—I appreciate your deference to the full committee chairman as to what is going to happen next. What, just so I understand given as you did indicate the challenge of hastily built——

Mr. BURGESS. The gentleman did not state a parliamentary inquiry.

Mr. KENNEDY. And so my question about——

Mr. PALLONE. He didn’t finish his sentence.

Mr. KENNEDY [continuing]. The existence of nondisclosure agreements is unanswered, so it is unanswered.

Mr. BURGESS. The gentleman, Mr. Holtz-Eakin, is recognized 5 minutes for the purpose of summarizing your opening statement.

Mr. GRIFFITH. Mr. Chairman. Mr. Chairman, parliamentary inquiry.

Mr. BURGESS. For what purpose does the gentleman from Virginia seek recognition?
Mr. GRIFFITH. Mr. Chairman, I inquire that if a Member asks a question that is not a parliamentary inquiry, is it not improper for the chairman to answer?

Mr. BURGESS. Yes.

Mr. GRIFFITH. So then you would actually be out of order if you attempted to answer Mr. Kennedy's question. Am I not correct?

Mr. BURGESS. Yes.

Mr. GRIFFITH. I yield.

Mr. PALLONE. Mr. Chairman.

Mr. BURGESS. For what purpose does the gentleman from New Jersey seek——

Mr. PALLONE. I just, I am not sure I understood what you were saying. You are saying you are going to get back to us about—I understand you are saying it is not a parliamentary inquiry, but did you say you are going to get back to Mr. Kennedy and respond to his question, or that Chairman Walden would? Is that what you said?

Mr. BURGESS. Well, the parliamentary inquiry was not about the proceeding with today's hearing on taking testimony from witnesses on the bill in front of us. I do respect the gentleman from Massachusetts a great deal, as he knows, and I do want to see his question answered for him, and I will seek the proper forum with the chairman of the full committee for him to do so.

Mr. PALLONE. So you will get back to us to respond to his question.

Mr. BURGESS. We will seek the appropriate forum.

The gentleman, Dr. Holtz-Eakin is recognized.

Mr. BUTTERFIELD. Mr. Chairman. Mr. Chairman.

Mr. BURGESS. For what purpose does the gentleman from North Carolina seek recognition?

Mr. BUTTERFIELD. I have a unanimous consent request.

Mr. BURGESS. The gentleman will state his unanimous consent request.

Mr. BUTTERFIELD. I would ask unanimous consent that the gentleman from Massachusetts be allowed to restate his parliamentary inquiry because I did not hear it. He was interrupted in the middle of the sentence.

Mr. GRIFFITH. I object.

Mr. BURGESS. Objection is heard.

The Chair yields 5 minutes to Dr. Holtz-Eakin for the purpose of summarizing your opening statement.

STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PH.D., PRESIDENT, AMERICAN ACTION FORUM; J.P. WIESKE, DEPUTY COMMISSIONER, WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE; AND J. LEONARD LICHTENFELD, M.D., DEPUTY CHIEF MEDICAL OFFICER, AMERICAN CANCER SOCIETY

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Dr. Holtz-Eakin, Thank you. Mr. Chairman, Ranking Member Green, members of the committee, I appreciate the chance to be here today to discuss these proposals to stabilize the ACA individual market. I am going to make three simple points. Point number one is that doing nothing is not an option. Under current law
the trend in the individual market is quite bad in terms of premiums rising, insurers exiting and coverage ultimately declining.

Second is that the proposals under consideration, reforms to grace periods, special enrollment periods, the age rating bands and continuous coverage provisions are all sensible policy that I would hope would garner bipartisan support. And then third that if indeed these measures were enacted there would still be much work left to do; that that would not be enough to stabilize them. Let me elaborate on each and then I look forward to your questions.

Under current law the exchanges are headed in the wrong direction. In 2017, the benchmark Silver Plans rose at an average rate of 27 percent coming on the heels of ten percent rises in 2016, so the insurance is becoming increasingly expensive. As was noted by Mr. Walden, in five States and in one-third of U.S. counties there is only one insurer that is a choice for those participating in this market.

Seventeen of 23 co-ops have failed and the insurance that is out there is not really equivalent to affordable care. Eighty-four percent of participants require taxpayer assistance to purchase these policies and when they do they face family deductibles that are about average $7,400 in the Silver Plans, average $12,300 in the Bronze Plans, which means in many cases they are never getting to the point where the insurance is paying anything even after they have purchased it. My expectation is that if current law were unchanged and things were left on autopilot we would see exchange enrollments decline, decline substantially perhaps as low as eight million or so by 2020.

Clearly something needs to be done. In each case these measures would tend to improve the risk pools, lower the premiums and thus attract people in and stabilize the markets in that fashion. Grace periods in the Affordable Care Act are 90 days. In all but two States, grace periods off the exchanges would be 30 or 31 days. So the playing field is not level in the individual market between off-exchange and on-exchange products. These long grace periods raise the prospect of an individual paying for 9 months and actually consuming a full year’s worth of healthcare coverage. That leads to obvious problems for insurers and the costs have to be shifted.

In some cases they will be shifted to the taxpayer and in some cases they will be shifted to other customers in the form of higher premiums and thus exacerbating the upward pressure on premiums. And in some cases insurers will be obligated to pay only 1 month of those costs and 2 months will be shifted to providers who will no longer want to participate in providing care to the people who need it in these markets. Moving the grace periods to match those off the exchange would be a very sensible way to take those pressures off.

For the special enrollment periods the ACA has 30 conditions in which individuals can enroll. By comparison, Medicare has seven and HIPAA provides for three. These special enrollment periods are a way for high cost patients, and all the evidence which is in my testimony suggests they are higher cost than the other enrollees, to enter into the market. Again insurers have to jack up premiums in anticipation of this and the result is that a large number,
perhaps as many as a third of the participants in the individual market, have entered using this mechanism. Tightening them up would be a sensible way to stabilize the market and take pressure off premiums.

The age ratings are 3:1. This relatively raises the cost of insurance for the young and healthy that is a group that has under-enrolled in the ACA exchanges. Getting them in is a key part of stabilizing it. Moving to 5:1 would match the data that is the ratio in costs and be a sensible thing for the committee to consider.

And then lastly is the proposal for continuous coverage. Here I think it is simply the case that the individual mandate is not working as envisioned. There are about six and half million people in 2015 who simply paid the penalty. There are another 12.7 who are simply exempt. The continuous coverage provision would be a way to encourage the young to enter the market at the age of 26, buy coverage, remain covered, and because they remain covered they can never be medically underwritten and charged a special premium because of a preexisting condition. It is a way to stabilize the pools and to ensure that they do not continue to deteriorate.

So I thank the committee for the chance to be hear today. I think these are sensible ideas which would be good steps towards stabilizing the individual markets, and I look forward to answering your questions.

[The statement of Dr. Holtz-Eakin follows:]
Patient Relief from Collapsing Health Markets

U.S. House of Representatives
Energy and Commerce Committee
Subcommittee on Health

Douglas Holtz-Eakin, President*
American Action Forum

February 2, 2017

*The views expressed here are my own and not those of the American Action Forum. I thank Juliana Darrow, Tara O'Neil Hayes, and Christopher Holt for their assistance.
Chairman Burgess, Ranking Member Green, and members of the Subcommittee, thank you for the opportunity to testify today regarding ways in which policymakers may provide relief to participants in the Affordable Care Act’s (ACA) collapsing health insurance markets.

The individual market is in dire need of improvement. Exchange enrollment is low, premiums are rising and insurers are leaving the market. However, actions can be taken to stabilize and even improve the individual marketplace until a replacement plan is fully implemented. There are several simple changes that, if enacted, will provide relief to both consumers and insurers. As I have previously testified, these common-sense improvements to the current law should have bipartisan support.

In this testimony, I hope to convey three main points:

1. Given current law, doing nothing is not an option. The ACA is in a downward spiral. Prices will continue to rise and insurers will continue to leave unless significant changes are made.

2. These reforms are good policy regardless of the performance of the markets or the political climate. They should receive bipartisan support.

3. While these changes will certainly help, they will not be enough to produce a vibrant individual market. More will need be done to stabilize the market until a replacement plan can be fully implemented.

Let me consider the reforms in turn.

Grace Periods

Under the Affordable Care Act (ACA), customers buying subsidized insurance coverage on the Exchanges are given a 90-day grace period during which insurers must continue offering coverage even if premiums are not paid. This means that consumers on the Exchange can receive coverage for twelve months while only paying for nine. Individuals can easily take advantage of this provision by not paying premiums but continuing to use care. Insurers are not allowed to cancel coverage even if the individual continues using medical care for 90 days. This creates an uneven playing field for both insurers and taxpayers because grace periods are often much shorter in the individual market off the Exchange. As of 2012, all but two states had grace period requirements of 30 or 31 days for plans offered in the individual market.

Additionally, nonpayment does not prevent future insurance coverage. Health insurance companies cannot refuse enrollees that have had plans cancelled due to failure to make previous payments, or use premiums paid for new coverage to cover outstanding debt. A McKinsey study found that 21 percent of Exchange plan enrollees in 2015 stopped paying for coverage at some point during the year. In 2016, half of those individuals (49 percent) repurchased the same plan they had stopped paying for the year before; two thirds (67...
percent) of those same individuals had also stopped paying for coverage at some point during the 2014 plan year.4

Insurance companies are financially responsible for claims incurred only during the first month of missed premium payments, meaning that doctors are at risk of not being paid for care consumed at their offices for the last 60 days of a grace period. Plans on the Exchange have 34 percent fewer providers than commercial plans offered off the Exchange.5 The risk of not being paid for up to two months may be contributing to this phenomenon.

When setting yearly premiums, insurers, and providers both must take the potential of nonpayment into account and therefore raise prices for everyone. These increased premiums are also passed on to the taxpayers who are responsible for subsidizing the cost of 84 percent of individuals purchasing insurance through the Exchange.6 Aligning grace periods on and off the Exchange will level the playing field among consumers, and reducing the 90-day grace period could significantly diminish the risk of losses for insurers and providers. This would help stabilize the insurance market and decrease costs for all consumers and taxpayers.

Special Enrollment Periods

The ACA has allowed for over 30 circumstances in which an individual may enroll in an Exchange plan through a Special Enrollment Period (SEP).7 Medicare allows just seven of these instances, while the Health Insurance Portability and Accountability Act (HIPAA) requires three.8 Many individuals shopping for coverage on the Exchange take advantage of the ability to sign up for coverage throughout a plan year. Analysis by America’s Health Insurance Plans (AHIP) shows that in the first two years of marketplace enrollment, up to one third of enrollees gained coverage through special enrollment periods.9 Between February and June of 2015 nearly 950,000 people signed up for coverage through SEPs on healthcare.gov.10 The abundance of qualifying circumstances and the lack of a robust SEP eligibility verification process undermines the business model that insurers rely on and destabilizes the market. Too much SEP flexibility can cause individuals to wait until they are sick to enroll in coverage; this would be like waiting for your house to catch fire before buying homeowners insurance.

Multiple large insurers have tabulated statistics and expressed concerns about the misuse of SEPs. Individuals enrolling through SEPs had health care costs 24 percent higher than individuals who enrolled during open enrollment in the first three months of coverage in 2014.11 Data from Covered California shows that cost differences between customers who enroll through SEPs were 15 percent to 50 percent higher than those who enrolled during open enrollment in the four largest state plans.12 UnitedHealth reports that more than 20 percent of its marketplace customers did not sign up during open enrollment and that those customers use 20 percent more health care.13 Blue Cross Blue Shield Association calculates that exchange customers using SEPs are 55 percent more expensive than the enrollees who are covered through open enrollment.14
Individuals who enroll in coverage during SEPs are also more likely to drop coverage. Anthem reports that enrollees who use SEPs are more than twice as likely to drop coverage after a short period of time. Aetna reports that SEP enrollees stay on a plan for less than four months, on average, while enrollees who sign up during open enrollment maintain coverage for an average of eight to nine months.\(^\text{15}\)

Instituting a formal process requiring documentation for eligibility verification will help to reduce the number of individuals taking advantage of the current enrollment system. Requiring eligibility to be verified prior to coverage becoming effective would reduce the number of fraudulent claims. To protect individuals who are eligible and in need of urgent care, coverage could be made retroactive to the day of application, once eligibility was confirmed. Congress should also be informed of the number of individuals who attempt to enroll during an SEP but are unable to do so. Information on whether enrollment was not permitted because the individual did not submit necessary documentation or because the documentation was invalid should also be provided. This will allow policymakers to make more informed decisions on needed policy changes.

**Age Rating Bands**

The ACA only allows for a 3:1 difference in premiums between the youngest and oldest individuals in an insurance pool. However, average health care expenses for a 64 year old are 4.8 times greater than that of a 21 year old.\(^\text{16}\) Because this 3:1 rating does not reflect the actual difference in health care costs between the young and the elderly, it artificially inflates premiums for younger and healthier individuals forcing them to further subsidize coverage of older and typically sicker individuals.

These high premiums have caused low enrollment of young adults on the Exchange. In 2016, 3.5 million young adults (18-34) enrolled in Exchange plans. This represented only 28 percent of enrollees even though this age group was anticipated to make up around 40 percent of the enrollee population.\(^\text{17}\) According to US Census data, the uninsured rate for those aged 19-34 is 4.6 percent higher than the uninsured rate for those aged 35-64.\(^\text{18}\)

Increased enrollment among young adults would contribute to market stability by infusing the risk pool with more low-risk individuals. Adjusting the age rating limit to allow premiums to reflect the pre-ACA average cost difference of 5:1 would reduce premiums and remove some of the financial disincentive preventing younger people from purchasing insurance. This is a standard provision across ACA replacement plans, because better aligning premiums with costs is the only way to allow insurance to work without excessive regulations.

**Continuous Coverage**

Continuous coverage provisions are a standard feature of many ACA replacement plans. This type of policy serves as an alternative to the individual mandate. In addition to the intrusion on individual liberty, the individual mandate has proved to be less effective than expected. Many individuals, particularly the younger, healthier individuals just discussed,
choose to forego insurance, and pay the associated penalty instead of purchasing coverage they do not want or need. Preliminary Internal Revenue Service reports state that 6.5 million people paid the penalty for not having coverage in 2015. An additional 12.7 million people were exempted from the mandate. Based on calculations made from Congressional Budget Office projections, AAF estimates that 2.7 million people were expected to pay the penalty in 2015. This large difference in reality compared to projections suggests that the individual mandate is a flawed and ineffective mechanism for ensuring insurance coverage for Americans.

The continuous coverage model, on the other hand, incentivizes individuals to purchase coverage without taxing those who choose to go without. Under such a policy, any individual who remains continuously covered would be permanently protected against medical underwriting in which insurers set premiums based on one's health status. This incentivizes both healthy and unhealthy individuals to enroll and maintain coverage. People with pre-existing conditions who were already insured would simply have to maintain coverage to benefit from these protections. Everyone who is currently uninsured, whether having a pre-existing condition or not, would be provided a one-time open enrollment period to gain coverage so they, too, could receive the benefit. This protection would especially incentivize young individuals to buy insurance because they would be guaranteed relatively low premiums throughout their lifetime. Again, bringing these individuals into the market would greatly stabilize the insurance risk pool, which would allow insurers to compete for these new market entrants by providing policies with lower premiums and greater benefits. Continuous coverage requirements would also incentivize insurers to invest in preventive and wellness services that will keep their consumers healthy and their costs down as they age.

Conclusion

Substantial reform is imperative to ensure a successful health insurance market, but in the meantime, enacting legislation that resolves at least some of the problems in the short term is essential. The changes discussed here today, while necessary, will not fix everything. Additional financial resources will also be needed to both keep insurers in the individual market and the millions of individuals relying upon them for coverage.
Notes

1 https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/
3 http://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/
4 http://avalere.com/expertise/managed-care/news/0226-03-34-percent-fewer-providers-than-the-average-for-comm-
14 http://www.americanactionforum.org/insight/age-bands-affordable-care-act-simple-changes-can-go-a-long-
18 AAF projection is based on the total amount of expected revenue from payment of penalties in 2015 divided by 2 percent of the national
19 median income that year, as the penalty in 2015 was either $325 or 2 percent of income, whichever was greater. Thus, this is a low estimate of
20 the number of individuals who were expected to pay the penalty in 2015.
Mr. Burgess. The Chair thanks the gentleman. Mr. Wieske, you are recognized 5 minutes to summarize your opening statement, please.

STATEMENT OF J.P. WIESKE

Mr. Wieske. Thank you, Chairman, and thank you, Ranking Member. I appreciate the time and the effort in discussing this important issue. As you know, as a regulator in the State of Wisconsin we have been on the front lines of having to deal with the issues surrounding the implementation of Obamacare. It has been frustrating to hear consistently that the folks don’t seem to understand that States have an important role here and that States do have existing laws in place that have protected their consumers.

I would like to just kind of flash back before the ACA and talk a little bit about the Wisconsin insurance market before the ACA, what happened with the ACA, and what we hope to see in the future. In short, prior to the ACA Wisconsin had an excellent uninsured rating and we continue to do so in Wisconsin. We could rate consistently in the top six for the least number of uninsured. We still rank in the top six for the number of uninsured in the last report.

Wisconsin covered its folks who were vulnerable and were not eligible for the private market through a high-risk pool. And I know there has been a lot of talk about high-risk pools across the country. Wisconsin’s high-risk pool works, worked while it existed. In fact, I got a call 2 weeks ago from a legislator who had constituents asking him to reinstate the Wisconsin high-risk pool because the coverage they had under Obamacare was inferior to what they had under the high-risk pool.

They had numerous plan options. The coverage was obviously expensive. There is no question about that. Although if you see the numbers in my testimony with the Federal subsidy those rates went down considerably. And I think one of the most important features that Wisconsinites had in that high-risk pool was they could go to any doctor in the State. There is not a single plan in our exchange where you can go to any doctor in the State and get coverage without having really significant deductibles and having out-of-network costs.

It was funded on assessments on the insurers as well as mandatory discounts for the providers, and the coverage, consumers had a huge number of options inside that plan. And typically, I think what is interesting about the high-risk pools is that they stayed on those high-risk pools for about 3 to 4 years and once they were there they moved into other group coverage later, so it was a great gap coverage.

I will also note that we had relatively low premiums in Wisconsin compared to, and you can see in my testimony that the rates went up considerably. They went up much more on the young folks than they went up on the older folks because of the age band and that has caused an abandonment by and large of the market, individual market, by a lot of the folks in the younger age bands unless they have medical conditions.

It has been very expensive for coverage. The fortunate thing in Wisconsin is we haven’t seen the high increases. We had 16 per-
cent increases this last year. We still have 15 insurers in the State doing business. We still have a co-op doing business and that is in part because we recognize that our job as a regulator is to minimize the consumer disruption. However, I think one of the big issues going forward is if we don’t look at the transition coverage and if we don’t make changes going forward we are expecting to see the small group market start to implode and that is going to put folks, more folks in the individual market which is unaffordable And that will impact taxes. That will impact everything across the board.

So we have serious concerns about not reforming the individual market impacting the small group market, not repealing Obamacare and ending up killing the small group market as well, which is on its way. About 80 percent of folks in the small group market are still in transition plans, so that is important to understand.

Going forward I think it is important to understand that States have a number of laws on the books. We have preexisting condition laws in Wisconsin. We have mental health parity laws. We had the coverage to age 27, in fact, not 26, in the State prior to Obamacare passing. We did a number of consumer protections and we take consumer protections seriously in the State, and we do a lot of work and we deal with consumers directly, and we deal with insurers directly and we have discussions with insurers directly. We have done this for years. We have been regulating the health insurance market since the 1940s.

And I will stop and indicate that we are ready to be here and help and be part of the solution as State regulators and that not all of these solutions need to be federally centric. Thank you.

[The statement of Mr. Wieske follows:]
Testimony of
Deputy Commissioner J.P. Wieske, on behalf of the
Wisconsin Office of the Commissioner of Insurance

Before the
Subcommittee on Health
U.S. House Committee on Energy and Commerce

Regarding:
Patient Relief from Collapsing Health Markets

February 2, 2017
2125 Rayburn House Office Building
EXECUTIVE SUMMARY

The state experience with the Affordable Care Act (ACA) or Obamacare has been mixed. States like Wisconsin had a well-functioning market prior to the passage of the ACA. Our individual and small group markets were competitive allowing consumers numerous choices including co-ops, HMO’s, not-for-profit plans as well as traditional health insurance options.

For consumers who could not meet the underwriting requirements of private coverage, the state had a high-risk pool which provided relatively affordable health insurance coverage while offering a choice of plan designs, and provided subsidies for those with family incomes up to $34,000.

The ACA has changed the Wisconsin health insurance market. Consumers have fewer choices. Rates have increased significantly. A number of our insurers have seen a significant loss in capital. Insurers have left the individual market and those that remain have reduced service areas and plan offerings. To make changes to their coverage, consumers must now work with the federal government and not with the insurer from whom they wish to purchase coverage. In the long run, the ACA market is not sustainable.

It is our belief health insurance should be primarily regulated at the state level and states should have the ability to determine what is best for their market. What works in Wisconsin may not be the best solution for California or New York. A return to the states does not mean an unregulated health insurance market. Indeed, the ACA includes many standards that were first implemented at the state level.
TESTIMONY

Good morning Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health. My name is J.P. Wieske and I am the Deputy Commissioner of Insurance for the Wisconsin Office of the Commissioner of Insurance (OCI). I have been with OCI since October of 2011. As part of my duties, I have been involved with a number of health insurance issues including serving on Wisconsin’s high-risk pool board, working with our state legislature, and assisting with operationalizing the Affordable Care Act (ACA). In addition, I have been actively involved with the National Association of Insurance Commissioners (NAIC) serving as chair of the Regulatory Framework Task Force, Network Adequacy Subgroup, and a group discussing pharmacy benefits.

Thank you for the opportunity to testify on the state of Wisconsin’s health insurance market.

While the Wisconsin market has been healthier than most, the ACA has caused significant harm. Before describing the current state of the market, it is important to understand what it looked like prior to the passage of the ACA.

As a regulator, Wisconsin has been traditionally known as a state with tough but consistent rules. We were one of the first states with a number of market and consumer protections that eventually became models for the NAIC and were subsequently included as part of the ACA. These included independent external review, standardized applications, coverage for adult dependents, coverage for certain health care services associated with cancer clinical trials, guaranteed renewability in the individual and small group markets, and a robust review of insurer market conduct. Our financial review of companies has been led by highly experienced staff. In short,
we ensured, and continue to ensure, that insurers in the health insurance market deal with consumers fairly and maintain the financial means to pay consumer claims.

Pre-ACA, the Wisconsin market was certainly not the least expensive in the country; however, we typically landed in the lowest third of states. While the medical care provided in Wisconsin is high quality, it is not inexpensive. The medical costs in our market are relatively higher than other states. In fact, a U.S. Government Accountability Office (GAO) report released in the early 2000s named eight Wisconsin cities among the 10 most expensive medical areas in the country. However, our competitive health insurance market ensured Wisconsin consumers paid relatively low rates despite the relatively high medical costs.

Wisconsin consumers in both the individual and small group markets had a large number of insurers and plans to choose from. They could choose from large national companies or small regional insurers, a managed care plan with a narrow network or a plan with limited managed care and a broad network, or a for-profit company or not-for-profit company. In some areas of the state, consumers could choose to participate in one of Wisconsin’s two pre-ACA co-ops.

Wisconsin also had a number of other important consumer protections. Wisconsin – in fact all states – included guaranteed renewability requirements in their laws. Many of these laws predated the 1997 HIPAA law, and required insurers to continue to cover all individuals and groups at the option of the insured—regardless of their health status. It meant consumer coverage could not be cancelled as a result of a health condition. The small group market included guaranteed issue, pre-existing condition credit, and rate limits. The individual market included pre-existing
condition limits, and guaranteed issue requirements for HIPAA-eligible individuals. In some states, it was true that individuals could be declined for private coverage due to their health status, but in most cases these individuals were provided with alternative coverage.

For consumers that could not qualify for private coverage, Wisconsin had a high-risk pool called the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP) Authority. HIRSP provided comprehensive coverage to consumers with the ability to choose any medical provider practicing in Wisconsin. It was funded by premiums from consumers, assessments on insurers, and contributions from medical providers. Consumers could choose from a variety of plan options, and for the most impoverished consumers, further subsidies were made available. The cost of coverage closely mirrored the cost of private coverage in the state.

Many other issues were dealt with at the state level. Some states limited the permissible age bands (while not as narrowly as the age bands in the ACA which proposed a 3 to 1 ratio), though few, if any, needed to prescribe a specific curve as required by current federal rules. In the pre-ACA market, the age curve varied from insurer to insurer, allowing consumers some advantage in shopping for coverage. There was very little need to create an artificial process for a special enrollment period especially when consumers could purchase coverage throughout the year. Rules were established by law or regulation and insurers were required to follow those rules or face significant regulatory penalties. Ultimately, all issues were dealt with more efficiently by not inserting an additional layer of bureaucracy through a government entity – like the federal exchange – interfering in the relationship between an insurer and its customer. It is ludicrous that a consumer should need to receive the “OK” from any federal bureaucracy to add their spouse or
newborn child to their policy. This delay adds to the frustration of consumers with the ACA, as their insurers are forced to send their requests to the federal exchange for approval. It is the proper role of government to set rules, and to ensure insurers are complying not to add an expensive and inefficient bureaucracy.

Overall, pre-ACA, Wisconsin had a well-functioning health insurance market that protected consumers, guaranteed access to affordable health insurance for the most vulnerable, and had significant state authority to enforce our laws.

The ACA made a number of changes to the rules governing health insurance markets across the country. These “one-size-fits-all” changes have impacted rates, consumer choice, and the ability for a free market to operate. A one-size-fits-all approach does not work in health insurance policy. The ACA forced the nation to spend years and billions of taxpayer dollars trying to centralize health care coverage at the federal level. Federal bureaucrats dictated complex rules and inconsistent “sub-regulatory guidance” to state insurance commissioners, and left us in a difficult position to balance mounting mandates with consumer protections. Ultimately, our job is to serve the citizens of Wisconsin and not the federal government.

While we did not agree with the market destabilizing approach of the ACA, when the Supreme Court affirmed its legality, Wisconsin operationalized the law. Wisconsin has fared better than most states, thanks in part to our decisions to minimize consumer harm and our efforts to protect a competitive health insurance market. Still, Wisconsin consumers have suffered under the ACA.
In Wisconsin’s individual market alone, we have seen: premiums double, plan designs dictated by federal bureaucrats to meet political goals rather than meet consumer needs, and loss of competition in the health insurance market. The unprecedented federal encroachment over a consumer’s freedom to make decisions such as individual mandate and more recently the auto re-enrollment process, which allows federal government to choose a health care plan for individuals if they do not choose one for themselves, sent the message that citizens cannot be trusted to take care of themselves. Government should never substitute its judgement for the judgement of its citizens.

Healthcare is inherently personal and local. Someone from Rhinelander, Wisconsin should not have their health care choices dictated to them from somebody in Washington. What may work for Wisconsin may not work for New York and California. In the insurance market, it is not our job to design health plans and dictate to insurers the products they must offer. For the consumer, it is not our job to force individuals to spend their money on a product the federal government deemed appropriate as a condition of receiving a federal subsidy. Our job in government is to pursue solutions that remove barriers and set appropriate parameters to allow the private health insurance market the ability to offer affordable products designed to address a variety of consumer needs, based on individual circumstances. Vulnerable consumers need protections available from the law, but they also need to access a functioning health insurance market.

I want to particularly note that repeal does not mean an unregulated health insurance market. It means a return of control back to the states to allow for a health insurance market that is responsive to consumer needs. It means states can design solutions to protect the vulnerable.
Centralizing authority in the federal government and in exchanges has not made the markets
better and has not improved the consumer experience as evidenced by state insurance markets
near collapse, the loss of capital in health insurance markets, and a number of insurers looking to
exit the individual market.

**ACA Impact on Wisconsin Health Insurance Rates**

With the enactment of the ACA came guaranteed issue, new rate bands that increased costs for
the young and healthy, additional coverage mandates, and the elimination of HIRSP,
Wisconsin’s high-risk pool. Wisconsin insurers were quickly faced with an uncertain influx of
individuals with serious health conditions; 20,000 alone from HIRSP. They were also faced with
vague regulations from the federal Department of Health and Human Services (HHS) that
changed constantly and were not communicated consistently from HHS. The special enrollment
period definitions were initially vague, and HHS choose not to apply the rules uniformly i.e.,
consumers using certain “magic words” received an SEP regardless of circumstances while
others were rejected despite their status. In short, insurers wanting to continue to participate in
the Wisconsin health insurance market ultimately had no choice but to increase rates. The net
result was that Wisconsin consumers paid more for coverage, including those individuals who
previously received coverage through HIRSP.

To offset the increased risk insurers would take on under the ACA, HHS issued regulations
creating risk adjustment, reinsurance, and risk corridor programs, i.e., the “three Rs.” Each of
these programs was to have either state components or to be managed entirely by the states.
However, in one of their first acts of ignoring state concerns, HHS changed course and modified
regulations to allow the federal government to take over the “three Rs” from states. Unfortunately for Wisconsin consumers, this change would negatively impact them as insurers struggled to plan for and capture their estimated risk and receive their fair share of funding from these programs. HHS continues to struggle to manage these programs in a way that fairly compensates insurers taking on a significant portion of the risk.

Rising health care costs and adjusting to the fundamental market changes the ACA imposed both continue to drive up the cost of health insurance. These pressures are further exacerbated by uncertainty related to the risk pool, federal funding, and federal regulations that constantly change without significant notice. Insurers are operating in a turbulent environment and many are struggling to remain profitable and offer affordable coverage that meets consumer needs.

**Detailed Impact of the ACA on Wisconsin Health Insurance Rates**

In an effort to prepare consumers for the coming market, OCI issued a press release in 2013 to highlight the expected increases. The chart used in the release is below:

<table>
<thead>
<tr>
<th>Percent Increase From Pre to Post 2014, Average Per Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Milwaukee Eau Claire Green Bay Madison Appleton Wausau Kenosha La Crosse</td>
</tr>
<tr>
<td>21 78.11 68.75 53.73 124.85 54.18 77.44 37.59 88.53</td>
</tr>
<tr>
<td>40 40.85 48.35 53.73 73.43 36.75 35.03 15.15 41.58</td>
</tr>
<tr>
<td>63 45.48 58.12 22.54 70.04 32.01 26.07 9.72 37.29</td>
</tr>
</tbody>
</table>
The chart shows increases varied from a low of almost 10 percent for a 63-year-old in Kenosha to almost 89 percent for a 21-year-old in La Crosse. For purposes of comparison, we used a $2,000 deductible plan pre- and post-ACA. Male and female rates were averaged pre-ACA. In many cases, the post-ACA plan had a higher deductible but we attempted to match the plan design as close as possible. When multiple plans were available, the rates were averaged. Below are the premium tables used to develop the percentages:

### Pre 1/1/2014

<table>
<thead>
<tr>
<th>Family</th>
<th>Milwaukee Pre 1/1/14</th>
<th>Eau Claire Pre 1/1/14</th>
<th>Green Bay Pre 1/1/14</th>
<th>Dodgeville Pre 1/1/14</th>
<th>Madison Pre 1/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>155.98</td>
<td>176.79</td>
<td>162.71</td>
<td>102.41</td>
<td>116.95</td>
</tr>
<tr>
<td>40</td>
<td>252.07</td>
<td>257.02</td>
<td>240.85</td>
<td>172.38</td>
<td>193.78</td>
</tr>
<tr>
<td>50</td>
<td>376.72</td>
<td>358.56</td>
<td>364.56</td>
<td>266.39</td>
<td>282.66</td>
</tr>
<tr>
<td>63</td>
<td>563.70</td>
<td>556.99</td>
<td>579.86</td>
<td>408.21</td>
<td>449.88</td>
</tr>
<tr>
<td>Family</td>
<td>716.57</td>
<td>753.46</td>
<td>682.23</td>
<td>466.62</td>
<td>546.25</td>
</tr>
</tbody>
</table>

### Post 1/1/2014

<table>
<thead>
<tr>
<th>Family</th>
<th>Milwaukee Post 1/1/14</th>
<th>Eau Claire Post 1/1/14</th>
<th>Green Bay Post 1/1/14</th>
<th>Dodgeville Post 1/1/14</th>
<th>Madison Post 1/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>277.81</td>
<td>298.34</td>
<td>250.13</td>
<td>311.05</td>
<td>262.96</td>
</tr>
<tr>
<td>40</td>
<td>355.04</td>
<td>381.28</td>
<td>319.67</td>
<td>397.52</td>
<td>336.06</td>
</tr>
<tr>
<td>50</td>
<td>496.16</td>
<td>532.83</td>
<td>446.74</td>
<td>555.53</td>
<td>469.65</td>
</tr>
<tr>
<td>63</td>
<td>820.09</td>
<td>880.69</td>
<td>738.39</td>
<td>918.21</td>
<td>764.96</td>
</tr>
<tr>
<td>Family</td>
<td>1,062.90</td>
<td>1,141.44</td>
<td>957.00</td>
<td>1,190.08</td>
<td>1,001.22</td>
</tr>
</tbody>
</table>

Pre-ACA, Wisconsin was able to offer a guaranteed access environment that kept private market coverage affordable with many insurers and plan options to choose from. Pooling the high-risk individuals together and managing their needs separately was a huge factor in the state’s success in offering a competitive insurance market that was able to respond to consumer needs; both
those in the private market and those in the high-risk pool. HIRSP rates were comparable to private market rates, with many plan options that offered deductibles ranging from $1,000 to $7,500, and a broad network that allowed members to choose from any medical provider in Wisconsin. With the implementation of the ACA, the impact on our HIRSP members—our most vulnerable citizens—was more pronounced. Their coverage was replaced with more expensive coverage, limited plan design options, and limited access to their choice of providers.

Listed in the table below are the 2013 HIRSP rates without subsidies applied. Individuals with household incomes between $0 and $34,000 were eligible for both deductible discounts (not on the HSA-eligible plans) and premium discounts (between 15 percent - 43 percent, depending on income). The premiums reflected under HIRSP Federal were possible as a result of federal dollars sent to states as a means to transition from a pre- to post-ACA marketplace. They are included to demonstrate the impact federal high-risk pool block grant assistance may have on offering rates to high-risk pool members that are comparable to similar plan options in the private marketplace.

<table>
<thead>
<tr>
<th>HIRSP Plan Options Comparable to those used in the Private Market Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td>21</td>
</tr>
<tr>
<td>40</td>
</tr>
<tr>
<td>50</td>
</tr>
<tr>
<td>63</td>
</tr>
</tbody>
</table>

1 2500 Refers to the deductible level. For more information on HIRSP visit: https://docs.legis.wisconsin.gov/mise/10b/informational_papers/january_2013/0053_health_insurance_risk_sharing_plan_informational_paper_53.pdf
Since 2014, the market rates have continued to increase annually. The years 2015 and 2016 saw relatively moderate average increases of almost 3.8 percent and 8.3 percent, respectively, though many consumers received much higher or lower increases depending on their particular plan. The increase on the federal exchange in 2017 averages roughly 16 percent with a high of 37 percent and a decrease of more than 10 percent. Wisconsin’s increases are likely more moderate than what is seen in other states due to the highly competitive nature of our market. It takes 17 insurers to comprise an 80 percent share of the individual health insurance market. That said, the challenges imposed by the ACA have led to individual market exits which reduce consumer choice; and if continued as a trend for future years, threaten the ability of our market to prevent rates from reaching levels seen in other states. Wisconsin’s competitive market is a saving grace for consumers as a means for holding down what would be even higher increases. Insurers in our state are fighting an uphill battle to adhere to ACA regulations and still remain viable enough to offer competitive products.

The Impact of Special Enrollment Periods
Wisconsin serves as chair of the NAIC Health Care Reform Alternatives Working Group and after hearing about numerous problems, we asked for feedback. What we found was extremely problematic. Consumers faced significant uncertainty in applying for a Special Enrollment Period (SEP). We were told it took weeks for consumers to get proper permission from the federal exchange, if they received permission at all. In other cases, the industry highlighted consumers were provided coverage without any documentation or proof of eligibility for an SEP. The rules were vague, and the exchange staff, at the time, was not properly trained. Insurers highlighted loss ratios exceeding 150 percent on their SEP business. Even more problematic, it
was clear many consumers were using the process to receive costly medical care and then immediately dropping coverage. HHS acknowledged the issues and has promised to seek more documentation, though at this point it appears HHS will only review 50 percent of cases.

**Consumer Choice and Interfering with a Free Market Model**

So far, for plan year 2017, Wisconsin has had several insurers exit the individual market completely, leave the federal exchange, or reduce the number of counties they are willing to serve. As a result, there were over 37,000 individuals enrolled in a plan offered by an insurer that will not be available to them in 2017. These numbers may pale in comparison to other states, but for affected consumers the issue is serious. The HHS solution was to “auto re-enroll” these individuals into a new plan with a new insurer. While federal regulations indicate this can only occur if permitted under state law, HHS was unwilling to change course in light of several states, including Wisconsin, indicating the auto re-enrollment process violates several state laws. Wisconsin was required to issue new bulletins and requirements on insurers, and hold public sessions to inform the public of the problematic issue.

Auto re-enrollment is impacting consumer choice at the market level as well. HHS is cherry picking which insurers will get additional business. This is interfering with a free market which has successfully offered affordable choice meeting consumer demand. HHS added lives to insurers who, in some cases, were given a leg up in growing their business and for others unanticipated additional lives may result in financial harm. When insurers were made aware two months out from the open enrollment period that several thousand lives are now anticipated in
being auto-enrolled with them, they are faced with significant rating and operational considerations.

A Look Ahead: Impact of Transitional Plans

It is important to remember the volume of consumers covered under transitional plans in the individual and small group markets. In Wisconsin, as of December 31, 2015, there were 203,587 covered lives under transitional plans. In 2018, when these plans are no longer available, consumers, in particular employers, will experience rate increases as they are forced to purchase coverage meeting all ACA requirements.

Conclusion

In conclusion, Wisconsin had a strong health insurance market offering products responding to consumer needs prior to the ACA. Since the passage of the ACA, insurers struggle to continue to stay viable and offer affordable coverage to Wisconsin consumers. Rates continue to increase and an insurer’s ability to predict risk from year to year remains difficult in light of an unstable federal regulatory environment where the rules keep changing without attention to the diverse insurance markets that exist across the country. Each state is unique. Forcing health insurance markets into a standardized set of federal regulations adds an unnecessary layer of complexity that stifles both an insurer’s and state regulator’s ability to be innovative and have the flexibility necessary to meet consumer needs.
Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. Dr. Lichtenfeld, you are recognized 5 minutes to summarize your opening statement, please.

STATEMENT OF J. LEONARD LICHTENFELD

Dr. LICHTENFELD. Thank you, Mr. Chairman and Ranking Member Green, and members of the subcommittee. My name is Len Lichtenfeld. I am Deputy Chief Medical Officer for the American Cancer Society and I appreciate having the opportunity to be with you today.

I am also pleased to be here on behalf of the nearly two million patients and people who will be diagnosed with cancer this year and the over 15 million cancer survivors that are living today as a result of successful treatment. These Americans who are your constituents, for them access to comprehensive, affordable health insurance coverage truly is a matter of life and death.

Mr. Chairman, we appreciate your stated support for retaining two very important patient protections enacted as part of the ACA, the preex provision that bans discrimination against people based on their health condition; and secondly, guaranteed issue of coverage. And we look forward to working with you on the language in the legislation to make sure these provisions work to do just that. Providing patient access to coverage is obviously meaningful, but only insofar as the coverage itself is affordable and provides enough benefits to be meaningful for someone with cancer. And that is certainly the lens through which we view these particular pieces of proposed legislation.

Prior to 2010 the insurance coverage was defined as just about anything marketed and sold by the industry and often contained exclusions, and hidden clauses resulted in denial of claims for all sorts of medically needed services. Current law requires that insurance provide major health coverage. When people buy insurance, especially when they are required to do so either by mandate or continuous coverage requirements, it is important to remember that insurance must cover a defined set of benefits to cover those individuals when they do become ill.

My written statement goes into greater detail, but in the limited time I have with you today I want to focus on why cancer patients need access to health insurance and how we can improve the system to address their needs. Research shows that individuals who lack health insurance coverage are less likely to get screened for cancer, more likely to have their cancer diagnosed at a later stage when the chance of survival diminishes and the treatments are certainly much more complicated. I know from my days as a practicing oncologist that it is very difficult to tell someone they have cancer; it is even more difficult to guide them through what is hopefully successful treatment. What is worse than that is being told by a patient they can’t afford the treatment because they lack health insurance coverage or because their health insurance doesn’t provide coverage for the oncology and cancer related services necessary for their journey.

Individuals with cancer including cancer survivors know how important it is to maintain health coverage. And unfortunately, before the patient protections provided under the ACA many were unable
to obtain health insurance coverage because of the cancer diagnosis constituting a preexisting condition and others faced lifetime or annual limits on their coverage while others were still only able to purchase a health insurance coverage with limited benefits that provide inadequate reimbursement when they needed it most.

Individuals with cancer want and need continuous access to comprehensive health insurance coverage. Unfortunately, the realities of life sometimes interfere with this goal. We have made great strides in cancer treatments over the years, but unfortunately many treatments still result in unimaginable fatigue and other symptoms that can be very debilitating such that the individual is unable to work.

Research suggests that between 40 and 65 percent of cancer patients stop working while receiving cancer treatment with absence from work that ranges from 45 days to 6 months depending on the treatment, and sometimes these folks lose their jobs and their affordable employer-sponsored coverage.

Imagine a diagnosis with cancer and undergoing treatments that make work impossible, repeated absences result in a loss of your livelihood, you have no income, yet you had a terrible disease and you need to get coverage for that illness. Cancer treatments have left you physically unable to even look for a new job. This is not only a hypothetical it is very real, and everyone in this room knows patients with cancer who have gone through such experience.

So as you contemplate changes to the healthcare market, we urge you to give great consideration to how the various policies under consideration intersect and how an individual with cancer would be impacted. We are not saying the current market is perfect, more needs to be done to ensure affordability, but affordability cannot be judged on premium alone. We need to also consider out-of-pocket costs and the value of the benefits provided. Catastrophic plans will have lower premiums, but few cancer patients will be able to afford the deductibles, co-pays and other out-of-pocket costs associated with oncology treatment.

In closing, I appreciate the opportunity to share our views from the American Cancer Society on how the healthcare system needs to ensure that individuals with cancer have access to the products and services necessary for their treatment, and I am glad to answer any questions from the committee. Thank you very much.

[The statement of Dr. Lichtenfeld follows:]
Statement of J. Leonard Lichtenfeld, M.D.
Deputy Chief Medical Officer
American Cancer Society

“Patient Relief from Collapsing Health Markets”

United States House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

February 2, 2017
Chairman Michael Burgess, Ranking Member Green, and other members of the Subcommittee:

I am Dr. Len Lichtenfeld, Deputy Chief Medical Office for the American Cancer Society. On behalf of the Society, thank you for the opportunity to testify today. ACS is a nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing the disease, saving lives, and diminishing suffering through research, education, advocacy, and service. The Society, operating through its national office and 11 geographic divisions throughout the United States throughout the United States, is the largest voluntary health organization in the United States.

In the United States there are more than 1.6 million Americans who will be diagnosed with cancer this year. An additional 15.5 million Americans living today have a history of cancer. For these Americans — many of your own constituents — access to affordable health insurance is 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.

Yet for many years, a cancer diagnosis made it nearly impossible to get or keep insurance. Before the Affordable Care Act was passed into law, millions of cancer patients found themselves unable to purchase insurance because of their pre-existing condition. Even those who were able to obtain coverage often found that annual or lifetime limits severely curtailed their coverage leaving them vulnerable to enormous costs. Some people even found their insurance policies rescinded after being diagnosed with cancer.

One such example is that of Kathleen Watson, a now 61-year-old woman living in Lake City, Florida. Kathleen sought to purchase insurance on the individual market, but was denied because of a pre-existing diagnosis of leukocytosis, a condition of too many white blood cells that is often a sign of leukemia, but in and of itself is not a cancer diagnosis. She was denied coverage by several insurance carriers outright and as a result she could not afford treatment and delayed necessary medical care.

---

2 Id.
Kathleen continued applying for coverage, and in 2008 a plan in the individual market finally accepted her application. In 2009, after having enrolled in the plan, Kathleen was diagnosed with chronic non-Hodgkin’s lymphoma. However, as she began treatment the plan denied all her claims – the plan even denied the claim for testing her bone marrow to confirm her diagnosis. Later the Florida insurance commissioner determined the plan was not credible and Kathleen’s insurance was cancelled. Kathleen says about this time, “The stress was overbearing. I couldn’t sleep — always worried, didn’t know what the next step would be. When everything is yanked out from underneath you, you don’t know where to turn. I lost my 401k, savings, everything.” She was left with $250,000 in medical debt and no health insurance coverage. This medical debt continues to affect her credit today.

In the intervening years Kathleen—unable to get insurance on the individual market because of her pre-existing condition—was able to find work and get employer-sponsored coverage and cancer care. I am happy to report that she is now cancer-free.

However, four months ago Kathleen suffered a non-workplace injury that has left her unable to work and on short-term disability. Her inability to work means her employer coverage expired at the end of the December. Keenly aware of the need for health insurance with her history and health complications, Kathleen enrolled before the deadline in an individual plan through the state exchange. Fortunately, her disability income allows her to make just enough to qualify for subsidies in the exchange instead of falling into Florida’s Medicaid expansion coverage gap. Her new exchange plan includes all of her doctors and financial assistance that makes accessing her recommended cancer follow-up and other necessary health care affordable.

She’s gone from being uninsured and uninsurable in 2004, with a delayed diagnosis, and heaps of medical debt to finally being able to purchase a quality individual plan that is affordable in 2016.

Kathleen’s story is just one example of the significant strides we have made in the quest to prevent cancer and central to this success is ensuring that all Americans can access and maintain affordable health insurance coverage. As Congress considers legislation to change the current health insurance market we urge you to consider how the policies will impact a person with cancer or other serious illness. Further, we believe any changes should be grounded in the following principles for ensuring that cancer patients have access to the care they need for their cancer treatment.

**Protecting Patients** — For cancer patients and survivors, getting and keeping insurance is paramount. The following patient protections contained in current law should be retained: prohibition on pre-existing condition exclusions; prohibition on annual and
lifetime limits; maximum out-of-pocket limits; and prohibition on insurance policy rescissions.

**Comprehensive Coverage** – Insurance should cover the major health needs of cancer patients and survivors, including hospitalization, specialty cancer care, physician services, prescription drugs, rehabilitative care, and mental health services. Streamlined “basic” policies that do not include explicitly defined comprehensive benefits put cancer patients and survivors at risk of inadequate treatment, and could jeopardize access to necessary preventive care, treatment and follow-up care.

**Affordable Coverage** – Affordable premiums and cost-sharing (including deductibles, copays and coinsurance) should be retained to ensure that persons with cancer and survivors can buy and maintain insurance coverage.

**Equitable Coverage** – Changes to the insurance market should guarantee that people at all income levels have access to an affordable and consistent standard of coverage in every state. While 31 states and the District of Columbia have chosen to expand their Medicaid programs following the 2012 Supreme Court decision, unfortunately low-income individuals in 19 states lack access to comprehensive and affordable coverage options because their state decided not to expand their Medicaid program.

**Preventive Care** – A substantial number of all cancer deaths can be prevented and the substantial cost of the treatment of advanced disease could be reduced through the use of existing evidence-based prevention and early detection strategies. Research shows that required cost-sharing – including copays, coinsurance and deductibles – can be a significant barrier for patients who need preventive services. This is especially true for lower-income patients and patients on a fixed income, for whom these payments can represent a significant percentage of their income. Individuals need access to evidence-based preventive services.

We appreciate the invitation to testify today on four bills before the committee, which appear to work together to address concerns expressed by the insurance industry about the viability of the individual and small group markets. While we recognize the importance of strengthening the markets in order to keep the system working, we are concerned about how these bills, one

---


of which is not completely written yet, might impact care and access to adequate and affordable coverage for individuals with cancer.

As the Subcommittee considers legislation to change health care markets, we want to share with you our thoughts on how some of the proposals currently under consideration would affect people with cancer and cancer survivors.

**Continuous Coverage**

Under current law, non-grandfathered health plans in the individual market are prohibited from taking into account an individual’s pre-existing condition or health status when issuing health insurance coverage. The Kaiser Family Foundation estimates that 27 percent of adult Americans under the age of 65 have a pre-existing condition.8 Prior to January 1, 2014, health insurance issuers were permitted to refuse to cover an individual who had a pre-existing condition; could provide coverage but limit and/or refuse to cover care associated with the individual’s pre-existing condition; or, could charge the individual a higher premium based on her pre-existing condition (thus making insurance unaffordable). A survey conducted before these exclusions were prohibited 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, were charged more, or had a specific health problem excluded from their coverage.9

In its current, admittedly incomplete draft, it appears that the continuous coverage legislation before the committee would exempt individuals from pre-existing condition exclusions only if they maintain continuous coverage (defined as having a gap in coverage of less than 63 days). Individuals who fail to maintain continuous coverage could be subject to medical underwriting. As currently discussed, this provision could actually restore the discriminatory practice of pre-existing condition exclusions insofar as individuals with pre-existing conditions could be charged higher premiums.

As the Subcommittee moves forward with the legislation, we would welcome the opportunity to work with you to ensure policy changes do not impact a patient’s uninterrupted access to health insurance coverage and necessary treatment. However, a one-size-fits-all approach that imposes penalties for any interruption in coverage fails to recognize the many legitimate reasons that patients have coverage gaps. For instance, many people may experience a gap in coverage when they lose their job and their employee coverage. Research suggests that

---


between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to 6 months depending on the treatment.\textsuperscript{10} Gaps in coverage also occur as a result of a divorce or death of a spouse when one spouse is no longer covered on the other’s health plan. Moving from one state to another may result in a gap in coverage. All of these examples – and many others – are common reasons why a person may have an unexpected gap in coverage. Penalties imposed on people in these situations may adversely impact access to care, interrupt life-saving treatment and make insurance unaffordable when they attempt to regain coverage.

Gaps in coverage are detrimental to individuals in active cancer treatment who need regular access to care and services. When that access is disrupted, the effectiveness of the treatment could be jeopardized and the individual’s chance of survival could be significantly reduced. Evidence-based protocols for chemotherapy and other cancer treatments often require treatment delivery on a prescribed timeline. Interruptions to this timeline because of coverage gaps can be detrimental. A gap in coverage can also cause a fatal delay in initiation of a treatment protocol. Recent research shows that delays in the initiation of chemotherapy for breast cancer patients resulted in adverse health outcomes.\textsuperscript{11}

Allowing health insurers to charge higher premiums to those with pre-existing conditions who experience a gap in coverage of more than 63 days is overly broad and would unfairly penalize those who lose their coverage unexpectedly. Individuals with cancer may lose their job because their cancer and/or cancer treatment makes them unable to work. This also includes cancer survivors who are more likely to report being unable to work because of their health or having employment disability, including more missed work days or additional days spent in bed due to poor health.\textsuperscript{12}

Enacting a policy that penalizes individuals for losing their health insurance coverage – particularly at a time when they have also lost their employment – imposes an undue cost burden on individuals. Moreover, once an individual with a history of cancer is no longer


protected from the pre-existing condition exclusion policy, it remains unlikely that he/she will be able to purchase health insurance coverage at all.

Special Enrollment Periods

Special enrollment periods (SEPs) allow individuals with qualifying life changes—like divorce, marriage, birth, a permanent move, or loss of employer-sponsored health insurance—to enroll in a plan that best meets their needs. These SEPs are vital for individuals with cancer who may often experience a job loss (and subsequent loss of employer-sponsored health insurance) if their cancer and/or cancer treatment makes them unable to work. In addition, some individuals with cancer may have to move to a different location in order to be closer to family members who can provide necessary caregiving and/or to be closer to specialized treatment facilities to treat their specific form of cancer.

The legislation under consideration by the Subcommittee would require an individual seeking to enroll in health insurance coverage through an SEP to submit evidence of eligibility for the SEP before being permitted to enroll. We are concerned that the result of this seemingly minor change in policy could be cancer patients failing to access health coverage and treatment in a timely way.

Restricting SEPs and requiring enrollees to document their eligibility prior to coverage will lead to gaps in coverage, which can be detrimental to an individual who needs access to cancer treatment immediately. If the Subcommittee were to consider such legislation, the policy should provide a review process by which an individual could obtain expedited coverage when medically necessary.

We also note that it may be challenging for individuals to obtain the required documentation necessary to qualify for an SEP. For example, employers are not required to automatically provide former employees with documentation of loss of minimum essential coverage (MEC). This makes documentation for qualification under a loss of MEC difficult—particularly if the individual’s loss of employment was not a planned event, such as retirement.

According to the Urban Institute, fewer than 15 percent of eligible people elect to use an SEP to enroll in a health plan. While an industry-funded report indicates that individuals who enroll in health plans through an SEP have higher health care costs compared to individuals who enroll during an open enrollment period, the report does not provide data on why they are

---

seeking enrollment during an SEP. The individual may be a cancer patient seeking enrollment following the loss of employment due to illness. This SEP-qualifying individual will generate new costs, but it does not mean he is intentionally abusing the SEP system.

In addition, we are concerned that under the proposed legislation, the individual may not enroll in a health plan via an SEP until the Exchange verifies that the individual is qualified. But there is no requirement for the Exchange to act. For example, if the individual with a prior cancer diagnosis submits documentation for SEP eligibility within 63 days of losing creditable coverage, but the Exchange fails to act in a timely manner, the individual may not be able to enroll in a health plan within the 63-day time period. Thus lacking “continuous coverage,” the pre-existing condition exclusion provision would be triggered, allowing the health insurer to medically underwrite the policy. Absent additional legislative clarity, health insurers could use the combination of the SEP and restrictive continuous coverage provisions as a back-door way of denying coverage to potentially high-cost individuals. We strongly urge Congress to ensure that such highly discriminatory actions would not be permitted.

We share the Subcommittee’s concern about policies that could result in individuals “gaming” the SEP system. But people in cancer treatment or those who have a pre-existing cancer condition have no incentive to drop coverage. Many lose coverage when they lose their job because they are sick. Policy changes should not inadvertently prevent persons with cancer from having access to coverage. We are committed to working with the Subcommittee to advance this goal.

**Age Rating**

Under current law, health insurance issuers in the individual market are prohibited from charging older adults more than three times the premium charged to younger adults for the same coverage (e.g., 3:1 age rating). The legislation under consideration by the Subcommittee would relax these requirements and permit health insurance issuers to charge older adults five times that charged to younger individuals (e.g., a 5:1 age rating). The legislation also would allow states to impose a different ratio — either a higher or a lower ratio.

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. Thus, increasing the age rating bands would mean that older individuals (those more at risk of developing cancer) would face significantly higher health care premiums or be priced out of the market completely. This problem would

---

be exacerbated in states that choose to go beyond the 5:1 age rating provided in the legislation. Prior to the enactment of the ACA's age rating band restrictions, older adults faced significant problems accessing health insurance coverage, in large part because of age rating restrictions (compounded by the ability of issuers to use health status when setting premiums).  

Research suggests that relaxing the age rating bands would result in a slight reduction in premiums charged to older cohorts. One study estimated that increasing the age bands to 5:1 would result in premiums for a 64-year-old to increase from $8,500 to $10,600 per year (a $2,100 increase), while premiums for a 21-year-old would decrease from $2,800 to $2,100 (a reduction of only $700). In addition, the policy would actually result in higher federal expenditures of an estimated $9.3 billion due to the advance premium tax credits.

**Grace Periods**

Under current law, individuals who have failed to pay premiums have a three-month "grace period" in which to repay overdue premiums before the issuer is permitted to terminate the individual's health insurance coverage. This policy is designed to ensure that individuals who are temporarily unable to afford a few monthly premium payments are permitted the opportunity to catch up before their plan terminates coverage. If an individual fails to pay her premium outside this grace period, coverage is terminated retroactive to the end of the first month of the grace period and the individual is responsible for the entire cost of any medical expenses incurred in the second and third months of the grace period.

The legislation under consideration by the Subcommittee would retain the three-month grace period for plan years beginning before January 1, 2018, but would eliminate this patient protection for subsequent plan years. States would have the authority to set the appropriate grace period. If a state chooses not to do so, the default period would be one month.

We are concerned that limiting the grace period would pose an undue burden on individuals who experience sudden or unexpected personal financial changes—such as coping with having to pay large deductibles and out-of-pocket costs associated with a serious disease like cancer. The out-of-pocket costs of a newly diagnosed cancer patient can be beyond the means of many Americans. When an individual is diagnosed and initially undergoes cancer treatment she usually incurs a significant portion in out-of-pocket costs between the deductible, and frequent

---

18. Id.
copayments and coinsurance associated with services and/or medications. Nearly half of all American adults report being unable to cover an emergency expense costing $400 without having to borrow or sell something to do so.19 Yet many standard plans offer deductibles of $2,500 or more. Individuals often need additional time in order to try to obtain funds to cover these unexpected medical costs. Enacting legislation that would reduce the grace period would curtail the ability of individuals to retain their health insurance coverage at a time when they need it most (e.g., while they are undergoing treatment for a serious disease or illness).

Moreover, we are deeply concerned that the legislation fails to provide a minimum protection— a state could conceivably limit the grace period to only a few days. While we would expect few states to take such draconian action, we nevertheless urge the Subcommittee to consider providing a federal floor of patient protections.

Finally, we urge the Subcommittee to consider how this provision will be impacted if the other legislative proposals discussed above were implemented. For example, if an individual failed to pay her health insurance premiums for more than 30 days and her coverage was terminated, she would be uninsured and thus potentially face medical underwriting if she lacked coverage for a period of time provided under the legislation.

Conclusion

Thank you for the opportunity to testify before you today. As the Subcommittee considers changes to the health insurance market, we urge you to give serious consideration as to how these four bills would interact with each other in restricting patient access to adequate and affordable insurance coverage, particularly if there is a break in continuous coverage.

As you continue consideration of legislation to strengthen the market, we hope that you will consider how this will work for people with cancer. We look forward to working with you to ensure stability in the market and a health care system that meets the needs of individuals with cancer.

---

In the United States there are more than 1.6 million Americans who will be diagnosed with cancer this year. An additional 15.5 million Americans living today have a history of cancer. For these Americans access to affordable health insurance that covers their condition is a matter of survival. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer, are more likely to have their cancer diagnosed at an advanced stage, have worse outcomes and more expensive care.

As Congress considers legislation to change the current health insurance market we urge you to consider how the policies will impact a person with cancer or other serious illness. Any legislation should ensure existing patient protections (e.g., ban on pre-existing condition exclusions; prohibition on annual and lifetime limits; maximum out-of-pocket limits; and prohibition on insurance policy rescissions); and provide comprehensive, affordable, and equitable health insurance coverage (including coverage of preventive services).

While we recognize the importance of strengthening the markets in order to keep the system working, we are concerned about how these bills might impact care and access to adequate and affordable coverage for individuals with cancer.

**Continuous Coverage:** ACS strongly supports the current law which prohibits health issuers from taking into account an individual’s pre-existing condition or health status when issuing health insurance coverage. We are concerned that the legislation under consideration could allow issuers to medically underwrite policies for individuals who fail to maintain continuous coverage. As the Subcommittee moves forward with the legislation, we would welcome the opportunity to work with you to ensure policy changes do not impact a patient’s uninterrupted access to health insurance coverage and necessary treatment.

It is important to understand that if a patient loses coverage due to any number of unforeseeable life events, such as loss of employment or a move to accommodate treatment, that patient could be virtually uninsurable thereafter.

**Special Enrollment Periods (SEPs):** SEPs are vital for individuals with cancer who may experience a job loss (and loss of employer-sponsored health insurance) if their cancer and/or cancer treatment makes them unable to work. Restricting SEPs and requiring enrollees to document their eligibility prior to coverage could lead to loss of continuous coverage.

**Age Rating:** The purpose of insurance is to cover people when they become sick. Increasing the age rating bands would mean that older individuals (those more at risk of developing cancer) would face significantly higher health care premiums, and could be priced out of the market completely.

**Grace Periods:** We are concerned that a severe limitation of the grace period for paying premiums would pose an undue burden on individuals who experience sudden or unexpected personal financial changes—such as coping with having to pay large deductibles and out-of-pocket costs associated with a serious disease like cancer. Enacting legislation that would reduce the grace period would curtail the ability of individuals to retain their health insurance coverage at a time when they need it most (e.g., while they are undergoing treatment for a serious disease or illness).
Mr. BURGESS. And the Chair thanks the gentleman. The Chair thanks all of our witnesses for being here today and for your testimony. We will move into the question portion of the hearing. The Chair does note that he was delayed in arriving at the hearing, so in compensation for that I am going to defer my questions to the end and recognize the gentleman from Texas, Mr. Barton, for questions.

Mr. BARTON. It is rare that I am speechless, Mr. Chairman, but I am tempted to defer also because I had to go to a private meeting and missed—I was going to read my briefing book. I guess I am—but if you are recognizing me, I am going to try to go through it.
I am tempted, but since you are Diet Coke man and not a Diet Dr. Pepper man I am a little skeptical.

I do want to, first of all, commend the chairman for holding the hearing and commend our witnesses. I am going to ask a general question about the overall effectiveness or necessity of maintaining some sort of a health exchange option as we move away from the Affordable Care Act. Could each of you gentlemen comment on whether as we move to replace the Affordable Care Act we should give States the option to have something similar to a health exchange and also if we should have a national exchange in addition to that.

Dr. HOLTZ-EAKIN. I certainly think there is good reason to give the States such an option. I have always thought that the most important thing would be to have healthy competition in the individual market. Exchanges can provide the consumer information necessary to make that competition work better, and the place where I have reservations is only when the exchange becomes a means for excessive regulation.

But the exchange, per se, is a marketplace where consumers can get information and purchase policies that they like. It is a very valuable concept.

Mr. BARTON. OK.

Mr. WIESKE. I think the concept of the exchange, it is good way to deliver subsidies but it is a three percent cost on top of the insurance. That is roughly what they are charging back the insurers for coverage to the exchange, and this is a website. I am not so sure three percent is the, I mean that may reflect the actual cost, so I think there is a value proposition there. I think prior to the ACA there were a number of websites that provided coverage as well.

And again, depending on what the purpose of the exchange is, I think he is right, that it has become a means to add to the regulatory burden on insurers and consumers, so I am not so sure of the value in part because of the cost, but I don’t think, you know, I think there is, there may some reason for it.

Dr. LICHTENFELD. Mr. Barton, I appreciate your question. But speaking on behalf of the American Cancer Society, our major concern is that consumers have the opportunity to get affordable coverage that is going to meet their needs at their time of need, and the mechanism by which the committee decides going forward to achieve that must provide the information that people need to make that decision in a reasonable way.
There obviously are folks here who are involved in the insurance community much more directly than I am or that we are, but it is a matter of information, affordability, and access, and that adequate coverages are available and that the consumer be aware of those options as they go forward with their insurance.

Mr. Barton. Mr., is it “Wee-ski” or——

Mr. Wieske. Wieske, yes, sir.

Mr. Barton. Wieske, not “wise guy,” just Wieske. Your State has a high-risk pool, and another thing that we want to try to do as we move away from the ACA is guarantee that people with pre-existing conditions get adequate access to insurance. The full committee chairman has put out kind of a placeholder bill dealing with high-risk pools. How would you envision based on your State’s experience that working absent all the bells and whistles and mandates that we have currently under the ACA?

Mr. Wieske. So sure, you know, I think the first thing is, is a high-risk pool isn’t necessarily the solution for every State. I don’t want to speak for other States. I will say that in the State of Wisconsin, while we had a high-risk pool, it was highly effective. It is still politically popular amongst both Republicans, Democrats, and especially amongst some subscribers of the high-risk pool. And they miss the coverage. It was a well-thought-out coverage. It was a well-thought-out program.

So I think, you know, I think the key issue is always how you deal with the funding. And that has been one of the bugaboos, I think, in a number of States is when there is insufficient funding for a high-risk pool. You know, there was one State, California, had a waiting list for their high-risk pool. Florida closed their high-risk pool in the early 1990s, and it remained closed for a number of years. Other States had relatively low dollar caps.

So there are issues in design, so the important piece is design. The other important piece is understanding how the funding works and having a stable funding source. I think it has been consistent that the insurance industry is required through the individual small group and large group market to contribute to the cost of the high-risk pool to make sure that it is affordable for consumers. I think as well having good medical discounts that attach to it are also important, but funding is sort of the key piece in making sure that it is maintained over time.

Mr. Barton. You think it can be workable.

Mr. Wieske. I think it worked incredibly well in Wisconsin and it provided great coverage and a lot of options for consumers, yes.

Mr. Barton. My time has expired. Thank you, Mr. Chairman, for your——

Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions, please.

Mr. Green. Thank you, Mr. Chairman. Last Congress our committee passed several important pieces of legislation on health care, a number of them fixing the SGR, extending FQHCs, and 21st Century Cures is probably the biggest one. Speaker Ryan once described the 21st Century Cures as the most important legislation to be passed in the 114th Congress.
During the process of passing the Cures many members of our committee heard stories from patients and advocates across the country who were battling tough diseases and hoping for new treatments. Passing the Cures which contained new funding for research on diseases such as cancer we gave so many of them hope that one day they would get that treatment to be needed. Nationwide, the ACA is that delivery. It doesn’t do us any good to invest in medical research if we don’t have a physician or a facility—and I am from the Houston area, we are fortunate to have MD Anderson.

Although up until the Affordable Care Act, MD Anderson being a State institution did not take a significant number of indigent persons even though they were Texans, and, but now they have something even if it is Medicaid. And, of course, Texas didn’t expand Medicaid expansion, so we need to have this delivery system.

And we can do things bipartisan, you know. I am hoping that is what we can do to fix the ACA, because there has never been a law passed by Congress that doesn’t need to be looked at over a period of years. And, by the way, I served 20 years in the State legislature in Texas, and we wrestled with our high-risk pool. The problem is that we didn’t fund it, and if you only have high-risk people, they can’t afford the insurance.

How does Wisconsin, Mr. Wieske, fund your high-risk pools? Is it premium? I thought I saw in your remarks it was premium taxes.

Mr. Wieske. So there are number of funding mechanisms, so it was divided out equally. There was no actual State dollars that went into it. However, it was divided out between a 40/30/30 share, so 40 percent was the cost for consumers, 30 percent was the cost for insurers, and 30 percent was the cost for the medical providers. They were required to have that level of contribution remain consistently over time which was true-upped every year in order to maintain the affordability. There was enough money there that it was private sourcing that actually provided the subsidy for folks under $34,000 of family income, so there was subsidies for folks under $34,000 of income as well.

Mr. Green. Well, again and other States have tried that. I, like I said, worked as a State legislator doing work across State lines to see what we could do, but—and I have a district in Houston. It is very urban. Up until the Affordable Care Act 44 percent of my constituents who worked did not get insurance through their employer.

And so that is why the ACA is so important to an urban area and there are places all over the country. I would be interested sometime just to talk with you how Milwaukee, a very urban area, compares with most of the rest of Wisconsin, but, you know, that is my concern, that not every State is like Wisconsin.

Dr. Lichtenfeld, thank you for being here. This bill requires insurers to cover preexisting conditions like cancer, but the bill doesn’t say that insurers can’t charge more for that cancer patient. That is one of the major issues, you know, the requirement that people have insurance so the insurance companies can spread that risk. Insurance is about spreading the risk, and if you only have cancer patients in the insurance plan nobody will be able to afford
it. So that is why—and if they have to, you know, once you are diagnosed and you will have to spend it, tell me, is that one of the problems the American Cancer, your client has problems with?

Dr. LICHTENFELD. I am part of the American Cancer Society and honored to be so. Of course it is a concern. You know, nobody goes out and says I want cancer or that I know I am going to get cancer, and that is what insurance is about, making sure that the benefits are adequate, that the cost is affordable and as I mentioned not only the premium cost but also the ancillary costs that inevitably come along. Making sure that patients and consumers have access to care is what this is all about.

We are not here to in a sense solve all the problems in our testimony today. We are here today on behalf of cancer patients throughout this Nation and consumers to try to make sure that those principles are adhered to. That some of the fundamental protections in terms of affordability, limits on out-of-pocket expenses——

Mr. GREEN. Before I run out of time, you don't see this proposed legislation is serving cancer patients?

Dr. LICHTENFELD. What we believe is that this is a work in progress and we want to participate in that progress and help reach solutions in a manner that is acceptable for the people we serve.

Mr. GREEN. Thank you. Thank you, Mr. Chairman.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair now recognizes the gentleman from Kentucky, the vice chairman of the Health Subcommittee, 5 minutes for questions, please.

Mr. GUTHRIE. Thank you, Mr. Chairman. I have a chart. I would like to start by walking through a chart if we can have that posted.

Now the chart we see here uses CBO data on where folks get their health insurance coverage in 2016. As you can see, roughly half of the country received coverage through their employer. That is 155 million people. Fifty seven million patients are enrolled in Medicare, another 57 million are Medicaid beneficiaries that were eligible before the Affordable Care Act.

When it comes to the Affordable Care Act there are 11 million recipients who were made Medicaid eligible by law, and a little under 11 million folks on exchange programs and roughly one million enrolled through basic health programs. What this chart illustrates is that we are talking about seven percent of the population all at the potential disruption of where 93 percent of people across the country receive their health coverage. Even more, the IRS said about eight million folks paid the mandate penalty and another 12 million claimed an exemption from the penalty.

So of the 27 million uninsured Americans, 20 million chose to either to pay the individual mandate tax or claim an exemption. Look, we are going to hear a lot of numbers today and remember these. Seven percent of the country can be directly associate their coverage through the Affordable Care Act and all but seven million uninsured Americans paid the penalty or claimed an exemption.

So instead about talking numbers let's talk about people behind the numbers. So Dr. Holtz-Eakin, can you tell me the national average of premium increases for on-exchange patients this year?
Dr. Holtz-Eakin. For the benchmark Silver Plan it is 27 percent.

Mr. Guthrie. And Commissioner Wieske, what is the number for your home State of Wisconsin?

Mr. Wieske. It was roughly 16 percent.

Mr. Guthrie. Let's talk about ways to drive these costs down. Dr. Holtz-Eakin, as you point out in these reforms noticed today, taken individually or separately are good policy and should receive bipartisan support. If our immediate task is to stop the leaks before replacing the pipes, is this a good place to start with the bills before us today?

Dr. Holtz-Eakin. I believe so. Yes, these are sensible reforms that will get part of the way.

Mr. Guthrie. Thank you, and I agree with your written conclusion this will not fix everything but these are necessary changes. One of those longer term changes we strongly considered is continuous coverage. Would you please briefly describe the value of this incentive model and how it is aimed at patients keeping health care instead of simply getting coverage?

Dr. Holtz-Eakin. So the basic concept is to deal with preexisting conditions in two ways. The first is for existing folks you go to a high-risk pool model like has been discussed. But for a young person, the minute they come off their parents' policy at age 26 they are young and cheap and if they buy a policy and keep coverage in any form throughout their life, regardless of whatever condition they develop, they cannot be medically underwritten and their premium cannot be raised based on their health condition.

As a result, there is a huge incentive to get the young people in the pool and have insurance, because they are keeping the insurance over a lifetime insurers have a very different view of them than now. Now they are a 1-year snapshot, they should do everything they can to avoid costs. If you are looking at them over a lifetime you want to do the prevention, you want to do the wellness, you want to take care of them in very different ways. So this continuous coverage solves the problem of preexisting conditions by getting them in the pool to begin with and provides a better foundation for a different kind of medical model.

Mr. Guthrie. OK, thank you. And Mr. Wieske, you answered some of these in your testimony, but I will just give you a couple minutes, a minute and a half here, to kind of drill down on some of the things that you said and just point it out again. Can you compare the market, what the market looked like in your State before and after the passage of the ACA?

Mr. Wieske. Yes, I think roughly, I mean we actually did not see any gain in coverage if you look at the numbers, if you count our exchange folks, the current exchange folks, and then you look at the high-risk pool and you look at the market before. And so roughly we saw no gain in coverage as a result of Obamacare, at least the numbers don’t bear that out.

And it is important to note that the methodology to calculate the uninsured changed in 2013 so it is an apple to oranges comparison to a certain degree. But our market was much more affordable pre-ACA, there was access to coverage.
Mr. GUTHRIE. What were the difference in options before and after?

Mr. WIESKE. Well, we had roughly 25 carriers operating in the individual market in Wisconsin and along with the high-risk pool and now we have about 15 in the exchange, but if you look at any particular region we have roughly five at the most, closer to three. There is only one region where we have one, and I think three counties where we have two.

So there are fewer choices in our individual market. It is more costly and the plans are obviously centered, they are sort of Government-designed plans rather than having a lot of different options for——

Mr. GUTHRIE. But not an increase in coverage?

Mr. WIESKE. Pardon me?

Mr. GUTHRIE. You have fewer options, more costly and not an increase in coverage?

Mr. WIESKE. Correct.

Mr. GUTHRIE. Thank you. I am out of time. I yield back.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from New Jersey, 5 minutes for questions, please.

Mr. PALLONE. Thank you, Mr. Chairman. The gentleman from Kentucky put up that chart and, you know, acting as if when you repeal the ACA the only thing you are impacting is people who bought individual policies on the marketplace. But the subject, certainly the Walden bill, the chairman’s bill today is talking about standards. He is talking about, you know, preexisting conditions. That affects over a hundred million people.

There is no reference in this half-baked bill we would assume because it doesn’t put it back in that the essential benefit package is impacted, which is going to be my question to Mr. Lichtenfeld. So, you know, I don’t understand how you are putting up that chart and acting as if what we are talking about here today is just the people in the marketplace. This affects everyone. The ACA guaranteed an essential benefit package. You start cutting back on that and offering skeletal or catastrophic plans, that is going to affect everybody on that chart including those who have, the majority that have employer-sponsored plans and the same thing with preexisting conditions.

So, you know, I want everyone to understand. When you start talking about standards and repealing this bill, anti-discriminatory practices, essential benefits, this isn’t just the people in the marketplace.

Now Mr. Lichtenfeld, my concern about the Walden draft is it would not limit in any way what insurers can charge for insurance. Before the ACA under HIPAA some people were guaranteed access to nongroup policies for which they could not be turned down nor have preexisting conditions excluded, but there was no limit on what they could be charged. And left with this only remaining option for discriminating based on health status, insurers charged very high rates for coverage effectively blocking access for a lot of cancer patients sometimes 2000 percent of standard rates.

So roughly what percent of cancer patients do you think could afford to pay such highly surcharged premiums, and in your experi-
ence what happens to people who are diagnosed with cancer who can’t afford health insurance? How is their access to treatment affected?

Dr. LICHTENFELD. What we know at the American Cancer Society is that we did a considerable amount of research in the early 2000s to help support our views, shall we say, on the necessity of insurance. And what we found from that research, which we can certainly provide to the committee, is that patients were diagnosed at a later stage and did poorly compared to those who had insurance.

So we do think that the legislation, the current policy has enabled patients in order to get access to care. Certainly there are issues. We recognize that there are imperfections that have to be worked on. One of our concerns with regard to the essential health benefits is the reality that we need to make sure that whatever we do here, whatever the committee in its wisdom decides, that we have adequate coverage to make sure that patients who have cancer can get the care they need without the limitations that might otherwise occur. And clearly affordability is a major issue.

Most patients, it is no secret the majority of patients who would be impacted by this discussion today are people who are age 50 and older. And those folks would have, if they end up in a situation where there is a high premium and they couldn’t afford it they would be put back in a situation where they would have difficulty getting the care they need for the illness that they have.

So in response to your question, these are certainly concerns that we have and hopefully we will be able to work with the committee moving forward to address those issues.

Mr. PALLONE. Well, thank you, Doctor. You see, my concern is that when the GOP talk about replacement, what they really want is competition downward, skeletal, skimpy plans, you know, plans that—you know, before the ACA you could buy a plan that didn’t cover prescription drugs or even hospitalization. And, you know, now we have these essential benefits, but Mr. Walden’s draft assumes to repeal the entire ACA including essential health benefits. Sixty two percent of plans before we put the ACA in place lacked maternity coverage, I mean there was all kinds of exclusions.

And, you know, just give me—I mean if the ACA benefit standards were to be repealed how would cancer patients be affected? I mean they might—limited doctor visits, much higher deductibles. I have only got a few seconds, but if you will just comment. I know you kind of mentioned it.

Dr. LICHTENFELD. Mr. Pallone, I have lived through that experience as a physician and I am aware of what happened in the past and we at the American Cancer Society would be very concerned if we went back to that. We hope that there are solutions within the committee that will avoid that and provide—speaking with my colleague to my right, certainly some States have been excellent. Unfortunately others have not and we had huge problems in the past that we do not want to revisit. Cancer patients really need to know that they have insurance that works. Thank you.

Mr. PALLONE. Thank you, sir.
Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for your questions, please.

Mr. Murphy. Thank you, Mr. Chairman. Dr. Lichtenfeld, thanks for your statement on the importance of maintaining preexisting conditions. We all agree with that. Those protections are important and guaranteeing issue is part of Chairman Walden’s bill, too. We agree that these rating protections are important as well and really look forward to working with in your patient community and the broader chronic condition patient community.

Can you talk about how Medicare Part D could serve as a role model, as a model for how we do this, how we approach this?

Dr. Lichtenfeld. Well, as you are aware, Mr. Murphy, sometimes in some respects Medicare Part D works and in some places there have been some difficulties with how it has been applied. I am not sure that that is necessarily the model. I am not sure that there is any single model. I think that this is obviously a work in progress to be discussed and we look forward to participating in those discussions.

At the end of the day we need to make certain that cancer patients can afford with regard to Part D, can afford their medications whether given in the doctor’s office, whether they are bought over the counter or at a pharmacy. Those are critical. And it is also important to make sure that that coverage is uniform across the country. That is what we think is——

Mr. Murphy. Dr. Holtz-Eakin, can you comment quickly on that too, just in a few seconds comment quickly on that question too about how Part D can serve as a role model on that?

Dr. Holtz-Eakin. I think the Part D program has been enormously successful because it is built on very strong competitive pressures and on the ability to have very flexible plan design. And so we have seen that in the prescription drug plans competing with one another and offering products that seniors very much approve of.

Mr. Murphy. Thank you. Mr. Wieske, did Wisconsin—let me talk about the high-risk pool. So does Wisconsin collect data on patients who are in these high-risk pools by medical condition, so cancer, certain chronic illnesses and infections, mental health?

Mr. Wieske. We did. I served on the board of the high-risk pool. They had extensive information obviously on all the patients. It was—and some of them were there for an extended period of time, others were not. They had an intensive care management. So it was a very high number of high-risk conditions.

Mr. Murphy. I am wondering how deep you could dive into that data. So Kaiser tells us about, in terms of the number of people who remain in the high-risk pool, about 45 percent are in their second year. Many have acute conditions and get better.

And whether it is a chronic condition like cancer or, you know, the short term ones, maternity, and other complications like mental health, did you do a deeper dive when multiple illnesses occurred to see who were those people who were the big over utilizers by behaviors or high utilizers by medical conditions, so we can help analyze what are the differences there?
Mr. WIESKE. Yes. In short, yes. There weren't a lot of incentives. There were deductibles that attached. I think the lowest was $1,000 deductible. So there were specific efforts made to deal with high utilizers that were utilizing inappropriately in contacts from the administrator.

But most of the folks on the high-risk pool were there about 3 to 4 years. They had specific medical conditions. Presumably they were covered or had group coverage at the end of their——

Mr. MURPHY. So here is an issue in where I think both sides of the aisle can agree that when you have a high deductible which is meant to discourage people from overutilizing the system that may work in some cases to keep people from running to the emergency room for every problem. On the other hand it hurts people from going to get medical care when they need it early on, which Dr. Lichtenfeld was describing the person for early stage cancer.

I am particularly concerned here about such things as the mental health disorders. Generally a person with serious mental illness goes 60 to 80 weeks and adults longer between first symptoms and first treatment. And those complications were for example in Medicaid, five percent of Medicaid patients it is 55 percent of Medicaid spending and virtually all of those have a concurrent mental health problem. Your State has gone above and beyond the numbers in terms of mental health parity.

Mr. WIESKE. Right.

Mr. MURPHY. Have you looked at that also as an issue in terms of having parity and making sure people are getting concurrent mental health services whether they start with a chronic illness or start with a mental illness that does something to help drive down costs?

Mr. WIESKE. Well, I think we have done a number of efforts I think both through the Medicaid program has done a fabulous job of working through that. I think we have new efforts related to the opioid issue which has gotten more attention and certainly in the opioid task force.

There are a number of issues that we get to, but I think you are exactly right that there is this management in reflection of that this is an illness like any other illness and you need to treat it as such is sort of ingrained in Wisconsin.

We have had mandates that attached mental health for decades, so while we have some mental health parity that applies we also have requirements that go back into the 1980s. We have had mental health coverage since the 1980s.

Mr. MURPHY. Well, I might take issue with you when you say Medicaid has done a fabulous job on that because we have had a lot of problems this committee has discussed. But I mentioned Wisconsin's data because we have seen from private markets and others that when private companies insure and they make sure their employees are covered with mental health benefits and concurrently looking at the impact, the cross pollination here of chronic illness and mental illness, cancer is an example of that—high rate of depression, anxiety, panic—it drives people back to the emergency room versus if a doctor is working with them, so a lot of serious concerns there.
If you are able to give us more data on that or if you and I could sit down and talk about that, the same with Dr. Holtz-Eakin and Dr. Lichtenfeld, I would love to talk to you. This is an area where I have got to believe both sides of this committee can agree we can work on more effective health care and driving down costs.

I realize I am out of time, Mr. Chairman. Thank you for indulging me.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions, please.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. My colleagues on the other side of the aisle claim to be concerned with, quote, protecting infant lives, unquote, which is what they called their panel last year that investigated Planned Parenthood and failed to prove any wrongdoing. But we know full well that that panel was created to attack women’s health choices and not protect infant lives.

But when it actually comes to protecting infant lives, Republicans are happy to put insurance companies back in charge, allow them to reinstate lifetime caps on coverage and medical underwriting. This would directly impact some of the most fragile and vulnerable patients in our country, including premature infants, infants with congenital abnormalities, and their families.

So I would like to enter into the record an article featured on Slate called “Our Insurance Paid $2.5 Million to Keep Our Child Alive.”

Mr. BURGESS. Would the gentlelady yield? Is that a unanimous consent request?

Ms. SCHAKOWSKY. Yes.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. SCHAKOWSKY. The author explained that her child was born with congenital defects and their family accrued $2.5 million in medical bills by the time that child was 3 years old. This, by the way, to make our Ranking Member Pallone’s point, they had employer-based coverage, and the benefit package made sure that they were covered.

And should Republicans have their way and reinstate lifetime caps on insurance coverage this child might already have reached her lifetime limit on coverage at the age of 3 and would be forced to pay all of her future care out-of-pocket if they could possibly afford it. Because of the ACA, more than 27 million children have benefitted from the ban on lifetime caps and overall more than 105 million Americans have benefitted.

Before the ACA, 89 percent of insurance plans included a lifetime limit on benefits. To add insult to injury, under Chairman Walden’s bill this child may be subjected to an astronomical premium cost for the rest of her life based on her preexisting condition from birth.

Let me ask you, Dr. Lichtenfeld, what does it mean for premature infants or children born with congenital abnormalities if these conditions are once again permitted to be medically underwritten?

Dr. LICHTENFELD. Well, obviously, when speaking about that specific issue, those costs can rise rapidly and last for a lifetime, and...
we are concerned on behalf of cancer patients that lifetime caps or annual caps or whatever caps might in fact limit the treatment they receive.

When you deal particularly in the cancer world with young people with cancer whether they be children, whether they be young adults, there is a very real issue about the cost of their care over time. And if in fact they become rated within the insurance market going forward as they age that would become obviously a very serious burden.

Ms. SCHAKOWSKY. Have you seen that in your practice of young people who actually either have or live in fear of these lifetime caps?

Dr. LICHTENFELD. Before the ACA it was a real problem and people even within organizations that I am familiar with would run up against, you know, and group insurance, would run up against caps and that would be a serious issue particularly patients for example with bone marrow transplants.

When you talk about young people it is definitely, I can speak on information from the bone marrow transplant community, the financial toxicity of that care and the inability to work going forward for many of these young folks is a very real issue. And we do believe that that is something that needs attention as this again as this process moves forward.

Ms. SCHAKOWSKY. And so once the ACA passed did you see then an improvement in those situations?

Dr. LICHTENFELD. We do believe there was an improvement. It certainly removed the major concern that cancer patients have. We talk a lot these days about financial toxicity. We talk about the stress. We talk about mental health issues as was brought up——

Ms. SCHAKOWSKY. What is your phrase, financial——

Dr. LICHTENFELD. Financial toxicity.

Ms. SCHAKOWSKY. That is what I thought.

Dr. LICHTENFELD. It is a very real issue within the cancer community, the high cost of drugs, the high cost of care, the deductibles, the co-pays, whatever it may be, caps is clearly something that is part of that conversation.

Ms. SCHAKOWSKY. Have you seen Chairman Walden’s bill and how it would impact children or adults that have cancer?

Dr. LICHTENFELD. Well, you know, to be honest with you again that is, there are things that are in the bill and things that are not in the bill so we still have a ways to go. So rather than supposing what is going to be offered, I would rather defer that until we have more information.

Ms. SCHAKOWSKY. OK, thank you. And I yield back.

Mr. BURGESS. The gentlelady yields back. The Chair thanks the gentlelady. The Chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for your questions, please.

Mr. LANCE. Thank you very much, and good morning to the panel and I apologize for not being here for all of your testimony. We are shuttling back and forth between two subcommittees.

To Mr. Holtz-Eakin, thank you for being here. In your testimony you mentioned that the individual mandate was an ineffective mechanism to encourage the enrollment of young people in the exchanges. In what ways is the continuous coverage concept a more
effective tool to engage people to gain and maintain health insurance coverage?

Dr. HOLTZ-EAKIN. It is a natural and economic incentive and health incentive. You know, most of the replacement plans that have been offered that we have looked at would maintain the provision under current law where you can stay on your parents’ policy until you are 26.

At that point a young person who recognizes they are cheap to insure so it is easy for them to get insurance, they may develop, may not be medically underwritten so they aren’t going to get their premiums jacked up because of their health, that is a real incentive to get in early. That broadens the risk pool and when people do develop conditions you have both the high risks and the low risks in the pool. That is always the goal in insurance.

Mr. LANCE. Would others on the panel like to comment on that?

Dr. LICHTENFELD. I would, thank you.

Mr. LANCE. Certainly.

Dr. LICHTENFELD. You know, the continuous coverage issue is one that is obviously again under discussion, but our concern at the American Cancer Society is and on behalf of our constituents, of our patients, is the details of what happens because the risk is very real.

I mean what—you know, no one again expects to get cancer, and sometimes when it happens it happens very quickly and it absorbs people and they can lose their jobs and then they might lose their insurance and then they enter the market under the proposals and they may be rated at a premium they can’t afford.

So how the committee addresses this going forward again is a major concern of ours to get it right, to make sure that the rules are appropriate and that people who get a sudden illness may not be capable of dealing with a continuous coverage provision of 30 days, for example, are able to have some leeway and understanding that meets their needs at their particular time.

Mr. LANCE. I certainly agree that we want to get it right. It is just my concern that young people have not been involved to the extent we would like them to be involved. And we want to repair the ACA and I have never favored its repeal without a replacement. I think it needs to be repaired and we are trying to focus on repairing it and that is why we are conducting this hearing along with other hearings.

To the commissioner, given your background as a State insurance commissioner, could you speak to some of the effects you have seen at the State level regarding the 3:1 age band, special enrollment periods and the 90-day grace period?

Mr. WIESKE. I think you can see in our testimony that the impact of cost, the increases have been borne by the young which has made it unaffordable, just caused the risk pool to deteriorate which has caused, you know, sort of a death spiral.

We have seen consistent changes from the insurers in the areas that they are covering. There is a lot of chaos. We had 37,000 folks that lost coverage from their particular insurer in Wisconsin last year which pales in comparison to the 100,000 in Minnesota that lost their coverage last year. So there have been pronounced effects.
You know, the problem with the SEP process is it is confusing for consumers, it doesn't make, you know, the current one it doesn't make any sense. It is harm to insurers. If you use magic words that go into the, with HHS you get your SEP. If you don't use the right magic words even if you deserve it you don't get an SEP. That has been a consistent problem when it is done at the Federal level, so there has been problems. We would like to see it go back to the companies to administer.

Mr. LANCE. Dr. Holtz-Eakin, would you care to comment on that, please?

Dr. HOLTZ-EAKIN. I think all the evidence that we have seen on it and summarized in my written testimony suggests that this is exactly right. It is not just a Wisconsin problem, this is a pervasive problem. It is worse in the risk pool and it has had the insurers unable to price things effectively.

Mr. LANCE. And I hope that the American people who are undoubtedly listening to our deliberations recognize that there has been this type of terrible situation across the country, not only in Wisconsin and Minnesota, but in other States, as well. And the goal of the ACA was a good goal, and the question is how to achieve that goal in the most effective and efficient manner recognizing that we want no one to be discriminated against, for example, based upon a preexisting condition. I yield back 5 seconds, Mr. Chairman.

Mr. BURGESS. The Chair thanks the gentleman. Before we go to our next question, the Chair would ask that Members on both sides of the dais who are engaged in conversations be mindful of the fact that Mr. Griffith of Virginia is hard of hearing and he is having difficulty in keeping up with the important discussions going on. So the Chair would ask that side conversations be taken off the dais or kept to a minimum.

The Chair now recognizes the gentleman from North Carolina, Mr. Butterfield, 5 minutes for questions.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman, for yielding time. Let me begin, Mr. Chairman, by just echoing some of the sentiments that were expressed by Ranking Member Pallone at the outset of this hearing. I share those concerns. This topic is very perplexing and very difficult for us to grapple.

We hear different terminology as we have this debate. I hear Mr. Lance talk about repairing the ACA and I hear others talk about repealing the ACA, and so I am still trying to grapple with what we are talking about today. This appears to be another hearing to discuss Republican plans to change the healthcare system and reduce people's access to care and to make health care more expensive. That is the way it appears to me.

You are trying to enact these changes that will actually make health care more expensive for low-income individuals and children and families and older Americans. After 7 years of complaining about the ACA and actively trying to disrupt by ripping it apart and causing it to fail, it is disheartening now to see a plan that is half written and incomplete. I expect more. I think the American people expect more.

And I will say what my colleagues have said repeatedly, we are prepared and willing to work with you to improve the Affordable
Care Act, make no mistake about it. This is the second day we have been in this room discussing ways to make it harder for people to access health care.

I represent one of the poorest districts in the country in North Carolina where nearly one in four people live in poverty. Every day I hear from constituents about increasing access to health care, not decreasing it. Many of my constituents talk to me about expanding Medicaid and strengthening the ACA not making it harder to access health care.

My constituents overwhelmingly, Mr. Chairman—maybe I spent too many years in a courtroom, Mr. Chairman. If the committee will come to order.

Mr. Burgess. The gentleman from North Carolina is correct.

Mr. Butterfield. Yes.

Mr. Burgess. The committee does need to be respectful to the people who are speaking. Can I ask the committee to come to order?

Mr. Butterfield. My constituents, Mr. Chairman—

Mr. Burgess. The gentleman continues suspend.

Mr. Butterfield. Thank you. I guess I was spoiled by being in the courtroom, Mr. Chairman.

Mr. Burgess. The gentleman may proceed.

Mr. Butterfield. My constituents, Mr. Chairman, overwhelmingly support our new Governor in North Carolina who is doing all that he can to expand Medicaid. In my district the uninsured rate has been cut by one-quarter. More than 35,000 people have insurance as a result of the ACA. Across the country 20 million people have obtained health insurance since 2010. The uninsured rate in our country is at an all-time low. That is a fact.

I could talk for hours about the statistics that show North Carolinians and Americans are better off because of the ACA. Our healthcare system is better off because of it. It could be in an even better situation if detractors had not consistently fought it at every turn.

Now Republicans want to turn back the clock. They want to put insurance companies back in charge of health care, make it more difficult to keep your healthcare plan and make it more expensive for many Americans to pay for health care.

Chairman Burgess, I agree with your comments yesterday that seemed to indicate that this committee has gotten off on the wrong foot. I believe it has. Democrats will not stand idly by while we are forced to consider proposals that will restrict access to health care.

Mr. Chairman, I have received a letter from AARP which supports the positions that I have just articulated. I would ask unanimous consent that it be included in the record.

Mr. Burgess. Without objection, so ordered.

Mr. Butterfield. All right, I have 1 minute remaining. Dr. Lichtenfeld, thank you for your testimony in support of many of the improvements to our system made by the ACA. Many of my constituents in eastern North Carolina are from minority groups, racial minority groups.

Can you discuss some of the cancer health disparities experienced by ethnic and African Americans and Hispanic Americans
and would some of the potential changes to our healthcare system discussed today further exacerbate these disparities?

Dr. LICHTENFELD. Well, Mr. Butterfield, thank you for your question. I mean there is no question that ethnicity plays a role in access to care and there is also no question that socioeconomic status plays a role in access to care. Making certain that all individuals have appropriate access to affordable care that meets their needs particularly for cancer patients is so important.

I have lived in a rural area. I have experienced and seen the issue. I am in a State that did not expand Medicaid as have 19 other States have not done so, and what the evidence is showing us is that access to care through insurance by whatever mechanism is important to reduce the burden of cancer.

So we are aware of that. We are hopeful in the committee going forward will address that issue as well.

Mr. BUTTERFIELD. Thank you, Doctor, and thank you, Mr. Chairman. I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair now recognizes the gentleman from Oregon, the chairman of the full committee, Mr. Walden, 5 minutes for your questions, please.

Mr. WALDEN. Well, I thank the chairman. And I have been listening to the various comments and the testimony, and let me say again, this is a discussion draft. It is not a finalized bill. We are not coming here to cram something through that nobody has had a chance to have input on or read. I thought that is what you wanted. It is what I want.

And so there are some opportunities to weigh in. That is what a—this may be unusual for some, but that is kind of what a legislative process is supposed to look like. And I will tell you what. I read all your testimony, and I appreciate it from a lot of levels. I have heard some of the things hurled my way. I don't want lifetime caps. I care pretty deeply about older people and younger people, including infants, very personal place.

And I have seen markets that work and markets that don't. I fought on insurance companies when they were denying care and shouldn't. I fought to create high-risk pools when in my home State you didn't have the fix on a preexisting condition. I have seen cancer up close. My mother died of ovarian cancer, my sister-in-law, brain cancer. Like many of you, you or people in your families or in your communities deal with this. The notion that somehow because there is a break in the dais we don't care about getting this right is beyond the pale.

So I hope going forward we can have a really constructive discussion here about how to make this bill work, how to make sure regardless of what we or some other Congress does going forward that if you had a preexisting condition you will always have access to care and that there won't be some artificial cap that says through no fault of your own you have a disease that keeps coming at you, but sorry, you are on your own and you are destitute. That is not the choice here. The choice is how do we get it right.

The notion that this individual market is in a wonderful place is a fiction. All you have to do is listen to the experts that are out there and they will tell you this can't survive the way it is today.
If Hillary Clinton were in the White House and Democrats controlled everything, I tell you, you would be back because just like we had to deal with other problems over the years, just like the laws that have been passed and voted on by Republicans and Democrats to deal with problems in Obamacare, we are going to repeal this and we are going to come back with a plan that will work for everybody.

Now I want to ask the gentleman from Wisconsin, reading your testimony it was pretty evident you had a market that was working, not perfect but working. Tell me what happened when the ACA came down on top of what your State was doing, and tell me this, too: Is it possible for us here to pass this piece of legislation as appropriately written that will guarantee people have access to care of their preexisting conditions and that there won’t be caps on lifetime coverage, and could you still put together a market with those two conditions?

Mr. Wieske. We can in Wisconsin. I feel confident that—I mean we still have 15 insurers in the marketplace, in the market and selling insurance through the exchange. We have another six or seven that are selling off-exchange. We think that those will step up more to the plate if the rules reflect the actual costs.

We have had a number of significant market exits. We think we can get them to return if the market rules are more reasonable across the country. It is not our rules that are the problem it is the Federal rules. They are losing money. We have seen significant, if you talk to our financial folks you have seen significant loss of capital inside the insurers that will never return under this environment and that is why they are leaving the individual market.

The individual market is a residual market as was shown in the slides. It is roughly, you know, seven percent, five percent of any State’s market. It is very small and it is leading the losses and that is why they are exiting the market. That is what is causing the issue.

So I think a return to that if it returned to market principles with appropriate consumer protections that the market will return. It will take some time. Kentucky destroyed their market in the 1990s. It eventually came back. And so I think it will come back, yes.

Mr. Walden. Mr. Holtz-Eakin, do you agree with that concept?

Dr. Holtz-Eakin. I do agree with that. I think there is a lot of evidence that you can put in place sensible market rules and have vibrant individual markets. We don’t right now, but it can be done.

Mr. Walden. I know I have used up my time, Mr. Chairman, unless the doctor wants to respond. I would be happy to get his additional comments as well.

Dr. Lichtenfeld. Thank you. Thank you, Mr. Chairman, I appreciate that.

Mr. Burgess. Proceed.

Dr. Lichtenfeld. You know, we sit here and we talk in certain words such as market principles, and I understand that. I accept that and that is not the problem. But when market principles get in the way with people having affordable care particularly the older people, then we run into difficulty.

Mr. Walden. Right.
Dr. Lichtenfeld. So as you said and I said earlier in my testimony or in my comments, this is a work in progress, understood, here to help try to meet a resolution.

Mr. Walden. We appreciate that.

Dr. Lichtenfeld. That is what we are aiming for so that we don’t run into the problem where a principle becomes a barrier that then prevents people from getting access to care.

Mr. Walden. Right, thank you. Thank you for your indulgence and your help.

Mr. Burgess. The Chair thanks the gentleman. The gentleman yields back. The Chair now recognizes the gentlelady from California, Ms. Matsui, 5 minutes for your questions, please.

Ms. Matsui. Thank you, Mr. Chairman. When we started writing the ACA over 7 years ago, I consulted with a full range of healthcare leaders in my community in Sacramento. We called together the hospitals, the health plans, the community health centers, the patients, and all those that contribute to our healthcare systems. Everything was fully constructed because we knew that each policy affected the next and the system as a whole.

We all know that health care is complicated. You can’t simply consider these changes in a vacuum. The Republicans have been saying for almost 7 years that they have a better way, but what we have seen today does not protect people. It really does take coverage away.

One of the bills shortens grace periods to 30 days, which means that if someone misses just 1 month’s premium payment they can be kicked off of their health plan. For many workers with fluctuating income they may need to forego a payment 1 month in order to put food on the table and then pay it back the next when they receive their paycheck.

Now, if getting kicked off your plan wasn’t bad enough, the second policy kicks—which says, or we assume it will say, that you must maintain continuous coverage or else insurance companies will charge whatever they want the next time you sign up. If they know you are sick, they could offer you a plan, but only if you paid thousands of dollars a month, and what good is that? So now if a person ever misses even a single payment, they could be locked out of receiving health coverage for years or even for life.

Now we talk here in statistics and charts and things like that, and that is very important. But I think we have to all understand that health care is very personal, to all of us here it is personal. Chairman Walden mentioned how personal it is to him with his mother having ovarian cancer. My mother had ovarian cancer. Many people here have had individuals with lymphoma, blood cancer. It is very personal. And I think to a certain degree we have to understand that there are certain diseases like cancer that may hit you with such a shock at the very beginning and you have to figure out what you are going to be doing next.

So this is really a journey for most people with cancer, is that type of disease. So Dr. Lichtenfeld, in your experience, do cancer patients often spend a lot of time with their doctors and care teams to help get them well?

Dr. Lichtenfeld. I am sorry. Can you rephrase the question again? I may have missed it.
Ms. Matsui. Do your patients, cancer patients, often spend a lot of time with their doctors and their care teams to try to figure out what to do next, how to get them well?

Dr. Lichtenfeld. Cancer is a complex disease and there is no question that the most important objective is to get the patient well and that takes time, it takes effort and it takes teams. There are, as I mentioned earlier there is increased attention to mental health issues with respect to cancer, financial toxicity issues, which are above and beyond the care discussion, and there are now requirements being put into place that expect that type of discussion.

So yes, I mean it is not a simple process. It is complex. It is much more complex as time goes on. The drugs are more complex, the treatment, trying to help people get to the treatment, all of these are issues that have to be addressed as part of the cancer journey.

Ms. Matsui. So during this process do cancer treatments like chemotherapy have side effects that make it hard for patients to accomplish daily tasks?

Dr. Lichtenfeld. There is no question that the treatment is toxic for many situations and the fact that many patients are so impacted. I mean the fatigue issues are well known, the ability to work, whether someone, as I mentioned earlier the substantial number of people are not able to work. Meeting payment requirement is important, but yet perhaps the 30 days is not the right number that we should be talking about.

Ms. Matsui. So cancer patients don't get a pass at all on taking care of the finances.

Dr. Lichtenfeld. No, they don't get a pass. So I think we have to look through that cancer lens to understand the implications of what we do, and understanding it through that lens will give us guidance, we believe, in terms of how this should be constructed going forward.

Ms. Matsui. So it is possible that a cancer patient has to deal with so much that even when a loved one is managing their affairs a month's payment can be overlooked?

Dr. Lichtenfeld. It is incredibly complex. We have many life situations that are complex and cancer is certainly one of the most complex that we have to deal with.

Ms. Matsui. So if that patient is kicked off their plan for missing one payment what happens to that patient?

Dr. Lichtenfeld. Well, they end up, whether they could get the care the care would be interrupted, and then when they come back into the system so to speak their premiums under some discussions may be much higher than they would have been otherwise and that may last a lifetime.

Ms. Matsui. OK. I yield back.

Mr. Burgess. The gentlelady yields back. The Chair thanks the gentlelady. The Chair recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for your questions, please.

Mr. Griffith. Thank you very much, Mr. Chairman. I have heard a lot of folks talk about things and what their constituents are telling them. And while I have constituents who certainly have liked the ACA, a vast majority of my constituents have had problems similar to Mark from Stuart, Virginia, who writes in part,
talking about the increased premiums that he has had to pay, he says, “It has cost my family around $21,000 over the last 3 years.”

He goes on to say, “I would like nothing more than to see this law repealed as fast as possible and relegated to the trash heap of history.” He goes further, “Please be responsible in what it is replaced with and make sure it consists of commonsense measures that will help, not hurt, middle-class families.”

And I think that is why we are here. We are trying to figure out how we can do things that balance it out which is why, Mr. Wieske, I want to talk to you about the high-risk pools that were successful in your State. How many people did you all cover?

Mr. WIESKE. Roughly 25,000.

Mr. GRIFFITH. OK. And what rates were you able to offer these patients? I know you said they were affordable but just give me some idea of what they were.

Mr. WIESKE. They varied, so the deductibles varied from $1,000 deductible all the way up to a $7,500 deductible. I believe the rates for the typical, in my testimony I compared it to the rates that what a Silver Plan would be and it was a little bit lower than what the ACA plans are in Wisconsin currently.

Mr. GRIFFITH. OK.

Mr. WIESKE. So roughly about, depending on—it varied based on age—so between 200 and 500 dollars, roughly.

Mr. GRIFFITH. OK. And I thought it was interesting you said that 40 percent was paid by the insured, 30 percent by the insurers, 30 percent by the medical folks taking some discounts——

Mr. WIESKE. Correct.

Mr. GRIFFITH [continuing]. But then at one point I thought I heard you say there was also some private money?

Mr. WIESKE. There were subsidies that were also included as part of those assessments. So consumers who had, or members who had, incomes at or below $34,000 received subsidies, at the lowest end was up to a 43 percent subsidy on the premiums.

Mr. GRIFFITH. And the subsidy came from?

Mr. WIESKE. It came from the high-risk pool.

Mr. GRIFFITH. It came from the high-risk pool.

Mr. WIESKE. The high-risk pool funds, yes.

Mr. GRIFFITH. OK, so that would have been some State money?

Mr. WIESKE. No State money. There was no State money at that time.

Mr. GRIFFITH. Explain that to me. It came from the high-risk, was that the insurers?

Mr. WIESKE. It was the insurers and the providers, the discounts. So they were able to provide——

Mr. GRIFFITH. So that was part of the 40/30/30 that you were talking about?

Mr. WIESKE. Correct, right.

Mr. GRIFFITH. All right. And I think you have already answered it was not a one size fits all? You could make some choices within the high-risk pool itself?

Mr. WIESKE. Yes, yes.

Mr. GRIFFITH. All right, so we are trying to figure out how to craft which is why, you know, it is interesting. I have heard some criticism that Chairman Walden’s bill has a placeholder in it, but
we are trying to figure out exactly, you know, what we can do to make this and get all the ideas, Democrat and Republican.

So what in your opinion, if we are going to set up a high-risk pool what are the most important factors to consider when States design these high-risk pools? When we say to the States if we decide that is where we want to go, what should the States be doing to make their high-risk pools work as yours did?

Mr. WIESKE. Yes, I think affordability is the key. I think having a good partnership between the providers and the insurers and having a strong board that is interested in governing, a long-term board. It was outside of the—it was a quasi-governmental entity that ran the high-risk pool. I think that was effective. They hired outside experts.

They had, instead of taking the claims in-house they hired an administrator. They had a great administrator who did great work. So I think having a strong structure in place is the most important piece and then having the funding mechanism that is stable.

Mr. GRIFFITH. All right. And, you know, one of the things that I had thought we might have to do, but you all didn't have any State money, do you think we need to at least prime the pump, so to speak, and have some Federal money to help the States get their high-risk pools started, or do you think they can take your model and not have any Federal money?

Mr. WIESKE. I think you see if you look at the Federal, so early on the ACA did include funding for high-risk pools, and I think if you look at the premiums for that they dropped considerably. There was about a 150-$200 drop depending on the age in premiums. So I think Federal funding could certainly help make that coverage much more affordable.

And, again, I will say that high-risk pools are not for every State so there may have to be other options like reinsurance schemes or, you know, maybe some States do want to do guaranteed issue, but we found high-risk pools effective.

Mr. GRIFFITH. OK, I really do appreciate that. You know, this is a tough nut to crack on all those bills that we are considering, not only the ones for today but other bills you see us considering. All three of the witnesses, if you would please let us know.

I mean I am making suggestions to Chairman Walden's team to make some improvements on his bill that I think might need to be in there, but we encourage you to let us know what you see and what you think you can do because we are looking for constructive criticism. We want to take the time to get this right for the American people, and so as Mark from Stuart said to make that we are helping folks and not hurting middle class families in America. But thank you so much for being here today. I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for your questions, please.

Ms. CASTOR. Well, thank you, Mr. Chairman, and thank you to the witnesses for being here. I wanted to make sure that we go back again to the point because we have the chart that was up on the screen and the impression that may have been left that repealing the ACA applies just to the healthcare.gov marketplace.
And I think folks really need to understand that when you repeal the ACA as my Republicans are on track to do that affects all Americans, everyone. Medicare, Medicaid, or the folks, the 20 million Americans who did get coverage under healthcare.gov, the marketplace—and in Florida that was 1.7 million, larger than the population of some States have enrolled in the marketplace in Florida—but the employer based insurers where most of our neighbors get their insurance.

There are vital consumer protections that have improved the lives of our neighbors and you simply can’t gloss over that or ignore it and people need to really understand what they have gained, and Florida is a great place to look. In Florida we have 8.8 million that have their insurance through their job that means that all of those folks can no longer be discriminated against if they have a pre-existing condition like cancer, diabetes, asthma, heart disease—we estimate that that is about 7 million Floridians.

Under the Affordable Care Act, under your private policy your kids can stay on your policy until they are 26 years old. Insurance companies cannot cancel your policy if you get sick and they can’t impose lifetime limits or caps. All of that will be lost under the ACA Republican appeal plan. These consumer protections have been a godsend to our neighbors.

And let’s talk a little bit about cost because I am very, I am sensitive to the fact that the markets are different across the country, but you can’t deny that before the ACA healthcare costs were out of control. And if you look just in my State, the ACA has generated significant savings for Florida families.

And we have got to do more to control the cost. If we can really tackle pharmaceutical costs that would be a great help for families. I don’t see any bills on the agenda today that do that but that would be very positive. Florida families with employer coverage saw their premiums grow only 1.3 percent from 2010 to 2015 compared to 8.2 percent over the previous decade before the Affordable Care Act. That means, if you look at it in real dollars, a savings of about $7,600 per family.

The ACA also requires, and this doesn’t get a lot of play but it is very important. The ACA also requires health insurance companies to spend at least 80 percent of their premium dollars on actual health care, not administrative costs or profits, and if the insurance companies go over that 80 percent they have to—consumers get a refund. HHS reports that Floridians with employer coverage have received $109 million in refunds since 2012. That really makes a difference for the working families I represent.

So one of the bills that is on the agenda for discussion today is age rating. Boy, have you really hit a nerve back in Florida to ask that our older neighbors, and we are talking about those that are under 65, are going to pay a whole lot more for their insurance coverage.

The thing about the Affordable Care Act, it is this very considered, thoughtful balance. Over time it is going to need rebalancing. Like I said, markets like mine are very competitive even in the individual market with 61 plans to choose from. Not all parts of the country are like that. But if you start tinkering here and asking my older neighbors to pay a whole lot more before they go into
Medicare that is not smart. We want them to be as healthy as possible before they go into Medicare because we have our challenges there as well.

So watch out for this age rating, and I go back to the woman that I mentioned during my opening remarks who is 60 years old, working part-time in a small business, taking care of her youngster in high school, going to school. You ask her to pay five times the going rate instead of what is in the ACA now you probably price her out of this.

So let's be thoughtful in what we do. We have got to turn back this repeal effort, though, and make more considered and thoughtful policy here in Washington, DC. I yield back my time.

Mr. Burgess. The Chair thanks the gentlelady—the gentlelady yields back—and recognizes the gentleman from Florida, Mr. Bilarakis, 5 minutes for questions, please.

Mr. Bilarakis. Thank you, Mr. Chairman. I appreciate it very much, and I thank the panel for their testimony as well.

Mr. Holtz-Eakin, I understand you run your, CBO, and you currently run a think tank?

Dr. Holtz-Eakin. That is correct, sir.

Mr. Bilarakis. Your organization recently did a review on the various replacement plans that conservatives had introduced. There is the Better Way by House Republican Conference, the Patient CARE Act, the Improving Health and Health Care Act, Empowering Patients First Act, the American Health Care Reform Act, the 2017 project in the World's Greatest Health Care Plan.

When people say Republicans don't have a plan that is simply not true. There are many plans and competing ideas. However, it would be fair that there are certain common areas that are in most of these plans. Can you talk about the ACA provisions that in your expert opinion would most likely be kept? If you would elaborate, please.

Dr. Holtz-Eakin. Yes, I mean one of the reasons we wrote the paper is that there is an enormous amount of overlap and so it seems to me to be sensible to expect those to be present in any replacement plan.

So all of them allow children to stay on the parents' policy until age 26 as in current law, all prevent discrimination against those with preexisting conditions and guarantee the issuance of an insurance policy, all of them ban caps on annual or lifetime out-of-pocket costs for individuals, and then they all have subsidies for individuals, typically age based so the elderly, the older and more likely to be expensive patients get some help.

All of them have some sort of risk pool for those who can't be managed in the normal pool and all have some sort of approach to the continuous coverage idea where the differences quite frankly are in how do you handle the gaps. Handling the gaps, I want to echo what was said, is a really important issue. All of them have some provision to cap the most exposure that an individual would face if somehow they did develop a coverage gap for reasons outside of their control. So there is always common elements in these replace plans.

Mr. Bilarakis. Very good, thank you.
Mr. Wieske, when the ACA was passed there were several promises made about it. The American people were promised it would bend and cost curve through increased competition the health insurance market. In Florida today 73 percent of the counties have only one health insurer and average premiums increased by 19 percent last year. I fear that what it will look like 2018.

You mentioned that in Wisconsin you have an active insurance market pre-ACA——

Mr. WIESKE. Yes.

Mr. BILIRAKIS [continuing]. And then how was the health market before ACA and now with the ACA? Can you discuss it?

Mr. WIESKE. Yes, I think we saw the highly competitive markets were fortunate. We still have a lot of choice in our market, but it is evaporating slowly but surely. And we see carriers consistently move their market around, move their coverage areas around, so there is a lot of instability. They have changed their networks. They have changed their networks around in order to deal with affordability and competition and issues, and the net result for a consumer is consumers don’t have as many choices as they had before the ACA. They have fewer choices in coverage.

Mr. BILIRAKIS. Thank you. Mr. Holtz-Eakin, again just in case members of the minority might not be familiar with our Better Way agenda, can you please detail that the Center for Health and Economy analysis finds the plan broadly what it accomplishes. Again, the impact on premiums would they increase or decrease? What about provider access? Would there be an impact on the Federal budget? Can you go ahead and discuss that?

Dr. HOLTZ-EAKIN. The Center for Health and Economy, of which I am a board member, did an analysis of the Better Way plan. I won’t remember all the numbers right, but broadly speaking the insurance market deregulation lowers premiums something in the vicinity of 15 percent or so. Lower premiums improve private coverage in that plan and expand coverage. As a result of both the lower premiums and the subject structure there is less stress on taxpayers and there is budget savings in the Better Way Plan.

And underneath the plans is important I identify what kind of networks and provider access are available, and access has improved. And there is an index of medical productivity, something to think about in terms an index for bending the cost curve, and there is improved medical productivity in the plan.

Mr. BILIRAKIS. Thank you very much. I yield back, Mr. Chairman, appreciate it.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for your questions, please.

Mr. SCHRADER. Thank you very much, Mr. Chairman. I appreciate the panel for being here. I just want to put some emphasis on the goal of what we are trying to do here and that is not to just beef up an insurance market, but to provide good health care for Americans. That is really our goal.

The vehicle we currently have is dealing with the insurance market, I get that. But I think when we are talking about you can’t have the plans you want, et cetera, the goal here is to provide the essential benefits that basically provide health care for the scope
of the people of this great country. And if everyone just pays in their little bit just like you do in any insurance program everyone benefits at the end of the day.

I think we have to focus on the health care aspects here. I am a little concerned about the tenor of the hearing. I want to make sure we are talking apples to apples as we go forward.

Mr. Holtz-Eakin, you talked about that some of these fixes could help stabilize the markets, so I assume you don’t see these as replacement for the ACA but to stabilize the current market structure?

Dr. HOLTZ-EAKIN. Yes, the special enrollment periods, grace periods, those kinds, again these are what I think of as near term Band-Aids to make sure the current deterioration doesn’t continue and it works——

Mr. SCHRADER. I think that is fair. So they are not going to replace the ACA in and of themselves.

Mr. Wieske, you talked a lot about the high-risk pools and you have a robust market in Wisconsin. Knock on wood we still do in Oregon, but some States don’t, some counties don’t, depending on the State they are in. I get that. You talked about the Federal subsidy driving down the cost of the program if you will making it more affordable for Wisconsinites.

You know, if we get rid of the ACA in its entirety which has been proposed, and all the revenues, the 800 billion plus some of the other policy changes that make sure this is a deficit reduction, a piece of legislation, you know, what do you think? Don’t we need some Federal revenues to make whatever system we have going forward affordable for Wisconsinites?

Mr. WIESKE. I mean I think Federal revenues obviously make it easier, but functionally, I mean I will say our market functioned pretty well. There was guaranteed issue available. Nobody could be turned down in most States, I think all States, because of a health condition once they were insured, so that didn’t exist and that didn’t exist in Wisconsin. People were not dropped off their coverage due to——

Mr. SCHRADER. So I have to interrupt, I apologize. I don’t have a lot of time. Yes, and I think there is different opinions about, you know, who should get, you know, well, apparently some different opinions about who should get covered. I think everyone should have coverage and that means making it affordable and maybe even giving some people more of a break than some people think they deserve, because it all costs us at the end of the day if they don’t have health insurance and that is just not productive.

I want to make a statement and I would like everyone to think about this both Democrat and Republican and you certified smart people over there on the dais. I am very worried these young people we are trying to get onto the individual marketplace they don’t exist. I see no evidence that these people are out there no matter what we do—age bands, difference in premiums.

The reason I say that is, and I would love to be proven wrong but no one has been able to give me the information, insurers, you know, providers, whatever is that a lot of young people are on their parents’ plan, age 26. A lot of people have jobs, especially right now. They are working. The people that are on the individual mar-
ket are, in my State and I think most States, adversely selected. They are 50 to 65 years old. They have got a bunch of medical conditions.

And last but not least, with the Medicaid expansion that has been successful across the country and is part of the ACA—I think we have to understand that the Medicaid expansion is part of the ACA—the biggest portion of that population that signed up, they are young. Well, younger than me, under 45 years of age, eh. So that is good.

I am worried that we are chasing a unicorn here, folks. I am worried we are chasing a unicorn. I don't care what plan I have heard from my Republican colleagues or as Democrats. So I think we need to put that into the mix as we think about how do we make sure this individual market is stabilized. It has been a boon for a lot of folks. It has worked very well for a lot of folks. It has some problems and maybe some of these fixes would get to them.

And I would hope that the majority party would look at working with the minority party on some of these. The age bands don't have to be 5:1. The grace period doesn't have to be 3 months, you know, there is accommodations that we have talked about in previous hearings.

And I think we keep in mind that this is to stabilize the current ACA marketplace while my colleagues, trying to chase maybe a unicorn, maybe we have been chasing it and now it is their turn, but I hope we look at this and the goal again is to provide excellent health care to every single American in the greatest nation on earth. And I yield back.

Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman. The Chair now recognizes the gentleman from Indiana, Mr. Bucshon, 5 minutes for your questions, please.

Mr. Bucshon. Thank you, Mr. Chairman. Dr. Holtz-Eakin, your written testimony is packed with incredible statistics on age rating bands and I would like to read a few, just some facts. Average healthcare expenses for a 64-year-old are 4.8 times greater than that of a 21-year-old, and according to U.S. Census data, the insured rate for those age 19 to 34 is 4.6 percent higher than the uninsured rate for those age 35 to 64.

I raise this because you note that the administration predicted that the individual market would need about 40 percent in the enrollee population to be made up of young, healthy patients. Today that number is 28 percent. So the 3:1 age band in my view is just not an actuarially sound principle based on that. Would you agree that modifying the age variation in premiums would help balance risk and help stabilize the marketplace?

Dr. Holtz-Eakin. Yes, it would help. It would allow insurers to offer relatively cheaper policies to the young and relatively inexpensive. It is true that they would be relatively more expensive for the older and sicker. That is a financial reality. But getting those into the pool helps everyone over the long term.

Mr. Bucshon. So at the end of the day, do you think one of the biggest problems with what is happening in the exchange marketplace is mostly based on the fact that it is 28 percent young, healthy people versus 40 percent? Would you consider that the major factor or are there other reasons?
Dr. Holtz-Eakin. There are probably some other reasons. I think this sort of grace period or the special enrollment periods or things like that have exacerbated the fundamental problem. But this is a core problem and because of the exits and the rising premiums it is getting worse not better.

And we have discussed a little bit about the design of high-risk pools today, my basic theory is we have a high-risk pool, and it is called the exchange market, and it is just getting more and more like one every day.

Mr. Bucshon. OK. Mr. Wieske, do you have any comments on that?

Mr. Wieske. No, I think that is exactly right. And part of to understand is as you get more of the young folks in that drives the average rate down so that 5:1 may still be a 5:1, but it is not necessarily the same 5:1. It is a lower figure that you are starting with when you multiply it times 5.

Mr. Bucshon. Correct. So the 1 will be a lower starting point.

Mr. Wieske. Correct.

Mr. Bucshon. And I think that is one of the concepts I think that people try to overlook. If you take changing the age rating band and the concept that the 1 will stay in the same place that it is today, you can make the argument yes, costs will be so high for the older, sicker patients that it might price them out of the marketplace.

But my, you know, shifting the idea is to shift the whole marketplace back to a more actuarially sound position. So it is not just this, but there is some other actuarially unsound principles in the ACA that in my view have predictably resulted in where we are today.

Do you have any other final comments, Dr. Holtz-Eakin, on that? Anything else that is what you consider nonactuarially sound other than the age bands that we might be addressing that we haven’t addressed? Do you have any other thoughts?

Dr. Holtz-Eakin. I think the more you delegate the sort of regulatory process and the review process to the State insurance commissioners, the better you are going to get this because the pools are different State by State, dramatically different.

Mr. Bucshon. Very important concept.

Dr. Holtz-Eakin. And so I think you should recognize that in going forward.

Mr. Bucshon. OK. Mr. Wieske.

Mr. Wieske. Obviously we agree. And I think, you know, I think the other piece here is that you can take a look at the testimony and you can see the disparate impact that the ACA had on rates when it was implemented. And in my testimony we have numbers that show that the increases were substantially higher on the younger folks than they were on the older folks, so it is a return back to where it was before.

Mr. Bucshon. Dr. Lichtenfeld, I was a cardiac surgeon before I was in Congress, so I am going to ask and this is a serious question. Before the ACA, prior to the ACA, if you were referred a patient, you know, that has cancer for example, say, a GI doctor referred you someone that has a colon cancer and that person did not have medical coverage how did you handle that situation?
Dr. LICHTENFELD. With difficulty, quite frankly.
Mr. BUCSHON. Yes. Did the patient get medical care?
Dr. LICHTENFELD. Well, they may have gotten some medical care but they didn’t get adequate medical care.
Mr. BUCSHON. So if they needed follow-up chemo from their colon cancer for example what, a 5FU or whatever you guys do these days, did they get that or they didn’t get it?
Dr. LICHTENFELD. 5FU is one question, the newer treatments we have today are entirely different, OK.
Mr. BUCSHON. OK, the newer treatments then, yes. OK.
Dr. LICHTENFELD. And certainly, sir——
Mr. BUCSHON. I haven’t done GI or colon stuff in 25 years so I am behind.
Mr. BUCSHON. I respect the work that you have done. In fact, one time in my life I wanted to be a cardiac surgeon and didn’t make it, so——
Mr. BUCSHON. You made the right decision.
Dr. LICHTENFELD. But the reality is, you know, we as physicians always want to do what we can to stabilize somebody in their time of need. That is very important.
Mr. BUCSHON. Yes.
Dr. LICHTENFELD. Unfortunately cancer is a complex, long-term disease.
Mr. BUCSHON. Understood.
Dr. LICHTENFELD. And those folks will fall through the cracks. They did, and they are doing less so today.
Mr. BUCSHON. OK, thank you. I yield back.
Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for your questions, please.
Mr. KENNEDY. Thank you, Mr. Chairman, and I want to thank the witnesses for their testimony today, touch on a couple of issues. Mr. Wieske, you had testified and you spoke an awful lot today about the benefits of Wisconsin’s high-risk pool, sir. I wanted to make sure we just fleshed that out a little bit. My understanding is that when you talk about the comprehensive coverage that was provided to consumers and that the cost coverage closely mirrored the cost of private coverage in the State, I believe though that the premiums for the Wisconsin high-risk pool were set at twice the individual marketplace; isn’t that right?
Mr. WIESKE. No, that is not correct. They were set based on an actuarial basis, so the——
Mr. KENNEDY. So that is information coming from Kaiser Foundation.
Mr. WIESKE [continuing]. I am sorry.
Mr. KENNEDY. I am sorry. The information coming from the Kaiser Family Foundation indicated that those prices were twice the——
Mr. WIESKE. The numbers in my testimony were actually provided through the Legislative Audit Bureau, which did an audit of the State high-risk pool. I sat on the State high-risk pool board. The rates were set based on the actual contribution to costs by each of those that split the 40/30/30 that I talked about.
So that was where it was. It was not set in an artificial 200 percent of the Federal—I don’t know where they got that number, unless it came from the Federal high-risk pool piece, which is separate, and they had their own separate rules of how they set their rates.

Mr. KENNEDY. So if it is not—I understand that you are saying they weren’t pegged that way. Were the premiums though twice as high as they were for the high-risk pool as they were for the individual markets?

Mr. WIESKE. Yes. I don’t think so, no.

Mr. KENNEDY. No, OK. Didn’t Wisconsin’s high-risk pool exclude coverage for 6 months for a preexisting condition that made patients actually eligible for that pool in the first place?

Mr. WIESKE. It depended on how you came into the pool. So folks who had continuous coverage it mirrored the preexisting condition piece so that is something that could certainly be fixed. But folks that came from no coverage similar to folks who were facing a grace period who have not signed up for the ACA and can’t sign until the open enrollment period and have to wait until then to sign up if they don’t have coverage, if they came from no coverage they did have a 6-month waiting period.

Again it would be like an open enrollment period except you get to sign up anytime, but only for coverage of that condition. Now folks who came from other coverage that lost their coverage involuntarily did get preexisting condition credit and did not have a preexisting—

Mr. KENNEDY. So if I were, just to make sure I understand that if I did not have coverage before and came down with cancer I would have to wait 6 months for those cancer treatments to get covered?

Mr. WIESKE. Similar to if you did not have——

Mr. KENNEDY. Yes.

Mr. WIESKE (continuing). Coverage right now you could not buy coverage in the individual market. You have to wait until open enrollment.

Mr. KENNEDY. Dr. Lichtenfeld, can you tell me what the impact of having a cancer patient wait 6 months for treatment might be?

Dr. LICHTENFELD. We have actually been through that in the past where in fact some of the commercial plans in the group plans had exclusions of 9 months, so it is a pretty serious issue. And we have also had issues with regard to women who were screened for cancer, mammography for example, who did not get automatic coverage.

So the question was, well, you have screening, you know you may have breast cancer but you can’t get the care. So that has been addressed in some respect through the breast and cervical cancer early detection program. So it is a very real issue cancer doesn’t wait, and there is acute conditions that really don’t wait. So obviously the 6-month exclusionary period which has existed in the past in some places is something to be concerned about.

Mr. KENNEDY. So let me shift topics a little bit here, but I would appreciate your medical opinion on this. We have, as I mentioned in my opening comments a while ago now, this committee has dived into a partial examination of the failures of our mental
health system across our country and some of the systemic failures with that marketplace.

As you might be aware, the largest provider of mental health, or payer for mental health service in the country is Medicaid. And so the combination of mental health parity and the Medicaid expansion and some of the clauses in the Affordable Care Act themselves were a sea change in terms of access to care, understanding we still have an awfully long way to go.

I was hoping you might be able to comment on what the impacts of either doing away with that Medicaid expansion or issues around preexisting conditions what that would mean for folks suffering from mental illness.

Dr. LICHTENFELD. Mental health issues are serious and as I mentioned earlier they certainly impact patients with cancer and families of patients with cancer. Access to those services is very important. And clearly within the community and now with the opioid addiction epidemic that we have and the stress that that is putting on mental health services, we have to make certain that everyone has adequate access to mental health services just as we have talked about with respect to services for patients diagnosed with cancer.

Mr. KENNEDY. Thank you, sir. I yield back.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for your questions, please.

Mrs. BROOKS. Thank you, Mr. Chairman. I just want to clarify, Dr. Lichtenfeld, under current law, current law, if a patient is diagnosed with cancer they also have to wait, do they not, to get into a market?

Dr. LICHTENFELD. I am going to share with you that I can't respond to that directly. To my, you know, depending on the circumstances—I am trying as I think through this—they really are individual. If I may, they are individually specific to that person as to what happens to them, have they been engaged or not, and that is a very real——

Mrs. BROOKS. If they had not been engaged.

Dr. LICHTENFELD. If they have not been then that could be problematic.

Mrs. BROOKS. OK, so that—and Commissioner Wieske, would you—and I am sorry. How do you say your last name?

Mr. WIESKE. Wieske.

Mrs. BROOKS. Wieske, I am sorry. Is that your understanding——

Mr. WIESKE. Yes.

Mrs. BROOKS [continuing]. That under current law if an individual had paid the penalty or had, you know, and was not insured right now, if they develop cancer they too have to wait for open enrollment?

Mr. WIESKE. Healthy or not they have to wait until open enrollment. They cannot enroll until January of the next year unless there is a special enrollment period.

Mrs. BROOKS. OK, thank you. I would like to talk about what we are trying to explore which has to do with continuous coverage and the importance of continuous coverage as a potential tool in
incentivizing individuals to stay covered. And so some folks would suggest that this could lead to higher premiums based off of health status or preexisting conditions, but I believe that to be false.

And because we want to prohibit rating based off of health status, we want to prohibit rating based off of preexisting conditions, critically important, but in order to accomplish this fairness goal we have to stabilize the markets, as I understand actuarially sound market stabilizers.

And so, Commissioner Wieske, as Chair of the NAIC Health Care Reform how do both the State of Wisconsin and the association view the concept of continuous coverage?

Mr. WIESKE. Well, I think it is important. I mean I think a lot of the issues that surround the individual health insurance market are driven by the fact that again it is a residual market and the fact that folks jump in and out from carrier to carrier which has been exacerbated by the ACA.

So I think insurers——

Mrs. BROOKS. Can you expand on that please?

Mr. WIESKE. Sure. That in the ACA that you have seen people typically jump from one carrier to another obviously based on price, based on their interest.

Mrs. BROOKS. And when you say they jump from one carrier to another what is the time period in which they have been doing that?

Mr. WIESKE. Every year they look to switch as to what their best options are. That is appropriate shopping. But I think if you can design a system that where their coverage is more continuous, I think that the interest of the insurers change in driving more long-term health and I think that is really where the issue is, is that if you have only got somebody for a year or 2, your investment in their long-term health never pays off. It pays off for the next insurer.

So if you can have a long-term coverage with a single insurer you end up having a system where those further investments pay off for the insurer.

Mrs. BROOKS. And do we have some circumstances where people might be insured for 9 months and then drop out?

Mr. WIESKE. Yes, definitely we have heard that the—yes, consistently.

Mrs. BROOKS. Dr. Holtz-Eakin, I understand—what are your thoughts with respect to continuous coverage with respect to a mechanism for stabilizing the healthcare markets?

Dr. HOLTZ-EAKIN. As I said before, I think it is a very important concept. Obviously there are details that need to be worked out, but the incentives to get the young into the pool are very powerful. The issue of having a balanced pool gets taken care of organically because the young are always jumping in. Some will become more expensive as they get older; they are all in the pool.

But the fundamental issue has always been how do you get quality care at lower costs, and this gives insurers the correct incentives to look over a lifetime, work with the providers not just for short-term purposes but for the long term and that would be beneficial. We don't have those incentives in the system right now. The closest place for that quite frankly is employers. Self-insured em-
ployers often have employees for an average of 7 years. That is a time period over which you can make a big difference.

And I consider it no surprise that that is the place where we have seen the slowest cost growth in the U.S. health system.

Mrs. BROOKS. Can you share any actuarial cautions we should consider as we are shaping this process and what are some of the incentives that you believe could be really helpful?

Dr. Holtz-Eakin. I think the most important thing is to separate what the system looks like from how we get there, and today's discussion is largely that sort of stabilizing it so that you can get something in place. The high-risk pools will be at a minimum a very important part of the transition mechanism. Figuring out who goes in and who comes out and gets back into the regular pool, I think, is going to be a really important part of this.

Mrs. BROOKS. Thank you. I yield back.

Mr. BURGESS. The gentlelady yields back. The Chair thanks the gentlelady. The Chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman, and thank you to the witnesses for being here today. I guess it is an advantage to come early and hear what everyone has had to say and the questions that are asked and the answers that you have proposed.

I want to start out by commenting on Chairman Walden's remarks. He is a good man, and I take him at his word in terms of what he believes in. But for each one of us, we are legislators. We are legislators. So while we can all talk about what we believe in what is actually written down in legislation which you are here to give testimony on, we came to a hearing where Title II Continuous Coverage Incentive is blank, blank. It is blank. So I can't help but comment on that first.

There are so many things that have been said that I find either curious or really menacing. First of all, the Affordable Care Act in its promise which has been kept so far is that no one can take it away from you. That is not what the American people experienced before that legislation became law. Now today the only ones that can take it away from you are the Republicans. And that is what repeal is. Repeal is a heavy, heavy word. It is a wrecking ball.

We are sitting in a hearing room that was recently remodeled. The entirety of the Rayburn Building was not taken down. It wasn't destroyed and then rebuilt simply because these daises needed to be adjusted or the room repainted. So when the word repeal is used, it is chilling and, you know what, it is chilling to markets. It is chilling to markets. And I don't think that has been taken into consideration by our witnesses today.

Now this whole issue of insurance across State lines and what it is going to do, I can buy an insurance policy across State lines today. Maybe I pick Idaho, I don't know, Arizona, wherever. Terrific. Maybe it is lower cost than what I have now. The only problem is, when I get sick I have to travel to that State in order to take advantage of it. And within our 50 States, there are many different standards. Some States are low-ball States. They have practically no protections for consumers, so if that is what is opened up, that is a disaster, in my view.
Now what I want to ask each one of you is, do you support national insurance for people in our country, each one of you, yes or no? Quickly, because my time is running out.

Dr. HOLTZ-EAKIN. I don't know what national health insurance is.

Ms. ESHOO. That everyone in this country is able to get health insurance.

Dr. HOLTZ-EAKIN. Everyone has an opportunity to buy a policy, sure.

Mr. WIESKE. Everybody should have access to affordable health insurance.

Ms. ESHOO. Just access or be able to get it? I can go to Nieman's. I can have access at Nieman's.

Mr. WIESKE. I think access means that they can get it. If it is affordable, access means they can get it.

Ms. ESHOO. Dr. Lichtenfeld.

Dr. LICHTENFELD. Ms. Eshoo, and my personal thoughts are not relevant to my presentation today, I am here on behalf of——

Ms. ESHOO. Well, you are here on behalf of—say yes or no.

Dr. LICHTENFELD. I am here on behalf of the American Cancer Society and we are—just like everything else, we will certainly consider proposals if they are made. Our concern today is to make sure that——

Ms. ESHOO. That is it. I am losing my time.

Dr. LICHTENFELD [continuing]. Going forward that we——

Ms. ESHOO. Do you support that? You all say that you support the very good things that are in the ACA—no discrimination, pre-existing conditions, women, up to 26 on their parents' policy—so you would support a mandate in whatever replaces the ACA to include those, because it is a mandate.

Dr. HOLTZ-EAKIN. I didn't say that. I said every replacement we have studied continued those——

Ms. ESHOO. No, I am asking you do you support that? You accept that it is a mandate or is it voluntary? How are these things going to come about if they are not baked in as a mandate for an insurance policy?

Dr. HOLTZ-EAKIN. People are permitted to have their children on their policies up to age 26. They are not mandated to have them until 26.

Ms. ESHOO. But there is a mandate to the insurance industry that those reforms which cover everyone——

Dr. HOLTZ-EAKIN. Yes, it is the current law.

Ms. ESHOO [continuing]. So you accept that?

Dr. HOLTZ-EAKIN. Yes.

Mr. WIESKE. We had these reforms in place——

Ms. ESHOO. Do you, Mr. Wieske?

Mr. WIESKE. We had these, we performed——

Ms. ESHOO. No, I don’t want to hear about that. I just want to know if you——

Mr. WIESKE. But Wisconsin believes that it has a good market and it doesn’t need a Federal mandate to tell us what to do.

Ms. ESHOO. But do you support those being mandated relative to the insurance industry in our country, those reforms?

Mr. WIESKE. We would look at it in State law, yes.
Ms. ESHOO. Do you think that beyond your State it should be?
Mr. WIESKE. I can't speak for other States.
Ms. ESHOO. Do you want it for your State?
Mr. WIESKE. We will work with our legislature and the legislature will figure out what is——
Ms. ESHOO. Well, you know what, this is like nailing Jell-O to a wall because I don't think there is a commitment. I think you talk about these things and that they are good things, but unless these reforms are held onto that were made and have made an enormous difference in people's lives, including all the cancer patients in our country, then there isn't a commitment to them. And I think that this is part of the basics of what the integrity of what insurance plans need to have in the country. This has revolutionized people's lives.
Mr. BURGESS. The Chair thanks the gentlelady. The gentlelady's time has expired. The Chair recognizes the gentleman from Oklahoma, 5 minutes for questions, please.
Mr. MULLIN. I feel sorry for the panel. It is funny, because it seems like when I go after a panel like that they always get upset because I am badgering the witness or something. I understand everybody's opinions runs high on this, I get that. But I will be real frank with everybody. The Federal Government should get out of the people's way and we shouldn't be mandating anybody to do anything. That is not the role of the Federal Government. The Federal Government is to provide opportunities and resources for them to have access and affordable access, and that is what we are trying to do here: affordable access.
Oklahoma, which I represent, is one of the States that only has one insurer carrier in there. We are one of the one of five. We saw premiums rise by 76 percent last year. It is not because the Blue Cross Blue Shield is trying to be greedy, it is because they are trying to stay in business. I understand that. The regulatory environment is such that they have to continue to change so they can afford to provide the health care.
But because of the regulatory environment underneath, ironically, Affordable Health Care—which is anything but affordable—it is causing premiums to skyrocket, and then it causes less affordability, which means less access to our constituents. And all this committee is trying to do is find a way to bring those premiums down and allow access to be created.
So Mr. Wieske—and I hope I pronounced that right.
Mr. WIESKE. You did.
Mr. MULLIN. OK. My first questions to you: Could you help explain why the regulatory environment that we are finding ourselves in right now is causing the premiums to literally skyrocket?
Mr. WIESKE. Sure. I think it starts with the risk pool. You know, you may have a large risk pool, but when you have loaded dice it is very difficult to get a representative, you know, 1 through 6, a representative sample when the dice are loaded. In other words——
Mr. MULLIN. What do you mean by loaded dice?
Mr. WIESKE. What I mean is, is that the risk pool, the people who are purchasing coverage tend to need it and they tend to—that the folks who don't need coverage who are young and healthy are
outside of the market. And so, when you are looking at the people that are buying coverage through the ACA, that they are tending to be sicker.

And I think as Doug had indicated that it looks a lot like our high-risk pool looked from a risk perspective. It is a little bit better, but it looks a lot like that from that perspective. That is the concern. I think you need to lower the premiums for younger folks to get them into the marketplace.

I think a lot of the burdens, you know, the SEP issue I think is one. There is a number of others where the Obama administration has set such stringent rules that make no sense. Their three Rs program has been a disaster as far as hearing out how you pay for the reinsurance and adequately price for the risk. The timelines are ridiculous. You are pricing a policy in March for something that starts in January. You know, it used to be a month, month and a half before, insurers don't have the data. There is a whole host of—I could go on probably for hours and bore everybody here.

Mr. MULLIN. Well, so if I am hearing you correctly, if we keep things the way they are right now are we going to create an environment for more access or is it going to drive more insurers out of the market?

Mr. WIESKE. I think there will be a few States like Wisconsin that will hang on by our nails for a while, but I think you can see in a number of States where the Tennessee commissioner who testified yesterday in front of Senate Health indicated that her market was near collapse, I think that is what you are going to be looking at over time in a number of States in the current environment.

Mr. MULLIN. Well, you know, what we have been hearing is that both people, my side of the aisle and the other side of the aisle, we are passionate about our constituents. What strikes me is that here we are actually holding hearings on trying to fix a problem. I just wonder how much input you guys got to have when this thing was jammed down you all’s throat. At least now we are trying to open it up and allow you guys to comment on it. If it is really about our constituents, then why would the other side be so upset that we are actually having public hearings on trying to fix it and get it better? I don't understand that.

So I appreciate, I appreciate that you guys are coming here, giving your perspective, the States’ perspective, and we are getting input. And I appreciate the chairman, who has taken the time to listen and actually put up with some of the shenanigans that is going on on the other side, your patience, as you can tell, I wouldn't put up with. I appreciate you doing that, Chairman.

But at the end of the day this is about getting it right and fixing it for our constituents. So thank you for your time, thank you for coming in here and giving your expert opinion and we look forward to working with you to bring down the premiums so it can be affordable and it can create access for our constituents to have healthcare coverage if they so choose to, not mandate to do. Thank you.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The Chair would advise the subcommittee and the witnesses that a series of votes have been called on the floor. We are going to hear questions from Ms. DeGette for 5 minutes and then
I am sure the panel would appreciate a break. We will have one and then we will reconvene back here immediately after the vote series is over. So Ms. DeGette, you are recognized 5 minutes for questions, please.

Ms. DEGETTE. Thank you, Mr. Chairman. I will just say before I start asking questions, my colleague from Oklahoma says, well, at least we are having hearings on legislation. But I would point out that we just learned today that we are going to have a markup of these bills that we are allegedly having the hearings today on, next Tuesday. And as my colleague from California said, Title II of the bill isn’t even a title. It is Continuous Coverage Incentive, placeholder, and we are going to mark this up next Tuesday.

Mr. MULLIN. At least we are having an opportunity to read it.

Ms. DEGETTE. I think we should work together on this. Now I want to welcome the panel here. I especially want to welcome you, Dr. Holtz-Eakin. I know when you were director of CBO you appeared in front of this committee many times and I am glad to welcome you back. I want to ask—I want to focus most of my questions on you. First of all, you State in your testimony that the ACA is in a downward spiral, correct?

Dr. HOLTZ-EAKIN. Correct.

Ms. DEGETTE. And a downward spiral—well, you State in a downward spiral prices rise and insurers will continue to leave the market, correct?

Dr. HOLTZ-EAKIN. Yes.

Ms. DEGETTE. And the result of that is because people are leaving plans and therefore the programs will not be sustainable; isn’t that correct?

Dr. HOLTZ-EAKIN. And there will be less competition and it will affect prices.

Ms. DEGETTE. Right. So declining enrollment would be one characteristic of a death spiral would it not?

Dr. HOLTZ-EAKIN. Yes.

Ms. DEGETTE. Yes, it would. So I want to—my assistant is going to hand you actually a chart from the Congressional Budget Office, and it shows that Obamacare enrollment will hold steady from 2017 to 2027 and there won’t be decreasing enrollment. Do you see that chart?

Dr. HOLTZ-EAKIN. I do.

Ms. DEGETTE. Thank you very much. Now also, Dr. Holtz-Eakin. Mr. BURGESS. Will the gentlelady yield?

Ms. DEGETTE. No, I will not. Also, Dr. Holtz-Eakin, the Congressional Budget Office, your former employer, issued a report in January 2017 called “How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums.” Are you familiar with that report?

Dr. HOLTZ-EAKIN. I am not an expert on it, but I have read it.

Ms. DEGETTE. OK. So what the report basically looked at was the plan President Obama vetoed before, but what that plan did was it eliminated in two steps the laws mandate penalties and subsidies, but it left the ACA’s insurance market reforms in place like the preexisting condition and age 26 and all of that so it is pretty much like what we are talking about here today.
And here is what the Congressional Budget Office found. It found that under a schematic like that, quote, the number of people who are uninsured would increase by 18 million in the first year following enactment of the plan. Later, after elimination of the ACA’s expansion of Medicaid eligibility and the subsidies for insurance purchased through the marketplaces that number would increase to 27 million and then to 30 million in 2026. Are you aware of that finding?

Dr. HOLTZ-EAKIN. Yes, and I think it is wrong.

Ms. DEGETTE. OK. OK, I appreciate that, but that was their finding.

Dr. HOLTZ-EAKIN. It is also out of date.

Ms. DEGETTE. Now let me——

Dr. HOLTZ-EAKIN. You should, no, you should know before you——

Ms. DEGETTE. No, no. Excuse me, sir. I am asking the questions.

Dr. HOLTZ-EAKIN. I am giving you some question advice.

Ms. DEGETTE. The next finding that they made, on page 1 of their findings—and I do apologize, I only have 5 minutes. If you would like to supplement your testimony, I would welcome that, OK.

The next finding was premiums in the nongroup market for the individual policies purchased through the marketplaces or direct from insurers would increase by 20 percent to 25 percent. Are you familiar with that finding, sir?

Dr. HOLTZ-EAKIN. I don’t remember that one.

Ms. DEGETTE. You are not. OK, well, Mr. Chairman, I am going to ask unanimous consent to put both this chart from the CBO and also the report from January 2017 in the record.

Mr. BURGESS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. Thank you. Now were you—so if you want to talk about a death spiral, it seems to me that a death spiral would be caused if you left all of the things, the requirements for the insurance companies, in place but then you eliminated the Medicaid expansion, you eliminated the exchanges and the subsidies, and people left the markets in droves.

One more thing I just want to talk about, and that is premiums, because there have been a lot of allegations thrown around today that premiums have been skyrocketing. Are you aware of the CMS data that showed from 2000 to 2005 premiums were growing at 8 percent, from 2005 to 2010, 5.5 percent, and then under the ACA average premiums were growing at only 3.6 percent, Mr. Holtz-Eakin?

Dr. HOLTZ-EAKIN. What premiums?

Ms. DEGETTE. Private insurance premiums.

Dr. HOLTZ-EAKIN. Employer?

Ms. DEGETTE. Yes.

Dr. HOLTZ-EAKIN. The ACA didn’t touch employers.

Ms. DEGETTE. Yes, it did.

Dr. HOLTZ-EAKIN. That is why it continued to perform well.

Ms. DEGETTE. Yes, it did. Thank you very much, Mr. Chairman.

Mr. BURGESS. The gentlelady yields back. The Chair thanks the gentlelady. I do note the series of——
Ms. DEGETTE. Mr. Chairman, may I just put this chart, ask unanimous consent to put this chart in the record, because it also talks about Medicare and Medicaid going down.

Mr. BURGESS. If the gentlelady is willing to share that with the committee, unanimous consent request is made, and without objection, so ordered.

Mr. BURGESS. We have 6 minutes left in our vote on the floor. The Chair advises that the committee will stand in recess until immediately after votes.

[Recess.]

Mr. BURGESS. Call the subcommittee back to order, and to start I want to yield to Mr. Green for a point of personal privilege.

Mr. GREEN. Thank you, Mr. Chairman, for the time and if I could have everybody's attention. I want to—there is a decorum requirement we do in this committee, and it was after we went to vote but our witnesses are here as guests and if you get up and insult, whether it is Republican or Democrat, that is not part of the decorum, no matter what. And I am just going to admonish that that is not acceptable.

And so that is enough, Mr. Chairman. I just want to make sure that witnesses know they are here to answer questions and not to engage in arguments. Thank you.

Mr. BURGESS. The Chair thanks the gentleman and certainly once again thanks the witnesses for being here. And I know it has been a long day for all of us.

At this time, the Chair would recognize the gentleman from New York, Mr. Collins, 5 minutes for questions, please.

Mr. COLLINS. Thank you, Mr. Chairman. I am going to pretty much direct this to Dr. Holtz-Eakin. And I know we touched on the SEPs, the special enrollment periods. Representative Blackburn, who was chairing the Telecom, she is a sponsor of H.R. 706, I am a co-sponsor. It goes back to the last Congress, and to the two of us and I think to many, there is a lot of common sense in working on our special enrollment periods.

And what we have noticed is, during the Obama administration, the enforcement seemed to be quite lax when it came to the SEPs and in effect giving individuals what I would call presumptive eligibility instead of verified eligibility, and in doing so there is always some costs that would come around.

So, Dr. Holtz-Eakin, the last time that you testified before this subcommittee, you used the term, talking about the verification process, as being “extremely generous.” I think there was a little bit of tongue in cheek on that. Would you agree that that is still the case today, maybe if you want to expand on that at all?

Dr. HOLTZ-EAKIN. I think this is an important issue simply as a matter of the arithmetic as the risk pool. As many as up to a third of people in the pool entered through an SEP, and there are a lot of SEPs compared to other programs, like Medicare has seven.

So, you know, that is a big part of it and in the data these are more expensive participants than other members of the pool. So in a system where the fundamental problem has been the cost and the inability of insurers to appropriately plan for costs and bake into their premiums those costs, this seems to me like a candidate for reform and a place that you should look right away.
Mr. Collins. So in studying this how would you say it impacts the market?

Dr. Holtz-Eakin. It does two things. It brings costs into the pool and those costs were unanticipated and that leads directly to insurer losses. The second thing it does is it makes insurers quite nervous about next year’s unknowables and puts upward pressure on premiums just as a matter of caution to try to anticipate some of these people entering.

Mr. Collins. So Commissioner, in your past life—and I know you are familiar with the SEPs as well. I think in your written testimony you actually say what we found up in Wisconsin was extremely problematic. Even more problematic, it was clear many consumers were using the process to receive costly medical care and then immediately dropping coverage.

Mr. Wieske. That is correct. We actually did this on a national basis, looked at this on a national basis as well. We chair the Health Care Reform Alternatives Working Group at the NAIC and one of the plans indicated loss ratios on that business in excess of 180 percent, so significant losses and because of the dropping of coverage, they did not maintain it throughout the year.

Mr. Collins. So I will ask somewhat of a rhetorical question, but when that happens who is stuck paying for that?

Mr. Wieske. The whole pool is stuck paying, so the folks who are in the individual market because it is a single risk pool are paying higher premiums as a result.

Mr. Collins. And I think it is also safe to say when—I will just call this out for what it is, cheating, and when someone is cheating the system they are also cheating the sick and the vulnerable patients and potentially driving up their costs. There is always a cost to someone and, you know, that is just kind of a point taken.

So Mr. Chairman, I will yield back. I know there is some airplanes to catch and thank you all for your testimony.

Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman, and the Chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for your questions, please.

Mr. Engel. Thank you very much, Mr. Chairman. We all know the phrase be careful what you wish for. It is a saying that I think my friends on the other side of the aisle are finding particularly poignant lately. I think our colleagues are on the other side of the aisle are finally realizing that it is easy to make promises, it is a lot harder to deliver progress as the Affordable Care Act has. You know, there is no such thing as a free lunch. If all the good things about the Affordable Care Act are going to be kept costs are going to go up and a lot of people will not be insured.

And so I think it is leading us down a primrose path. We should have been working together all these years not to try to eliminate the Affordable Care Act 62 or 63 times, but to try to improve it.

All major acts, all major bills, all major programs have to be implemented and then you see how it goes, what works, what doesn’t and you tweak, you change it, you try to improve it. But all we have had here for the past several years is just ill-conceived votes to eliminate it entirely, and now that they apparently are they are going to be careful what they wish for.
Mr. Green said this hearing is taking place on Groundhog Day. It is fitting because today Republicans are holding another hearing not on new ideas but the same ill-advised bills we have debated before in this committee. There is one exception, a half written draft that they claim would protect Americans living with preexisting conditions, but when you look closely we punish them instead.

So I want to underscore how indefensible the situation is. My constituents are frightened. They are worried that their preventive services that the ACA guaranteed them free of charge are going to disappear. They are worried that insurance companies will again impose caps on their coverage. They are worried that without the ACA’s protections they will be charged more for insurance. And my colleagues on the other side of the aisle are really doing nothing to allay their fears.

Dr. Lichtenfeld, I would like to give you an opportunity to speak one more time on a matter you were asked about earlier. Speaking for the American Cancer Society, can you tell me whether you support every American having high quality health insurance?

Dr. Lichtenfeld. Thank you, Mr. Engel, and let me clarify the answer to that particular question which I may have misheard previously was that yes, I personally am the American Cancer Society. I do support universal access to adequate and affordable healthcare coverage.

Mr. Engel. Thank you. This draft would require insurance companies cover people with preexisting health conditions, however there is nothing in this text that prevents insurance companies from charging you more if you have a preexisting condition like asthma or diabetes.

So is it fair to say, Dr. Lichtenfeld, that under legislation without a ban on medical underwriting Americans with preexisting conditions like cancer could be priced out of the care they need?

Dr. Lichtenfeld. Once again thank you for the question. And it is our read and our concern that in fact that could happen.

Mr. Engel. Before the Affordable Care Act I think you did say in your testimony that cancer patients who could get coverage which didn’t always happen were still vulnerable to enormous costs; isn’t that right?

Dr. Lichtenfeld. Yes, sir.

Mr. Engel. And that would happen again without the ACA. So I want to talk about that last point for a moment because lately we often hear Republicans use the phrase universal access as in they want everyone to have universal access to health care.

They are careful to say universal access not coverage because this is what universal access is, a scheme in which insurers must cover you but can charge you whatever they want making it all but impossible for you to actually afford coverage. This is why they chose their words so carefully because the access they are promising isn’t truly access at all.

Democrats aren’t making pie in the sky promises, they are showing progress. Thanks to the ACA 129 million Americans with preexisting conditions cannot be turned away or charged more because of their health status. Healthcare costs have been growing at the slowest rate in more than 50 years, and I could continue. Let me just say this.
For 7 years Republicans have claimed to have a better way to reform America’s healthcare system. If that were true then I believe that this hearing would have been the perfect opportunity to lay out that path forward. But instead after 7 years we have the same old bills, tired bills and half of a draft. Our constituents have serious concerns. It is going to take a lot more than this to put those concerns to rest.

So I just want to say that because I think there is nothing more important than people’s health care, and I truly believe that if they destroy the ACA there is going to be a lot of people in this country that are going to be angry and scared. Thank you, I yield back.

Mr. Burgess. The gentleman yields back. The Chair thanks the gentleman. The Chair now recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for your questions, please.

Mr. Carter. Thank you very much, Mr. Chairman, and thank all of you for enduring this. We appreciate you being here and for seeing through this and for participating.

I want to start with you, Mr. Holtz-Eakin. You pointed out throughout the hearing today that premiums are rising and that insurers are dropping out of certain markets and we know the horror stories of some States don’t have but one insurance company that is participating now. And in full disclosure, before I became a Member of Congress I was a pharmacist and I owned three independent retail pharmacies at that time and I am a firsthand witness to what has happened to the free market in health care since the Affordable Care Act has taken, and I think that is the worst thing that has happened is that it has taken the free market out of health care.

How do we get it back? How do we get back to where we are competing? I often tell the story that right now Adam Smith is rolling over in his grave to see what we have done to the free market in health care. And how do we get the competition back? That is what is going to drive prices down, competition.

Dr. Holtz-Eakin. It is a hard question. I think in the hallmark of a good competitive system is some flexibility in the rules that surround competition. And I think the mistake of having something that is the same across all States where, you know, the market structures are very, very different is piece number one.

And piece number two is you compete on whatever you pay for, and so if you pay for procedures people will compete by producing procedures that we want to pay for good outcomes. And that would be——

Mr. Collins. You know, there are really three things that we want to do. We want to make health care accessible, we want to make it affordable and we want to cut out the red tape. We want to get the Federal Government out of the way of physicians and patients. And right now, there are so many, there is so much bureaucracy between the patients and the healthcare professionals, and that is what we are trying to do is to cut it out.

Mr. Wieske, I want to ask you because you have obviously experience in this. One of the things that I am concerned about is the anti-trust laws as they pertain to the insurance companies, and I really feel like this is hindering the competition in a number of different ways.
I am really big on trying to find exactly what is going on with prescription drug prices and particularly the role that PBMs play in that because I don’t feel like they bring any value whatsoever to the healthcare system. They only raise prices and cause them to rise. And when you look at the PBMs, you have three PBMs that have 80 percent of the market. That is not competition yet they are protected by the anti-trust laws. I mean did you address that in Wisconsin at all?

Mr. WIESKE. So, you know, I think what is interesting about the ACA market from an anti-trust standpoint is actually that the insurers are competing not to get business, and I think that is where the problem is coming in. In fact, in one State they specifically wanted to get out of the cities and one company only wanted to do the rural areas so they would have less enrollment.

And so, you know, I think that is what is interesting is they are actually not competing to get this business, they are competing to survive and just hope to live another day.

Mr. COLLINS. OK. Let me ask you this, because you said something earlier that really tweaked my interest. And you said that in your high-risk pool that you had in the State of Wisconsin that all providers participated.

Mr. WIESKE. They did.

Mr. COLLINS. Did you require them to?

Mr. WIESKE. It was required.

Mr. COLLINS. How do you require them to?

Mr. WIESKE. So it was when they——

Mr. COLLINS. Do you tie it in with licensing or something?

Mr. WIESKE. It was a requirement that they had to accept the high-risk pool patients and the rate that the high-risk pool set. They were part of the boards. They got the opportunity to work on setting those rates, but they were expected to contribute 30 percent to the surplus of the cost, 30 percent of the cost——

Mr. COLLINS. OK, you explained that. But what was the penalty if they didn’t participate?

Mr. WIESKE. We never ran into that so we didn’t have a penalty because they all participated. The patients went to the doctor, the doctor billed the high-risk pool for the services. I mean, ultimately, if they didn’t participate, they just wouldn’t get paid in the same rate, I guess, but, you know, functionally——

Mr. COLLINS. You know, I find that hard to believe, especially if you have a favored nations clause in there and they are forced to accept that rate payment, and then they are forced to give it to another insurance company as well.

Mr. WIESKE. We had a—I mean, before and after, I mean, we do have an extremely competitive market. We don’t have a dominant insurer that can get the most favored nation. The market share in Wisconsin, you know, the top about 18 comprise 80 percent, so, and the top 10 only comprise roughly about 45 percent or less of the market. So it is a different market.

Mr. COLLINS. Well, again I just want to stress, and again thank all of you for being here. I want to stress again what we are trying to do here is to make health care accessible, to make it affordable and to cut out the red tape and to bring the free market back. Let competition drive prices down. That is what is going to do it. That
is what we are trying to do. Thank you again, all of you, for being here. And I yield back, Mr. Chairman.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair recognizes the gentleman from New Mexico, Mr. Lujan, 5 minutes for your questions, please.

Mr. LUBÍAN. Mr. Chairman, thank you very much. Before I begin, there was a line of questioning from Mr. Kennedy to Mr. Wieske pertaining to a Kaiser report titled “High-Risk Pools for Uninsurable Individuals, Appendix Tables, 8903, the Henry J. Kaiser Family Foundation,” which referenced the premium increases in the State of Wisconsin amongst other States. I would ask unanimous consent that that be submitted to the record.

Mr. BURGESS. If the gentleman is willing to share it with the Chair, without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. LUBÍAN. Just to note so that there is no question about this, what this report says is that the premiums were double in Wisconsin, so I know that we will get the chance to maybe go over that a little bit later.

Mr. Chairman, if I could ask the staff to pull up the first slide upon our new smart screen, one thing that I wanted to go over was the question associated with where we are today with the bills that have been presented to this committee.

President Trump recently said that he insists that everyone will have health insurance, insurance for everybody, he said. President Trump also said that there will be lower numbers, much lower deductibles. He went as far as to say that he is ready to reveal it alongside Senate Majority Leader Mitch McConnell and Speaker Paul Ryan. That was January 16th, 2017. And here is the important quote. It is a very much formulated down to the final strokes.

So if we could go to the next slide, this is what we have today, down to the final strokes. So as we talk about these details I think it is just important that we keep an eye on what those final strokes really look like because that bracket sure is empty.

If we could go to the next slide I wanted to answer a question that was brought up by one of my colleagues about this being shoved down people’s throats. This is just a list of some of the hearings in the House and in the Senate that took place associated with the markup of the Affordable Care Act. I brought my copy in if anyone wants to take a look at it, which is coffee stained and marked up, highlighted up for everyone to see that we used not only to study this bill but to go and explain it to our constituents and answer questions from our constituents.

And if we could just go to the next slide, the next slide shows what this committee alone did with different amendments that came up before this committee. So Mr. Lichtenfeld, I understand that you are—or Lichtenfeld, I understand that you are a physician. Have you read Chairman Walden’s discussion draft?

Dr. LICHTENFELD. I have read the paper that you have shown here to the committee.

Mr. LUBÍAN. Do you remember it saying anything about protecting young people and making sure they can stay on their parents’ plans until they are 26?
Dr. LICHTENFELD. My understanding is, Congressman, and so as I said before a work in progress and that there is obviously language that is still to be discussed and debated.

Mr. LUJÁN. I will ask the question differently. Was it in the text that you read?

Dr. LICHTENFELD. I am sorry, sir?

Mr. LUJÁN. Was it in the text that you read?

Dr. LICHTENFELD. No, sir.

Mr. LUJÁN. Do you remember the text reading anything about establishing minimum standards of care to ensure Americans aren't sold a lemon health insurance plan?

Dr. LICHTENFELD. I do not recall that, sir.

Mr. LUJÁN. Do you remember it saying anything about making sure behavioral and mental health services are covered?

Dr. LICHTENFELD. Again I don't recall seeing that.

Mr. LUJÁN. Mr. Lichtenfeld, you are an oncologist, correct, sir?

Dr. LICHTENFELD. Yes, sir.

Mr. LUJÁN. I thank you for your work. My father sadly passed from a fight with stage 4 lung cancer a little more than 4 years ago. We appreciate the experts that provided our loved one’s care. Do you remember in Chairman Walden’s bill saying anything about making sure individuals are not penalized by lifetime caps on their insurance coverage?

Dr. LICHTENFELD. I do not recall seeing that, sir.

Mr. LUJÁN. So the discussion that we are hearing today is that there be an environment set up so that individuals rather than having a 90-day grace period with their coverage would be shortened to a 30-day grace period if they had a preexisting condition. And if they missed a payment, and the text doesn’t protect anyone that may be late with a payment, then they lose coverage. What I have heard today is the notion that people with preexisting conditions that would lose coverage would still be able to get coverage from somewhere else, right. But there is nothing saying that they will not pay a higher premium fee.

And under the notion of, again if you could please bring up the first slide. Under the notion that our colleagues are saying that premiums will be lowered, deductibles will be lowered, care will be better, no one is going to be cut off, I just don't see it in anything that has been read to us.

And then the last thing, after 7 years, if they bring the first slide up, please, the one with Fox News, we have not seen the Republican consensus plan before us. There was a lot of talk by one of our witnesses about a plan that was before us. There is no consensus plan before us. This is not a secret. For 7 years, over 60 times my Republican colleagues have voted to repeal the Affordable Care Act. For 7 years we have not seen this text.

I think it is important that when we are having these hearings about how to improve the Affordable Care Act it shouldn't be about repealing the Affordable Care Act. And I will just point that the text in Chairman Walden’s discussion draft, in its title it says, “upon repeal of the Affordable Care Act.” So people can spin this all that they want, please look at the text and what is happening right now. And there is a willingness for us to work together to make things better to improve things, but not under the guise of
repealing this. Let's find a way to really come together and do the right thing for the American people and not just the political thing.

Mr. Burgess. The gentleman's time is expired. The Chair is advised that one of the witnesses needs to catch an airplane. Is this accurate? The Chair would ask unanimous consent that we allow the witness to make their—no, we don't allow the witness. OK, the Chair would advise that the witness who identified himself as having travel plans will actually be leaving at 2:15.

And I do ask all Members to try to adhere to the 5-minute timeline. I have been lenient today because this is such an important topic.

Mr. Green. Mr. Chairman, I ask unanimous consent to place into the record—if you want me to start the list—a statement from the Asian Pacific Islander American health care——

Mr. Burgess. Without objection, so ordered. All of your——

Mr. Green. All of it.

Mr. Burgess [continuing]. Yes, consent requests will be honored.

The Chair recognizes Mr. Sarbanes 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman. I just got in here under the wire, so I want to thank the panel. I wanted to ask Dr. Holtz-Eakin, what are some of the pieces of the Affordable Care Act that you think we ought to keep in place?

Dr. Holtz-Eakin. Well, I think that, you know, the ban on, caps on benefits for annual and lifetime, 26 staying on your parents' policy. I certainly think that you should have some sort of provisions for preexisting conditions and access to insurance.

Mr. Sarbanes. What about the efforts to close the exposure in the so-called donut hole in terms of the prescription drug costs that our seniors had been facing, is that a piece we want to keep in place?

Dr. Holtz-Eakin. I think there is, I would be happier if there was a more comprehensive approach to Medicare reform that sort of put together a more sensible insurance policy A, B and D, provided a broader coverage there.

Mr. Sarbanes. But generally speaking this idea of trying to reduce the exposure that our seniors have to the prescription drug costs which the ACA addressed through this effort to close the donut hole, is that something you think we ought to hold onto?

Dr. Holtz-Eakin. I guess the reason I am hesitating, my understanding is part of this is the private industry's agreement to cover 50 percent of costs in the donut hole. I honestly don't know how that works whether that has the force of law or if that is a voluntary action by them.

Mr. Sarbanes. I think the industry's agreement to voluntarily address 50 percent of their costs in the donut hole was something that they were going to do transitional as the donut hole was being closed through actually providing additional benefits under Part D.

What about, you probably know that many seniors now as a result of the Affordable Care Act can have certain kinds of preventive screenings, annual wellness exams, other things where they used to have to come out of pocket for those expenses, those are now covered by the Affordable Care Act which is obviously a huge benefit
for our seniors. Is that a piece of the Affordable Care Act that you think ought to stay in place?

Dr. HOLTZ-EAKIN. Truthfully I don’t know. The question there is what has been the effectiveness versus the cost, and I would be happy to get back to you on that.

Mr. SARBAINES. Well, I think the effectiveness has been significant in terms of enhancing care and there is actually savings as well, because if you catch some things earlier that then don’t lead to acute care on the back end which have high costs associated with it, because you do the screenings and the preventive care service because you actually are reducing costs as well.

So I guess I am asking the questions just to make the point, Mr. Chairman, that once you break—there is this kind of slogan of repeal the Affordable Care Act, you know, it hasn’t delivered, et cetera. When you actually break it down into its component parts and look at the benefits that it is bringing, frankly, the public has a very positive view of a lot of these components to the plan.

And as you just indicated in your answers, I think there is a recognition by the experts that there is many, many pieces of the Affordable Care Act that it would be regrettable to leave behind. So I think we need to start in an honest place of conversation when we are talking about this landmark healthcare reform and the benefits that it has brought to so many Americans and move forward from that point. With that I yield back.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman. The gentleman recognizes the gentleman from New Jersey, Mr. Long, 5 minutes for questions, please.

Mr. LONG. Thank you, Mr. Chairman. Mr. Wieske, you mentioned in your testimony that a number of your insurers have lost significant capital because of Obamacare. How has that affected coverage options as well as provider network access for individuals?

Mr. WIESKE. So as I said just a few minutes ago, I think there are actually——

Mr. LONG. My apologies if you——

Mr. WIESKE. No, no. My apologies. My apologies.

Mr. LONG. I sat here all morning long for my turn to ask and we went to votes, so——

Mr. WIESKE. No, no. No. And they are competing not to get the business in a lot of cases and, you know, they want a limited number of coverage and they are losing money on that coverage and so they have dialed back their presence across the State. They have limited their networks. Most plans have gone to narrower and narrower networks. They have changed their networks. They have partnered with providers, provider groups to do it differently. They have done it under different insurance licenses. So they have taken a number of steps to sort of minimize their exposure to the market.

Mr. LONG. If nothing changes between now and next November, what would you see at that point?

Mr. WIESKE. I think we will see a number of carriers that—I think we will see every year where we are sort of—my fear because we deal directly with the filings and I deal directly with the filings, my fear is that I am a little bit panicked that we are going to have counties that are uncovered.
We have one county that has one right now. We have three counties that only had one for a number of years. I am deathly afraid that four or more of our counties will be left uncovered with no insurer offering coverage.

Mr. LONG. OK. And coming from an adverse State in terms of regions, have some areas of your State been hit harder by these changes?

Mr. WIESKE. Yes, there were big differences. I mean, you know, one of the issues is it almost feels like, and this is not insurance across State lines, but it narrowed the market considerably. So some of our plans that offered coverage that were near the border left those areas because of the rules and the way things work, and so that left those areas more exposed.

So the areas near the borders have more problems than some of the other areas. Absolutely there has been winners and losers in the ACA.

Mr. LONG. And what has that meant for consumers? We call them consumers, I call them constituents, but what has that meant for consumers and our constituents in those areas?

Mr. WIESKE. We have seen, you know, rising costs over time, you know, more than doubling of the average premiums that most consumers pay over the course of, you know, from what they were paying pre-ACA, so there are significant increases. The deductibles have increased over time. They are higher than they were pre-ACA on average.

And the networks are narrower. They are finding, you know, less choice in the type of providers they want to see because there are fewer, you know, they just want to offer narrower and narrower networks.

Mr. LONG. When you say they are higher, I remember back at Christmastime went to a Christmas party the Saturday, I think, before Christmas, and a local business owner came up talking about just his family’s premium had gone up 360 percent since the advent of the Affordable Care Act. I would hate to think what it was like if it wasn’t affordable, but these are the type of stories that we get from our constituents that everybody acts like everything is a panacea and everything is great out there.

But these numbers, I mean health care, health insurance always was going up, and the other side will argue, I have constituents that like it and they say oh, you know, health care goes up anyway. But 360 percent in that short of time is a pretty healthy increase, isn’t it?

Mr. WIESKE. It is. And I think what I am afraid of is States like Wisconsin that took advantage of the transition options, so-called grandmother plans, those plans will go the way at the end of ’17 in the small group market. Roughly about 180–190,000 of our 225–230,000 small group individuals are on those transition plans. They are going to get a significant increase when we roll from 2017 at the end of this year into ’18.

Mr. LONG. That is kind of what I was—

Mr. WIESKE. On pre-ACA plans, yes.

Mr. LONG. That was kind of what I was getting to earlier when I asked you about November, what you foresaw for next November. And what are your projections and concerns of what the market is
going to look like after that period in a few years if the current trajectory continues in your State?

Mr. WIESKE. We are expecting fewer carriers, probably regional. They happen to be regional in a lot of cases and probably only carriers, insurers that have a relationship, a contractual relationship with a health system. So you will have one health system and one insurer teamed up in a particular area and that will be the only coverage option. That is what we are afraid of in the future, no choice.

Mr. LONG. Do you view plan solvency in the market as a basic consumer protection?

Mr. WIESKE. Yes, we do. We do extensive work on solvency. Yes, sir.

Mr. LONG. What does that mean for consumers when their insurers exit the market like they have in droves in a lot of places?

Mr. WIESKE. It means that they obviously lose the coverage. They end up in what I would call ghost plans or phantom plans that don’t exist anymore but they still have coverage, and then you have to deal with the issue of the guarantee funds and making sure the consumers are covered. And it ends up, it is for a consumer it is confusing and it is problematic and it is a little bit of a nightmare if their insurer—now we have been lucky. We haven’t had any go insolvent in the State of Wisconsin. We have had carriers leave the market but we have not an insolvency in health that has had those problems so we have been lucky.

Mr. LONG. I have two daughters. One of them has a year and a half left in her residency program in pediatrics, so the future of health care is very concerning to her. And her younger sister just got a report out about 4 months ago from Hodgkin’s lymphoma and she has been off chemo for 15 months, I guess.

And so I know how important it is that people have coverage and stay covered because we had a little incident mid-chemo treatment when the Affordable Care Act told us she wasn’t covered one day when we got over there for treatment. That was kind of hair raising. So there is no easy answers to any of this that we are doing today.

And like I said, I was late because I was doing, to the first part of it because I had to do a telecom deal on rural broadband, so I wasn’t here for the gavel, and then I was here by the time we voted.

Mr. BURGESS. The Chair accepts the gentleman’s apology. The gentleman’s time has expired. I do need to note it is past 2:15. We have a witness that needs to leave. We will continue our—and will be excused. We will continue our hearing with the remaining witnesses. Of course, written questions may be submitted for Dr. Holtz-Eakin.

And Dr. Holtz-Eakin, we appreciate you being here. You have always been a friend to this committee, and we appreciate your participation today. So you are excused.

Dr. Holtz-Eakin. Thank you, Mr. Chairman.

Mr. BURGESS. And the Chair recognizes the gentleman from California, Mr. Cárdenas, 5 minutes for your questions, please.

Mr. Cárdenas. Thank you, Mr. Chairman. I am glad we are discussing this incredibly critical and important issue that is critical
to every American. I would like to read the following true story from a constituent from my city of Los Angeles, California.

This is before the Affordable Care Act was made available to her and her family: “In 2012 I was in between jobs and discovered that I was pregnant. My husband and I were thrilled to be expecting our baby. When I tried to sign up for insurance I was informed that my pregnancy was considered a precondition, preexisting condition, and no insurance company would cover me.

“My husband was working as a contract employee and was uninsured. I considered Medi-Cal and Medicaid program in California, but I was told that it could take months until I could actually visit a clinic. Fortunately, I was hired about a month later and I got back on a company’s insurance. However, if I had not been hired, I don’t know what I would have done. It was that we almost missed seeing a doctor until the second trimester.

“And as I experienced extreme daily stress worrying about whether I would be insured before I gave birth or be charged tens of thousands of dollars, such stress is never good for a baby. The fact that becoming pregnant prevented me from buying insurance was truly outrageous. I was so horrified that our system could do something like this.”

True story, it happened, and unfortunately, before the Affordable Care Act, there were way too many stories like that. What I hope that we can prevent as Members of Congress, as legislators, as responsible elected officials, that we not go back to those days. This is America, and this true story goes to the heart of what we are all here to talk about.

Why are we spending time analyzing a half-finished bill that doesn’t take care of all the issues that were promised both by presidential candidates and people all over this United States Congress? Things like to ensure that a woman and a man pay the same price for their plans. This bill here that I have in my hand, which was introduced and what we are discussing today, does not guarantee coverage for a preexisting condition. A lot of Americans don’t realize that if your 8-year-old daughter has asthma, that is considered a preexisting condition.

Also to ensure coverage that we actually have access, this bill that I have before me talks about access, but it doesn’t talk about ensuring coverage. The Affordable Care Act has stronger language such as ensuring coverage. This document speaks to access, but it doesn’t spell out what we really should be talking about. Are people going to be denied coverage for a preexisting condition? Are women going to be allowed just like before to pay more for their health care than it is for a man at the same age, conceivably right next door?

We have had nearly 8 years of talk about replace, but we have come up with nothing better in that time. Why aren’t we talking about enhancing the Affordable Care Act instead of these ideas of just repealing it?

I have a question for Dr. Lichtenfeld. I want to first thank you for coming today and for sharing your expertise with us and also for making sure that we can get some more information before the public. Under the half-written plan, could individuals with pre-
existing conditions like cancer, asthma, or diabetes be priced out of the care they desperately need?

Dr. LICHTENFELD. Thank you, Mr. Cárdenas. And our concern is that that could in fact happen unless it is absolutely laid out clearly what the plan is, that there could be problems down the line.

Mr. Cárdenas. And the bill as written today doesn’t have any language guaranteeing that that would not happen, correct?

Dr. LICHTENFELD. As I mentioned previously, that is correct. Yes, sir.

Mr. Cárdenas. OK. My next question is, Were the health insurance premiums across America in general going up year over year before the Affordable Care Act, or were they on their way down year over year before the Affordable Care Act?

Dr. LICHTENFELD. Premiums were going up.

Mr. Cárdenas. OK. Now on those premiums going up, people were still denied coverage because of a preexisting condition, correct?

Dr. LICHTENFELD. Yes, sir.

Mr. Cárdenas. But under the Affordable Care Act, that is not allowed in America today, correct?

Dr. LICHTENFELD. That is correct.

Mr. Cárdenas. OK. So I just wanted to point out a few things in the short time that I get to speak on this committee and just wanted to make sure that everybody out there understands we are talking about you. We are talking about your health, your grandparents to your grandbabies and everybody in between. We need to get this right. And right now the bill that we have isn’t even close. I yield back.

Mr. Burgess. The Chair thanks the gentleman. The Chair would remind the gentleman he receives the same amount of time as every other member on the subcommittee and some who have waived on the subcommittee, and the chairman has been most generous with not hitting the gavel.

The Chair would like to recognize the gentlilady from Tennessee, Mrs. Blackburn, 5 minutes for your questions, please.

Mrs. Blackburn. Thank you, Mr. Chairman, and thank you all for being here. I want to go to the bill that we are looking at on the special enrollment plans, the special enrollment periods. This is legislation that I have drafted and the reason I did it was because of what we saw happening with lack of verification in the special enrollment periods.

And I saw us going down a road that we traveled in Tennessee with TennCare which was back in the mid-90s. No verification, all of a sudden your plan is, your enrollees are being crowded out if you will, people that really need services. You begin to see networks narrow, reimbursements drop, the length of time you wait for reimbursements goes from 30 days to 60 days to 90 days to 120, 180 days. And you all know the path. And my bill is just very straightforward and you need to prove why you need that special enrollment period, you need to prove that you are who you are and that you qualify. I think that is an important thing for us to be able to do.

So the question, I have a couple of questions and I would like to hear you all weigh in on the need for verification for special enroll-
ment periods. I think it is important for the integrity of any program and I think it is fair for the taxpayers who foot the bill.

But shouldn't we simply be able to confirm if someone qualifies for special treatment that they self-attest that they are eligible that indeed they are, and especially if taxpayer subsidies are involved? Shouldn't we require that? And would a very small, but modest improvement to the plan be to move this verification from post-enrollment, which experience has told us very seldom gets done, to pre-enrollment? And I would like to hear what you all have to say on that.

Mr. WIESKE. Your bill is exactly right. I mean this is not actually that hard to get verification in my experience. This is something, special enrollment periods did not start with the ACA. Special enrollment periods existed with HIPAA and existed prior to that in the Newborn and Mothers Act and other pieces. Insurance companies were doing these verifications for years prior to the ACA.

The problem that we have run into is when the Federal bureaucracy takes it over that that creates other problems and they don't have the time or the resources to verify. We had one person in our office who had spent months trying to solve the issue because he was not using the magic words that the customer service wanted them to use. So I think it shouldn't be that hard to get to a verification.

Dr. LICHTENFELD. Well, Mrs. Blackburn, thank you for the question. And we are aware of some of the issues that have come up with regard to special enrollment. However, when we look at it through that cancer lens we also need to understand that there are some other issues that have to be looked at.

So it may be someone who is working and loses their job and has to go get insurance and within the cancer focus how quickly that is going to be done, what is going to be required and will it be done expeditiously. Should it be done pre- with the presumption of correctness and then later, or should it be done later when there may be a gap in care? Those gaps in care can be significant.

Also aware that how the one that administers it, whether it be Federal or whether it be insurance company, what the guidelines are that set around those requirements in terms of timeliness, all those are things that have to be considered.

Mrs. BLACKBURN. I think you might have missed the point that I am trying to drive forward. I think that—I am not saying you don't need special enrollment periods.

Dr. LICHTENFELD. No, I understand.

Mrs. BLACKBURN. Just what you are inferring. I am saying that if we have a special enrollment period and one is necessary that it is out of fairness to the taxpayer and to the integrity of a program that an individual before they are admitted to a program that they prove that they need it and that they prove that they are who they attest to be. That those attestations that they have made to get that coverage that those are vetted before they are allowed into that program.

Dr. LICHTENFELD. Mrs. Blackburn, I apologize if I wasn't clear on my statement. I didn't say we don't need special—I mean it wasn't my intent to say we don't need special enrollment.

Mrs. BLACKBURN. OK, right.
Dr. LICHTENFELD. I said it is the construct of how it is done that is important where we may have discussions about that issue.

Mrs. BLACKBURN. OK, thank you. Yield back.

Mr. BURGESS. The gentlelady yields back. The Chair thanks the gentlelady. The Chair recognizes the gentleman from North Carolina, Mr. Hudson.

Mr. HUDSON. Thank you, Mr. Chairman, and I thank the panel for your time today. But since I arrived here directly from a dental procedure I will probably yield the balance of time, without objection from you, Mr. Chairman, to Mr. Griffith from Virginia.

Mr. BURGESS. The gentleman is recognized.

Mr. GRIFFITH. Thank you very much. I thank my colleague from North Carolina, so I think I ought to ask my North Carolina question first. My district shares a border with North Carolina. Mr. Wieske, you indicated earlier in answering one of the questions that there were some issues around the borders. Could you tell me what was going on there and how that affected you all?

Mr. WIESKE. Sure. I mean I think when you are dealing with the exchange and the subsidy market it sort of shut down the sort of, you know, moving between the borders that happen, that those borders became a little bit harder than they were before. And so because you are one exchange versus another exchange it wasn't just buying health insurance it was that became an issue.

Mr. GRIFFITH. And let me ask you if you ran into any of the problems in your State that I ran into with constituents when it first rolled out. I had folks who were going to medical facilities—because my district is the corner of Virginia so I border North Carolina, Tennessee, Kentucky and West Virginia. And so one of the things that popped up almost immediately was, and it was particularly a North Carolina situation, I had a constituent who was receiving cancer treatment in Winston-Salem. It might have been Duke, but I am pretty sure it was Bowman-Gray.

And all of a sudden found out when she, she had to go on the exchange. She went on the exchange and found out that she could not leave the Commonwealth of Virginia more than one county. Well, that created all kinds of problems because she couldn't keep with her cancer team. Did you have some of those issues as well?

Mr. WIESKE. A few of those, but more insurers withdrew from the neighboring counties. So Pierce, Polk and St. Croix County typically use, which is on the western part of our State, typically use providers in Minnesota, have Minnesota systems. All the Wisconsin systems essentially withdrew from that area and at least exchange wise, and so it was primarily a Minnesota company that provided coverage that was licensed in Wisconsin. So they just had fewer choices. They had to go, they had to go, across the border.

Mr. GRIFFITH. Right. And so it is kind of interesting because earlier one of the folks was making a statement on the other side of the aisle and seemed to indicate that whatever plans we were coming up with they wouldn't work because you couldn't go, you would have to go back to the other State, I believe she said, to see the doctors, and yet my experience in my district was that that problem exists with Obamacare.

And it may be one of the things we need to take a look at it fixing, because that one county rule—and I described my district to
you and I only had problems in North Carolina. But one of the hospitals in the area that specializes in children’s care in Tennessee serves a big chunk of southwest Virginia but because independent cities, Bristol, Virginia is an independent city, Bristol, Tennessee, and the county surrounding it is the one county you could go to and the hospital is just over the line in the next county.

So it was not just the problem in North Carolina with cancer treatment, it was also problems with people being able to go see the specialists in North Carolina, because I had Bristol, Virginia and Tennessee, where as you know from the GEICO commercial the line runs right down the middle of the main commercial street there. And then I also have Bluefield, Virginia, which also has Bluefield, West Virginia, and you have to figure out which side of the line you are on there. It is not quite as clear cut as Bristol, Virginia and Tennessee.

So a lot of my constituents were impacted by that. And I know that it is—I assume that it is not a good idea to change, Dr. Lichtenfeld, it is not a good idea to change your doctors midstream particularly when you are satisfied with the cancer treatment you have been getting. And so it is not a good idea to switch even though Virginia has some very good medical schools as well; would that be correct?

Dr. Lichtenfeld. Well, actually my son was just interviewed at University of Virginia so we respect the medical schools for sure.

Mr. Griffith. Yes.

Dr. Lichtenfeld. You know, yes, that is correct. I mean continuity of care is important, how it is constructed, what the rules are, whether, what hospitals are allowed in the network, the location of the network, all that is important.

Mr. Griffith. Right, and closeness matters too. And in fact, big parts of my district they are a lot closer to other States’ hospitals then they are to the University of Virginia which would be closest to my district. Not to negate MCV, also another fine institution and others.

Let me switch gears, and I apologize, Mr. Wieske, you may not know the answer to this because it was a question for Dr. Holtz-Eakin about continuous coverage requirements. And he had said that that pushes providers and plans to invest in preventive and wellness programs to keep patients healthy, and the question would have been how does this impact the overall market, the overall risk pool? Are you in a position to answer that question? My team says you are but I don't know.

Mr. Wieske. I think in general, I mean I think if you are able to keep people in the market and they stay in it and they stay with their insurer it provides better health, better health outcomes, and potentially over time it should lower, make the risk pool more representative and overall lower costs.

Mr. Griffith. So similar to what I was talking about before. I see that Mr. Hudson's time is up and I yield back.

Mr. Burgess. The Chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Tonko, 5 minutes for questions, please.

Mr. Tonko. Thank you, Mr. Chair. And Mr. Wieske, first let me thank you for your service to the people of Wisconsin and for your
testimony today. In your written statement you refer numerous times to Wisconsin's well-functioning health insurance market pre-ACA and expressed a desire to see the ACA repealed and returned to a pre-ACA marketplace.

So I would like to learn a little more about what Wisconsin's health insurance market looked like prior to the Affordable Care Act. I took and downloaded a publication from your office's website entitled “Fact Sheet on Mandated Benefits in Health Insurance Policies,” and with the permission of the Chair I would like to ask unanimous consent that this document be entered into the record.

Mr. Burgess. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. Tonko. Thank you. Now Mr. Wieske, prior to the Affordable Care Act did Wisconsin mandate that all health insurance plans serving the individual market cover hospital services or prescription drug coverage? Yes or no on that, by the way.

Mr. Wieske. I don't believe——

Mr. Tonko. Yes or no.

Mr. Wieske. I don't believe it was mandated, but——

Mr. Tonko. The answer is no. Pre-ACA, did Wisconsin mandate that all insurance plans serving the individual market cover mental health or substance use care, yes or no?

Mr. Wieske. No.

Mr. Tonko. The answer is no. Pre-ACA, did Wisconsin mandate that all insurance plans serving the individual market cover maternity care, yes or no?

Mr. Wieske. No.

Mr. Tonko. Would it be fair to assume that plans in Wisconsin that offered these fundamental healthcare services in the individual market pre-ACA would be more expensive than plans that didn't offer these services, yes or no?

Sir, can we move——

Mr. Wieske. Well, the problem is——

Mr. Tonko. Yes or no, because I have got to move on with my time here.

Mr. Wieske. I am sorry, I can't answer the question, because you have three there.

Mr. Tonko. Well, fundamental healthcare services in the individual market pre-ACA, would it be more expensive than plans that didn't offer those services?

Mr. Wieske. For maternity and for the mental health, the answer is yes.

Mr. Tonko. So given your expressed support for the pre-ACA marketplace where plans that covered even the most basic healthcare services were astronomically expensive in the individual market pricing out anyone who might actually need care, you clearly support returning to a system where women and all people with preexisting conditions are charged higher prices for the care they need?

Mr. Wieske. No. My assumption is that the States would be able to——

Mr. Tonko. Yes or——so you are a no on that?

Mr. Wieske. Yes, because the States will reform their laws and better reflect the market.
Mr. TONKO. Well, we are looking at a Federal plan that would cover all States, so thank you, Mr. Wieske. To summarize what we just learned for all the folks watching on TV, health insurance in Wisconsin was less expensive before the Affordable Care Act unless you actually wanted to go to the hospital, fill a prescription, be covered for mental health services, or see a doctor. Women in Wisconsin were hit particularly hard, paying up to 42 percent more for their health insurance than men before the Affordable Care Act.

So when my Republican colleagues talk about their supposed desire to protect people with preexisting conditions, it is important to remember that you can't address this problem with a half-baked bill that doesn't actually require insurance plans to offer benefits to those who are sick. Otherwise, insurance companies will deny care to those with preexisting conditions with restrictive benefit designs that fail to cover basic services like hospitalizations, prescription drugs or mental health care.

I appreciate this hearing today because I think it is really critical to clarify the stakes of this healthcare debate for the American people. What Mr. Wieske and my Republican colleagues want to do is to rip health care away from millions and take us back to a healthcare system controlled by the big insurance companies, the system where your health insurance is worth less than the paper it is printed on, a system where you get charged through the nose if you need mental health care or are a woman, or God forbid, man or woman, if you get sick and have to go to the hospital.

I don't want to go back. The American people don't deserve to go back. We should instead be moving forward and building on the promise of high quality, affordable health care for all. And with that Mr. Chair——

Ms. DEGETTE. Will the gentleman yield?

Mr. TONKO [continuing]. I yield back the balance of my time.

Ms. DEGETTE. Will the gentleman yield? Will the gentleman yield me his 39 seconds remaining?

Mr. TONKO. Yes, I will. I will yield.

Ms. DEGETTE. Mr. Wieske, I thought that what Mr. Tonko was asking you was really important, which is with this bill that we are looking at today, there is no requirement that the States not charge people with preexisting conditions. That is just your hope that States wouldn't do that, right?

Mr. WIESKE. We had limits in place——

Ms. DEGETTE. Yes, Wisconsin did, but maybe——

Mr. WIESKE. Correct.

Ms. DEGETTE [continuing]. Utah or Colorado or Idaho didn't, right?

Mr. WIESKE. Right.

Ms. DEGETTE. That is just your hope?

Mr. WIESKE. Correct.

Ms. DEGETTE. Thank you.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back. The Chair once again observes that I have delayed my time for questions until the end because I was delayed arriving this morning, so I recognize myself for the balance of the time.

No, and I do appreciate our witnesses being here. I am sorry Dr. Holtz-Eakin had to leave, because he always brings a lot to the dis-
discussion. Mr. Wieske, let me just ask you—and again I asked you while we were kind of in between on the votes—you have not testified before our committee before, have you?
Mr. WIESKE. I have not.
Mr. BURGESS. And so that graphic that one of our members put up of all the hearings that were held prior to the Affordable Care Act, you never participated in any of those hearings, did you?
Mr. WIESKE. Correct.
Mr. BURGESS. And I think that is a shame, because I think you would have added to the discussion and you would have added to the debate and maybe some of the problems that we are now encountering and trying to fix could have been avoided had we listened to sane, rational voices like yours.
I will also point out our two members from Indiana have had to leave, but we didn't hear from Governor Mitch Daniels, and Mitch Daniels was reported in the Wall Street Journal, while all the discussion of the Affordable Care Act was going on during the 2008 election cycle and we were having hearings here in this very room, Mitch Daniels with his Healthy Indiana Plan had actually reduced costs by 11 percent over 2 years' time when every other HMO, PPO, Medicare, Medicaid was going up by 7 or 8 percent across the country.
Why would not we have asked people who were experts and who were performing well, why would not have asked their opinions before writing this big law that changed health care from soup to nuts in this country? And I—it is obviously a rhetorical question—I think we should have.
Much was made at the beginning of this session about the fact that Republicans wouldn't help, and I have to tell you that is not true. I contacted the transition team in 2008 and I said, “Look, I didn't give up a 25-year medical career to come sit on the sidelines while you guys do this. Talk to me. I am willing to talk to you.”
Dr. Lichtenfeld, they could have put me in a tight spot, you know, because what if I had been offered to choose between—you talked about toxic financial situations, what about our medical liability in a lot of States? That is a toxic situation. What if they had said to me, Dr. Burgess, we know you care a lot about medical liability. We would like to help you, but we have got to have your help on the public option. I don't know what I would have done. That would have been a pretty tough spot to put me in.
I don't know, maybe somebody who is familiar with making a deal might have, that might have occurred to them, but I was frozen out. I was frozen out by the then-chairman of this committee, Henry Waxman. I went to see him personally and said I didn't give up a career in health care to come sit on the sidelines. So the notion that we have simply dug our heels in and refused to help, it is offensive to me when I hear that espoused on the panel.
Now let me just ask in particular with these bills that we have that we are considering, just on the issue of narrow networks now. Dr. Lichtenfeld, I mean you encountered narrow networks probably before the ACA was passed and after it was passed. Do you have a feeling? Is it better or worse? Are narrow networks less restrictive now than they were before?
Dr. Lichtenfeld. Speaking personally, they are certainly more restrictive, and the testimony to that effect was made earlier. So the answer to that question is yes, they are more narrow.

Mr. Burgess. You know, we all give our own experiences. And I will confess that there was a special deal set up for Members of Congress, the Grassley Amendment required us all to buy insurance under the Affordable Care Act and there was a special deal worked up between President Obama and then-Majority Leader Reid in the Senate that allowed us to receive a subsidy and walk it into the exchange. I didn't do that because my constituents back home would never understand that kind of a special deal.

So I understand the difficulties that people felt in the individual market. My insurance was canceled at the end of 2013. I was one of the 5.7 million people who lost their insurance. I liked my coverage. I liked my doctor. But I couldn't keep it because I was told I had junk insurance and I had to get rid of it. I had to do something else. I had to buy all of these other things. It was not something that I asked for.

And when my constituents come to my town halls and say why did I have to do this, why did I have to make these changes, I wasn't asking for that—well, I felt their pain. And so I didn't have an answer for them but I could look them in the eyes and say, yes, I agree with you. I think it was bad policy. I hope we get a chance to rectify things someday.

So when people ask me did you lose your doctor or did you go on a narrow network, to tell you the truth I don't even know, because unlike every other American I bought on price, show me the cheapest Bronze Plan out there and that is what I bought and I really have no earthly idea who the people are that I had available to me.

On the issue of this 30 days, 90 days, I worried about that when the law was in the enactment phase in 2014 because, Dr. Lichtenfeld, now correct me if I am wrong here, but you have a 90-day grace period. You know, the insurance companies actually were talking a lot to the Democrats in those days, they weren't talking to Republicans. But 30 days, the insurance company is on the hook for that coverage. What happens to the rest of those 60 days, Dr. Lichtenfeld? Who covers that bill if the patient doesn't pay their premium?

Dr. Lichtenfeld. The answer to your question is that the person who provides the service ends up not getting paid under the current situation, if in fact the patient or the family doesn't pay that bill by 90 days.

Mr. Burgess. And I do need to point out this is only for someone receiving a subsidy in healthcare.gov exchange, because I actually thought I had a 90-day grace period on my premium. It turns out, no, you only get 30 days because you are not receiving a subsidy, so that 90-day period does not cover you.

But I did worry about that because I worried that former colleagues who practiced medicine would in fact be on the hook for those bills and it hasn't turned out to be the problem I thought it was going to be, but I think it is a problem that should be corrected. We shouldn't allow for the system to be manipulated where
physicians and hospitals actually don’t receive the compensation for the care that they provide.

There are a lot of things that we could still talk about. I have some questions that I will submit for the record. We have been here a long time. I do appreciate both of you being here. This is not easy. This is complex. I don’t know. I don’t know at the end of the day where this all shakes up but I do know this. If it was working perfectly, if it was working perfectly we wouldn’t be here today. It is not working perfectly. There are serious problems. There are serious fractures and we have been charged with fixing them.

So that is what this subcommittee does. You have got some of the smartest Members of Congress on this subcommittee, and I appreciate each and every one of them, those that are here and those that have had to leave. This is a good subcommittee, a great subcommittee. We are up to the task, and we will deliver.

So with that, I will yield back the balance of my time and then—oh my gosh, what have I got to do, all of these unanimous consent requests. Seeing there are no further Members wishing to ask questions, I would like thank all of our witnesses again for being here today.

Before we conclude the hearing, I would like to submit the following items for the record: a statement from Representative Bill Flores, a statement from Blue Cross Blue Shield, a statement from the American College of Obstetricians and Gynecologists, a letter from the Alliance for Retired Americans, a letter from the Healthcare Leadership Council, and a statement from America’s Health Insurance Plans.

[The information appears at the conclusion of the hearing.]

Mr. BURGESS. Pursuant to committee rules I remind Members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their response within 10 business days upon receipt of the questions. Without objection, the subcommittee is adjourned.

[Whereupon, at 2:51 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Republicans have threatened to take health care away from 30 million Americans through the repeal of the Affordable Care Act. My constituents are terrified that they will lose their health care. Hundreds have written and called me to express their fears. Republicans have said that they will protect them by passing something “better” than the ACA.

The majority now has the White House, the Senate, and the House, and you’ve had seven years to come up with a plan. Yet today, you show up with a half-written bill that does not guarantee protections for Americans with preexisting conditions. Today is your first opportunity to show the American people that you will protect them, to assuage their fears about losing their health care, and to show the American people that you have a better plan.

The plan we’re discussing today is not better, and as it is written, it does not protect those with preexisting conditions from exorbitant premium increases, because it does not include medical underwriting for those with preexisting conditions, leading to higher premiums.

This proposal is irresponsible and ignores the gravity of the situation for the millions of Americans who are afraid of what “repeal and replacement” of the ACA means for them.
[DISCUSSION DRAFT]

115TH CONGRESS 1ST SESSION

H. R. ______

To amend the Public Health Service Act to prohibit application of preexisting condition exclusions and to guarantee availability of health insurance coverage in the individual and group market, contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. WALDEN introduced the following bill; which was referred to the Committee on ______.

A BILL

To amend the Public Health Service Act to prohibit application of preexisting condition exclusions and to guarantee availability of health insurance coverage in the individual and group market, contingent on the enactment of legislation repealing the Patient Protection and Affordable Care Act, and for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
SECTION 1. SHORT TITLE.

This Act may be cited as the “Preexisting Conditions Protection and Continuous Coverage Incentive Act of 2017”.

TITLE I—PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS AND GUARANTEED AVAILABILITY OF HEALTH INSURANCE COVERAGE

SEC. 101. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.

(a) GROUP MARKET.—Subject to section 103(a) of this Act, subpart 1 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as restored or revived pursuant to PPACA repeal legislation described in section 103(b) of this Act, is amended by striking section 2701 and inserting the following:

"SEC. 2701. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS.

(a) IN GENERAL.—A group health plan or a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) DEFINITIONS.—For purposes of this section:

(1) PREEXISTING CONDITION EXCLUSION.—
‘(A) IN GENERAL.—The term ‘preexisting condition exclusion’ means, with respect to a group health plan or health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment in such plan or for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

‘(B) TREATMENT OF GENETIC INFORMATION.—Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

‘(2) DATE OF ENROLLMENT.—The term ‘date of enrollment’ means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

‘(3) WAITING PERIOD.—The term ‘waiting period’ means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with
respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.”.

(b) INDIVIDUAL MARKET.—Subject to section 103(a) of this Act, subpart 1 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–41 et seq.), as restored or revived pursuant to PPACA repeal legislation described in section 103(b) of this Act, is amended by adding at the end the following:

“SEC. 2746. PROHIBITION OF PREEXISTING CONDITION EXCLUSIONS OR OTHER DISCRIMINATION BASED ON HEALTH STATUS.

“The provisions of section 2701 shall apply to health insurance coverage offered to individuals by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in the group market.”.

SEC. 102. GUARANTEED AVAILABILITY OF COVERAGE.

(a) GROUP MARKET.—Subject to section 103(a) of this Act, subpart 3 of part A of title XXVII of the Public Health Service Act, as restored or revived pursuant to PPACA repeal legislation described in section 103(b) of this Act, is amended by striking section 2711 (42 U.S.C. 300gg–11) and inserting the following:
"SEC. 2711. GUARANTEED AVAILABILITY OF COVERAGE.

(a) GUARANTEED ISSUANCE OF COVERAGE IN THE GROUP MARKET.—Subject to subsection (b), each health insurance issuer that offers health insurance coverage in the group market in a State shall accept every employer and every individual in a group in the State that applies for such coverage.

(b) ENROLLMENT.—

(1) RESTRICTION.—A health insurance issuer described in subsection (a) may restrict enrollment in coverage described in such subsection to open or special enrollment periods.

(2) ESTABLISHMENT.—A health insurance issuer described in subsection (a) shall establish special enrollment periods for qualifying events (as such term is defined in section 603 of the Employee Retirement Income Security Act of 1974).

(b) INDIVIDUAL MARKET.—Subject to section 103(a) of this Act, subpart 1 of part B of title XXVII of the Public Health Service Act, as restored or revived pursuant to PPACA repeal legislation described in section 103(b) of this Act, is amended by striking section 2741 of such Act (42 U.S.C. 300gg-41) and inserting the following:

"SEC. 2741. GUARANTEED AVAILABILITY OF COVERAGE.

The provisions of section 2711 shall apply to health insurance coverage offered to individuals by a health in-
insurance issuer in the individual market in the same manner as such provisions apply to health insurance coverage offered to employers by a health insurance issuer in connection with health insurance coverage in the group market. For purposes of this section, the Secretary shall treat any reference of the word ‘employer’ in such section as a reference to the term ‘individual’.”.

SEC. 103. EFFECTIVE DATE CONTINGENT ON REPEAL OF PPACA.

(a) In General.—Sections 101 and 102 and the amendments made by such sections shall take effect upon the enactment of PPACA repeal legislation described in subsection (b) and such sections and amendments shall have no force or effect if such PPACA repeal legislation is not enacted.

(b) PPACA Repeal Legislation Described.—For purposes of subsection (a), PPACA repeal legislation described in this subsection is legislation that—

(1) repeals Public Law 111–148, and restores or revives the provisions of law amended or repealed, respectively, by such Act as if such Act had not been enacted and without further amendment to such provisions of law; and

(2) repeals title I and subtitle B of title II of the Health Care and Education Reconciliation Act of
2010 (Public Law 111–152), and restores or revives the provisions of law amended or repealed, respectively, by such title or subtitle, respectively, as if such title and subtitle had not been enacted and without further amendment to such provisions of law.

TITLE II—CONTINUOUS COVERAGE INCENTIVE

[PLACEHOLDER]
H.R.  

To amend title XXVII of the Public Health Service Act to change the permissible age variation in health insurance premium rates.

IN THE HOUSE OF REPRESENTATIVES

Mr. BUCSHON introduced the following bill; which was referred to the Committee on ______________________

A BILL

To amend title XXVII of the Public Health Service Act to change the permissible age variation in health insurance premium rates.

1 Be it enacted by the Senate and House of Representa­
2 tives of the United States of America in Congress assembled,
3 SECTION 1. SHORT TITLE.
4 This Act may be cited as the “State Age Rating
5 Flexibility Act of 2017”.

G:\VHLC\010417\010417-108.xml
January 4, 2017 (12:03 p.m.)
SEC. 2. CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)), as inserted by section 1201(4) of Public Law 111–148, is amended by inserting after “3 to 1 for adults (consistent with section 2707(c))” the following: “or, for plan years beginning on or after January 1, 2018, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide”.
H. R.  

To amend title I of the Patient Protection and Affordable Care Act to require verification for eligibility for enrollment during special enrollment periods in PPACA insurance plans, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mrs. BLACKBURN introduced the following bill; which was referred to the Committee on __________________________

A BILL

To amend title I of the Patient Protection and Affordable Care Act to require verification for eligibility for enrollment during special enrollment periods in PPACA insurance plans, and for other purposes.

1 Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

3 SECTION 1. SHORT TITLE.

4 This Act may be cited as the “Plan Verification and

5 Fairness Act of 2017”.
2
SEC. 2. REQUIRING VERIFICATION FOR ELIGIBILITY FOR ENROLLMENT DURING SPECIAL ENROLLMENT PERIODS IN PPACA INSURANCE PLANS.

(a) IN GENERAL.—Section 1311(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(c)) is amended by adding at the end the following new paragraph:

"(7) VERIFICATION REQUIREMENT FOR SPECIAL ENROLLMENT PERIODS.—

"(A) IN GENERAL.—The Secretary shall provide that, in the case of a special enrollment period provided for under paragraph (6)(C) that is with respect to a plan year that begins on or after January 1, 2018, qualified health plans offered through an Exchange may not make coverage effective with respect to an individual enrolling during such period until the Exchange verifies, through an approved verification process described in subparagraph (B), that the individual, with respect to such Exchange, is a qualified individual who is eligible to enroll during such period.

"(B) APPROVED VERIFICATION PROCESS DESCRIBED.—For purposes of subparagraph (A), an approved verification process described in this subparagraph is a process specified by
the Secretary through interim final rulemaking
that requires an individual described in sub-
paragraph (A) seeking to enroll in a qualified
health plan described in such subparagraph to
submit to the Exchange such documents as the
Secretary determines are necessary in order for
the Exchange to verify that the individual, with
respect to such Exchange, is a qualified indi-
vidual who is eligible to enroll during a period
described in such subparagraph. To the extent
practicable, such process shall be similar to the
review and assessment process pertaining to
special enrollment periods described at 81 Fed.
Reg. 12274 in the final rule entitled ‘Patient
Protection and Affordable Care Act; HHS No-
notice of Benefit and Payment Parameters for
2017’, published at 81 Fed. Reg. 12203 (March
8, 2016).”.

(b) STUDY AND REPORT.—

(1) STUDY.—The Inspector General of the De-
partment of Health and Human Services shall con-
duct a study on enrollment by individuals in quali-
fied health plans (as defined in section 1301(a) of
the Patient Protection and Affordable Care Act (42
U.S.C. 18021(a))) during special enrollment periods
provided for under section 1311(c)(6)(C) of such Act (42 U.S.C. 18031(c)(6)(C)) that are with respect to plan year 2016. Such study shall include, with respect to each such period, an identification of each of the following:

(A) The number of individuals who sought to enroll in such a plan through an Exchange established under such Act during such period but who were not allowed to so enroll during such period.

(B) The number of such individuals who were not allowed to so enroll through such an Exchange during such period on account of each of the following:

(i) The individual did not provide to the Exchange documentation to demonstrate that the individual was, with respect to the Exchange, a qualified individual (as defined in section 1312(f)(1) of such Act (42 U.S.C. 18032(f)(1))) who was eligible to enroll during such period.

(ii) Such documentation provided to the Exchange by the individual was invalid.

(2) REPORT.—Not later than June 1, 2018, such Inspector General shall submit to Congress a
report on the findings of the study conducted under paragraph (1).
To amend the Patient Protection and Affordable Care Act to better align the grace period required for non-payment of premiums before discontinuing coverage under qualified health plans with such grace periods provided for under State law.

IN THE HOUSE OF REPRESENTATIVES

Mr. FLORES introduced the following bill; which was referred to the Committee on __________________________

A BILL

To amend the Patient Protection and Affordable Care Act to better align the grace period required for non-payment of premiums before discontinuing coverage under qualified health plans with such grace periods provided for under State law.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Health Coverage State Flexibility Act of 2017”.

(Original Signature of Member)
SEC. 2. ALIGNING QUALIFIED HEALTH PLAN GRACE PERIOD REQUIREMENTS WITH STATE LAW

GRACE PERIOD REQUIREMENTS.

Section 1412(c)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(c)(2)) is amended—

(1) in subparagraph (B)(iv)(II), by striking “a 3-month grace period” and inserting “a grace period specified in subparagraph (C)”; and

(2) by adding at the end the following new subparagraph:

“(C) GRACE PERIOD SPECIFIED.—For purposes of subparagraph (B)(iv)(II), the grace period specified in this subparagraph is—

“(i) for plan years beginning before January 1, 2018, a 3-month grace period; and

“(ii) for plan years beginning during 2018 or a subsequent year, such grace period for non-payment of premiums before discontinuing coverage as is applicable under the State law of the State in which the Exchange operates to health insurance coverage offered in the individual market (or, in the case such a State law is not in place for the State involved, a 1-month grace period).”.

G:\PA\15\HACA\GRACEPD_01.XML
It Cost $2.5 Million to Keep My Child Alive

We’re fortunate that our insurance paid for most of it. But if Republicans remake the health care system, kids like her may not be so lucky.

By Virginia Sack-Smith

My daughter Violet is 3 years old. She loves ladybugs and donuts and asking the question “Why?” She was also born with a single-ventricle heart, thanks to a rare collection of congenital defects. Violet lived for six months in a hospital bed. Her heart has been stopped, its essential pumping action taken over by a bypass machine in three separate 12-hour operations, and she’s had nine other surgeries. She spent almost two years in physical therapy and feeding therapy learning to sit, walk, and eat.

Violet is 3 years old and has accrued $2.5 million in medical bills. When you add the bills still under dispute, the number is more than $3 million.

But we are a lucky family. My husband, Dan, and I are both college-educated, well-compensated professionals, and his job provides excellent health insurance that has covered all but a few thousand dollars of those bills. His employer also extended his paid family leave indefinitely so he never had to miss a day that Violet spent in the hospital. And we received tremendous support from our extended family and friends, many of whom sent food, books, toys, and yes, checks.

Still, as the Republicans continue plotting how to dismantle the Affordable Care Act following President Trump’s first executive order, I am worried. Violet faces a lifetime of medical interventions. Dan could lose his job, with it, our medical coverage. But even if he doesn’t, the GOP has talked about repealing provisions of the Affordable Care Act that would change the rules for employment-based insurers as well.

Get Slate in your inbox.

Enter your email.

I agree to the terms.

Ethics violations. Conflicts of interest. We’ll tell the truth about the new administration. Join Slate Plus.
Violet may no longer be permitted to stay on our health insurance plan, if necessary, until she's 26. She may have met her lifetime cap on coverage before her first birthday. (We racked up those early medical bills so carelessly, never thinking we might have to choose between saving her life then and saving it later.) And she may not be able to get another insurance plan because she's one of 129 million Americans with a pre-existing condition that insurers could refuse to cover. In her case, it developed sometime around the 10th week of my pregnancy. Pregnancy is a high-risk proposition for women with Violet's condition, and yet she may not have access to free or low-cost contraception when she's old enough to need it.

Yet, Violet is not the kid I'm worried most about. My husband and I have begun saving for these scenarios. And we come from upper-middle-class families, which means Violet has grandparents and great-grandparents who can do the same.

But there are more than 27 million other children who have benefitted from the ban on lifetime limits under the Affordable Care Act and may be left scrambling for coverage sometime in the future. Meanwhile, 40 percent of all kids and 75 percent of poor kids rely on Medicaid or its partner program, the Children's Health Insurance Plan (CHIP), for their health coverage, according to the Kaiser Family Foundation. In addition to repealing the ACA, House Republicans are also working to turn Medicaid funds into block grants, which would allow states to restrict eligibility for both programs. All together, an estimated 29.8 million Americans could be uninsured by 2019, reports the Urban Institute. Nearly 4 million of them are children. Nine hundred thousand of them are under age 5. And many of them are very, very sick.

About half of American kids with complex health needs are on Medicaid or CHIP, compared with just 35 percent of healthy kids, according to the Data Resource Center for Child & Adolescent Health. That's because families who might not otherwise have qualified often lose jobs in their quest to care for a sick child or need Medicaid to fill gaps in an employer-sponsored plan as their child's medical bills rack up. "Medicaid block grants would be devastating for these children," says Dr. James M. Perrin, a professor of pediatrics at Harvard Medical School. Anne Garcia, the founder of OpenHeart, a nonprofit research and advocacy organization in Houston, puts it even more bluntly: "Half of the 40,000 babies born each year with congenital heart defects require expensive surgeries in the first few months of life," she says. "These cuts in coverage could return us to the Dark Ages of pediatric cardiac medicine, when doctors had to send babies home to die in their mothers' arms."

I worry about those babies, because doctors could have told me the same thing, and instead have worked unstintingly to save Violet's life. I worry about the family who lived in the room next door to us in the pediatric intensive care unit last summer. They have one child on the kidney transplant list and another displaying early signs of autism. In addition to extensive hospital stays, they face years of therapy and home nursing bills.

Slate Academy: The United States of Debt

How did debt get so bad in the United States? Join personal finance columnist Helaine Olen as she takes an in-depth look at the reality of debt in America. What's it like to empty out your 401(k) to help a family member? What works—and what doesn't—for people struggling to get out of debt? Find out. Join us today.
I am scared for the kids who aren’t getting access to the latest and most advanced surgical techniques because the best surgeons don’t take their insurance. When Violet had a feeding tube implanted in her abdomen in 2014, our nurses were relieved that we had chosen a surgeon who did that as a laparoscopic procedure because it’s less risky and has a much shorter recovery. The poor kids in our area get sent to an older surgeon who still slices their abdomens wide open to insert the tube—because he’s the only one who takes Medicaid.

On Friday, the Centers for Disease Control and Prevention published a report finding that babies born with birth defects were 45 to 49 percent more likely to die in the first year of life if they had Medicaid coverage than if they were privately insured. Now imagine how much worse that death rate would be if even Medicaid was beyond their grasp.

Top Comment

The GOP plan for children like Charlotte is a mayonnaise jar for coins on the counter of your local 7-11.

And I’m frightened for the babies who lie alone in cribs every day, on every floor of every children’s hospital in the country. Their mothers, fathers, or other caregivers aren’t there because they can’t afford to miss work to be with their sick children. They can’t lose that job. They can’t lose their house. They can’t lose that health insurance.

Violet is 3 years old and she loves ladybugs, donuts, and asking the question “Why?” Those children also have passions and questions and potential. I don’t have their photos, so I’m including one of my own kid, the one who will be mostly OK, no matter what the Republicans do to our health care system. But if Congress guts Medicaid and repeals the Affordable Care Act without a viable replacement, Violet will be asking why. And so will the rest of America for generations.
Dear Chairman Burgess and Ranking Member Green:

Thank you for holding this week’s hearing entitled “Patient Relief from Collapsing Health Markets.” AARP shares the subcommittee’s desire to examine ways in which health care costs can be lowered and better care can be provided to all Americans. However, we are concerned that the proposed State Age Rating Flexibility Act of 2017 — that would loosen age rating bands to allow insurers to charge older Americans significantly more for health insurance — would severely limit, not expand, access to quality, affordable healthcare. In addition, ample evidence suggests that relaxing restrictions on age rating bands could increase — not reduce — federal outlays on health care.

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals into real possibilities, strengthens communities, and fights for the issues that matter most to families such as healthcare, employment & income security, retirement planning, affordable utilities and protection from financial abuse.

Impact on Older Americans

The Affordable Care Act (ACA) addressed key obstacles in availability and affordability of health coverage for older Americans not yet eligible for Medicare. The result has been a dramatic drop — by half — of the number of Americans age 50-64 who are uninsured.

The 3:1 age band restriction included in the ACA’s market reforms ensured that older Americans could no longer be charged more than three times the amount charged to younger Americans. Prior to the ACA, health insurance coverage was simply unavailable or unaffordable for millions of 50-64 year olds not yet eligible for Medicare. Many paid much more for less coverage than they do today — state departments of insurance permitted insurers to charge older Americans five times or more than younger people for the same insurance coverage. For older adults without access to employer-based coverage, the average out-of-pocket costs for premiums and health care purchased on the individual market were typically two-and-a-half times higher than those of similar age with employer-sponsored coverage. This limitation, combined with coverage subsidies, is critical to ensuring that pre-Medicare eligible Americans can afford coverage.

[State list]
Changes Would Increase Cost for Older Americans

Weakening or eliminating the 3:1 age band restriction would increase dramatically premiums for older adults, making coverage less affordable for 50-64 year olds. Meanwhile, such a change would provide only marginally lower costs for younger adults. Estimates show that changing the age rating limit to 5:1 would increase yearly premiums for an average 64 year old on a silver plan by $2,100 (from $8,500 to $10,600), while reducing premiums for a 21 year old by only $700 (from $2,800 to $2,100).

The even larger disparity created by a 5:1 age band fails to take into account the impact on affordability for seniors. Income analysis done prior to implementation of the ACA found that the median family income for uninsured 18-24 year olds was approximately $28,500 while it was about $30,000 for 50-64 year olds—a difference of just over $1500. Despite the small difference in income, seniors who already pay as much as $5000 or more would be asked to pay as much as $8000 more.

A September 2015 Commonwealth Fund analysis also found that such a change would result in 400,000 older Americans losing health coverage altogether. The study also found that the increase in premiums caused by 5-to-1 rate banding would be financed in large part by the federal government—if the coverage is more expensive, it will necessitate higher subsidies to ensure affordability.

A 3:1 Age Band is More Price Accurate

According to a 2013 Urban Institute study, the 3:1 band “results in age-based premiums that more accurately match age-related costs among likely purchasers than would a looser rate band.” The study further concludes that higher rate bands would significantly increase out-of-pocket rates paid by older Americans and that a 5:1 band tends to overcharge older adults relative to their actual health expenses.

Relaxing the current 3:1 age band is a bad deal for Americans and will lead to higher costs and reduced coverage. For these reasons AARP strongly opposes the State Age Rating Flexibility Act of 2017 and urges you to reject any efforts to expand age rating bands that shift large to older Americans.

Thank you for the opportunity to submit this letter. If you have further questions, please feel free to contact me or have your staff reach out to Brendan Rose of our Government Affairs staff at brose@aarp.org or 202-434-3770.

Sincerely,

Joyce A Rogers
Senior Vice President
Government Affairs
WEAKENING THE ACA LIMIT ON AGE RATING
WOULD HURT OLDER ADULTS

What is the 3:1 Limit on Age Rating?

An important ACA protection for older adults that bars insurance companies from charging them more than three times the amount younger adults are charged for the same coverage. This important protection ensures older adults who are not yet Medicare-eligible have access to affordable health coverage.

Changing the Limit on Age Rating from 3:1 to 5:1 will only marginally lower premiums for younger adults, but will put a significant financial burden on older adults.

ANNUAL HEALTH INSURANCE PREMIUMS:

FOR A 21-YEAR-OLD

For a 64-year-old

Even under 3:1, older adults already face significant out-of-pocket costs and can’t afford to pay more.

Average annual medical spending for those not qualifying for subsidies:

OLDER ADULTS

$15,620

YOUNGER ADULTS

$5,820

Source: Federal Reserve Board, “Young Adult Medsinsurance Indicators, 2015-2017, “Medicare Current Beneficiary Survey,” 2017, all rural-urban categories except metropolitan, more than 100,000 people.

AARP Real Solutions
Today in Obamacare: The GOP says the law is "collapsing." CBO says otherwise.

Updated by Sarah Kliff@vox.com Jan 24, 2017, 4:10pm EST

CBO: Obamacare enrollment will stay steady next year, hit 13 million in 2027. One of Republicans’ favorite ways to describe Obamacare is as “collapsing.”

“We’re acting quickly because Obamacare is collapsing under its own weight, and things will continue to get worse otherwise,” Senate Majority Leader Mitch McConnell (R-KY) said in a January 9 op-ed for Fox News.

“Obamacare is collapsing,” House Speaker Paul Ryan (R-WI) said at a press conference this week. “Don’t forget that.”
Today in Obamacare: The GOP says the law is "collapsing." CBO says otherwise. Vox

The latest data from the Congressional Budget Office, however, begs to differ. The nonpartisan budget agency released its long-term economic forecast earlier today, which predicts that enrollment in the Obamacare marketplaces will increase slightly and then hold constant for the next decade.

**Forecasters: Obamacare enrollment will hold steady**

*Health insurance coverage through the Affordable Care Act marketplaces (in millions)*

![Graph showing projected enrollment in Obamacare marketplaces from 2017 to 2027.](Image)

Credit: Sarah Kliff/Vox
Source: Congressional Budget Office

To be clear: The insurance marketplaces are way smaller than CBO had initially expected. Back when the law passed, the agency estimated that there would be 26 million people in the marketplace in 2017. We’re on pace to have a market less than half that size. A market with more people would likely have lower premiums, as it would mean more healthy people had decided to join.

Though the Obamacare marketplaces are smaller, they’re not, in CBO’s view, anywhere near collapsing. They are on pace to provide a relatively small but stable number of Americans with health coverage. This is in line with a memo that the ratings agency S&P put out last month, which projected that if the ACA stays in place, “2017 will likely see continued improvement [in the marketplaces], with more insurers getting close to breakeven or better.”

A little more than a year ago, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimated the budgetary effects of H.R. 3762, the Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015, which would repeal portions of the Affordable Care Act (ACA)—eliminating, in two steps, the law’s mandate penalties and subsidies but leaving the ACA’s insurance market reforms in place. At that time, CBO and JCT offered a partial assessment of how H.R. 3762 would affect health insurance coverage, but they had not estimated the changes in coverage or premiums that would result from leaving the market reforms in place while repealing the mandate penalties and subsidies. This document—prepared at the request of the Senate Minority Leader, the Ranking Member of the Senate Committee on Finance, and the Ranking Member of the Senate Committee on Health, Education, Labor, and Pensions—provides such an estimate.

In brief, CBO and JCT estimate that enacting that legislation would affect insurance coverage and premiums primarily in these ways:

- The number of people who are uninsured would increase by 18 million in the first new plan year following enactment of the bill. Later, after the elimination of the ACA’s expansion of Medicaid eligibility and of subsidies for insurance purchased through the ACA marketplaces, that number would increase to 27 million, and then to 32 million in 2026.

- Premiums in the nongroup market (for individual policies purchased through the marketplaces or directly from insurers) would increase by 20 percent to 25 percent—relative to projections under current law—in the first new plan year following enactment. The increase would reach about 50 percent in the year following the elimination of the Medicaid expansion and the marketplace subsidies, and premiums would surpass double by 2026.

The ways in which individuals, employers, states, insurers, doctors, hospitals, and other affected parties would respond to the changes made by H.R. 3762 are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT have endeavored to...
develop estimates that are in the middle of the distribution of potential outcomes.

In an effort to make this information more useful, CBO and JCT have updated their estimates of H.R. 3762's effects on health insurance coverage and premiums using CBO's most recent baseline projections, which were released in March 2016, and adjusted the effective dates in the legislation to reflect an assumption that enactment would occur one year later.

The Restoring Americans' Healthcare Freedom Reconciliation Act of 2015

H.R. 3762 would make two primary sets of changes that would affect insurance coverage and premiums. First, upon enactment, the bill would eliminate penalties associated with the requirements that most people obtain health insurance (also known as the individual mandate) and that large employers offer their employees health insurance that meets specified standards (also known as the employer mandate). Second, beginning roughly two years after enactment, the bill would also eliminate the ACA's expansion of Medicaid eligibility and the subsidies available to people who purchase health insurance through a marketplace established by the ACA. H.R. 3762 also contains other provisions that would have smaller effects on coverage and premiums.

Importantly, H.R. 3762 would leave in place a number of market reforms—rules established by the ACA that govern certain health insurance markets. Insurers who sell plans either through the marketplace or directly to consumers are required to:

- Provide specific benefits and amounts of coverage;
- Not deny coverage or vary premiums because of an enrollee’s health status or limit coverage because of preexisting medical conditions; and
- Vary premiums only on the basis of age, tobacco use, and geographic location.

Analysis of H.R. 3762 Relative to CBO's March 2016 Baseline

According to CBO and JCT's analysis, upon enactment, H.R. 3762 would reduce the number of people with insurance; and in the first new plan year, premiums in the nongroup market would rise and participation by insurers in that market would decline. Starting in the year following the elimination of the expansion of Medicaid eligibility and the marketplace subsidies, the increase in the number of uninsured people and premiums would be greater, and participation by insurers in the nongroup market would decline further.

Estimated Changes Before the Elimination of the Medicaid Expansion and Subsidies

Following enactment but before the Medicaid expansion and subsidies for insurance purchased through the marketplaces were eliminated, the effects of H.R. 3762 on insurance coverage and premiums would stem primarily from repealing the penalties associated with the individual mandate.

Effects on Insurance Coverage. CBO and JCT expect that the number of people without health insurance coverage would increase upon enactment of H.R. 3762 but that the increase would be limited initially, because insurers would have already set their premiums for the current year, and many people would have already made their enrollment decisions for the year. Subsequently, in the first full plan year following enactment, by CBO and JCT's estimates, about 18 million people would become uninsured. That increase in the uninsured population would consist of about 10 million fewer people with coverage obtained in the nongroup market, roughly 5 million fewer people with coverage under Medicaid, and about 3 million fewer people with employment-based coverage.

Most of these reductions in coverage would stem from repealing the penalties associated with the individual mandate. However, CBO and JCT also expect that insurers in some areas would leave the nongroup market in the first new plan year following enactment. They would be leaving in anticipation of further reductions in enrollment and higher average health care costs among enrollees who remained after the subsidies for insurance purchased through the marketplaces were eliminated. As a consequence, roughly 10 percent of the population would be living in an area that had no insurer participating in the nongroup market.

Effects on Premiums. According to CBO and JCT's analysis, premiums in the nongroup market would be roughly 20 percent to 25 percent higher than under current law once insurers incorporated the effects of H.R. 3762's changes into their premium pricing in the
first new plan year after enactment. The majority of that increase would stem from repealing the penalties associated with the individual mandate. Doing so would both reduce the number of people purchasing health insurance and change the mix of people with insurance—tending to cause smaller reductions in coverage among older and less healthy people with high health care costs and larger reductions among younger and healthier people with low health care costs. Thus, average health care costs among the people retaining coverage would be higher, and insurers would have to raise premiums in the nongroup market to cover those higher costs. Lower participation by insurers in the nongroup market would place further upward pressure on premiums because the market would be less competitive.

Estimated Changes After the Elimination of the Medicaid Expansion and Subsidies

The bill’s effects on insurance coverage and premiums would be greater once the repeal of the Medicaid expansion and the subsidies for insurance purchased through the marketplaces took effect, roughly two years after enactment.

Effects on Insurance Coverage. By CBO and JCT’s estimates, enacting H.R. 3762 would increase the number of people without health insurance coverage by about 27 million in the year following the elimination of the Medicaid expansion and marketplace subsidies and by 32 million in 2026, relative to the number of uninsured people expected under current law. (The number of people without health insurance would be smaller if, in addition to the changes in H.R. 3762, the insurance market reforms mentioned above were also repealed. In that case, the increase in the number of uninsured people would be about 21 million in the year following the elimination of the Medicaid expansion and marketplace subsidies; that figure would rise to about 23 million in 2026.)

The estimated increase of 32 million people without coverage in 2026 is the net result of roughly 23 million fewer with coverage under Medicaid, partially offset by an increase of about 11 million people covered by employment-based insurance. By CBO and JCT’s estimates, 59 million people under age 65 would be uninsured in 2026 (compared with 28 million under current law), representing 21 percent of people under age 65. By 2026, fewer than 2 million people would be enrolled in the nongroup market, CBO and JCT estimate.

According to the agencies’ analysis, eliminating the mandate penalties and the subsidies while retaining the market reforms would destabilize the nongroup market, and the effect would worsen over time. The ACA’s changes to the rules governing the nongroup health insurance market work in conjunction with the mandate and the subsidies to increase participation in the market and encourage enrollment among people of different ages and health statuses. But eliminating the penalty for not having health insurance would reduce enrollment and raise premiums in the nongroup market. Eliminating subsidies for insurance purchased through the marketplaces would have the same effect because it would result in a large price increase for many people. Not only would enrollment decline, but the people who would be most likely to remain enrolled would tend to be less healthy (and therefore more willing to pay higher premiums). Thus, average health care costs among the people retaining coverage would be higher, and insurers would have to raise premiums in the nongroup market to cover those higher costs. CBO and JCT estimate that enrollment would continue to drop and premiums would continue to increase in each subsequent year.

Leaving the ACA’s market reforms in place would limit insurers’ ability to use strategies that were common before the ACA was enacted. For example, insurers would not be able to vary premiums to reflect an individual’s health care costs or offer health insurance plans that exclude coverage of preexisting conditions, plans that do not cover certain types of benefits (such as maternity care), or plans with very high deductibles or very low actuarial value (plans paying a very low share of costs for covered services).

Effects on Participation by Insurers. In CBO and JCT’s estimation, the factors exerting upward pressure on premiums and downward pressure on enrollment in the nongroup market would lead to substantially reduced participation by insurers and enrollees in many areas. Prior experience in states that implemented similar nongroup market reforms without a mandate penalty or subsidies has demonstrated the potential for market destabilization. Several states that enacted such market reforms later repealed or substantially modified those
reforms in response to increased premiums and insurers' departure from the market.

After weighing the evidence from prior state-level reforms and input from experts and market participants, CBO and JCT estimate that about half of the nation's population lives in areas that would have no insurer participating in the nongroup market in the first year after the repeal of the marketplace subsidies took effect, and that share would continue to increase, extending to about three-quarters of the population by 2026. That contraction of the market would most directly affect people without access to employment-based coverage or public health insurance.

Effects on Premiums. In total, as a result of reduced enrollment, higher average health care costs among remaining enrollees, and lower participation by insurers, CBO and JCT project that premiums in the nongroup market would be about 50 percent higher in the first year after the marketplace subsidies were eliminated—relative to projections under current law—and would about double by 2026.

Comparison With CBO and JCT's 2015 Cost Estimate

This analysis differs in a number of respects from the one CBO and JCT did in December 2015. In particular, the projected increase in the number of uninsured people is now greater largely because, at that time, the agencies had not estimated the changes in coverage from leaving the ACA's insurance market reforms in place while repealing the mandate penalties and subsidies. Moreover, the current estimates of how H.R. 3762 would affect coverage are measured relative to CBO's March 2016 baseline, rather than the March 2015 baseline, which was the basis for the earlier estimates. Those baselines differ in part because CBO and JCT have reduced their projections of the number of people with health insurance coverage through the marketplaces and increased their projections of the number of people with coverage through Medicaid under current law.1

Future Legislation

If the Congress considers legislation similar to H.R. 3762 in the coming weeks, the estimated effects could differ from those described here. In particular, the response of individuals, insurers, and states would depend critically on the particular specifications contained in such legislation.

This document was requested by the Senate Minority Leader, the Ranking Member of the Senate Committee on Finance, and the Ranking Member of the Senate Committee on Health, Education, Labor, and Pensions. Kate Fritzsche and Sarah Masi prepared it with guidance from Jessica Bandin, Chad Chirico, and Holly Harvey and with contributions from Allison Percy and the staff of the Joint Committee on Taxation. An electronic version is available on CBO's website (www.cbo.gov/publication/52371).

Keith Hall
Director

High-Risk Pools For Uninsurable Individuals

Karen Pollitz

In the debate over the future of the Affordable Care Act (ACA), proposals have emerged that would repeal or weaken rules prohibiting health insurance discrimination based on health status, instead offering high-risk pools as a source of coverage for people who would be uninsurable due to pre-existing conditions.

In Congress, HR 2533 was introduced by members of the House Republican Study Committee to repeal the ACA and replace it with other changes, including state high-risk pools. This bill would authorize $50 million for seed grants to help states establish high-risk pools, and $2.5 billion annually for 10 years to help states fund high-risk pools. Recently, House Republicans released their proposal to replace the ACA, entitled A Better Way. This plan would significantly modify ACA insurance market rules to provide a one-time open enrollment opportunity; thereafter, only individuals who maintain continuous coverage would be guaranteed access to insurance without regard to their health status. This plan also would provide $25 billion over 10 years in state grants to help fund high-risk pools. Pools would be required to cap premiums (at unspecified levels) and would be prohibited from imposing waiting lists.

For more than 35 years, many states operated high-risk pool programs to offer non-group health coverage to uninsurable residents. The federal government also operated a temporary high-risk pool program established under the ACA to provide coverage to people with pre-existing conditions in advance of when broader insurance market changes took effect in 2014. This issue brief reviews the history of these programs to provide context for some of the potential benefits and challenges of a high-risk pool.

Distribution and Persistence of Population Health Spending

In the U.S. and other developed nations, population health care spending is highly concentrated: in any given year, the healthiest 50% of the population accounts for less than 3% of total health care expenditures, while the sickest 10% account for nearly two-thirds of population health spending. (Figure 1) Private health insurance pools risks so that premiums paid by most enrollees, who have low claims costs, help pay claims for the small share of enrollees with high costs.

Who is included in the high-cost and low-cost groups changes from year to year. Most people are healthy most of the time, but illness and injury can and do onset unexpectedly for millions of people. Some high-cost conditions, such as hemophilia or HIV, persist and require treatment for extended periods, even a lifetime. Other high-cost conditions may improve or resolve, allowing patients to return to low annual health care spending. In any given year, among the 50% least expensive people in a year, 75% will remain in that group for a second year; similarly, of people who are among the most expensive 10% of the population in one year, only 45% would still be in that group the following year.
Prior to implementation of the ACA, insurers selling individual insurance commonly practiced medical underwriting, excluding people with pre-existing conditions or charging them higher premiums. Medical underwriting effectively excludes a large proportion of total health care spending from the insurance pool. This can permit less expensive policies for healthier individuals, but requires some other mechanism, such as high-risk pools, to help finance costs attributable to the sickest individuals if they are to be covered. Enrollee premiums can finance a portion of the cost of such programs, but by definition, significant additional funding will also be required because the cost of each person covered will be substantial. For example, based on the distribution illustrated in Figure 1, per person costs in the top 10th percentile are more than 100 times, on average, that of people in the bottom 50th percentile.

**State High-Risk Pools**

Prior to implementation of the ACA, 35 states offered high-risk pools as a source of non-group health insurance for eligible residents. (Figure 2) The first pools were implemented by Minnesota and Connecticut in 1976; North Carolina implemented a high-risk pool in 2009. Pools offered eligibility to people in one or more of the following categories:

- **Medically eligible** - Originally, high-risk pools were created to offer coverage to state residents with pre-existing conditions that made them uninsurable in the medically underwritten non-group health insurance market. Medically eligible individuals had to demonstrate their application for individual health insurance had been denied or restricted, or — in about two-thirds of state pools with presumptively eligible medical conditions lists — that they had been diagnosed with an eligible condition.

- **HIPAA eligible** - Following enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) — a federal law requiring non-group coverage to be available on a guaranteed issue basis with no pre-existing condition exclusions to certain individuals who had lost group health plan coverage — most state high-
risk pools extended eligibility to HIPAA-eligible individuals. One state, Alabama, opened its pool only to HIPAA-eligible individuals.

HCTC eligible - The Trade Act of 2002 established a federal health coverage tax credit (HCTC) to subsidize HIPAA-like coverage for certain eligible individuals with trade-related job loss. Roughly two-thirds of state pools extended eligibility to HCTC-eligible individuals.

Medicare eligible - Finally, nearly two-thirds of state high-risk pools offered coverage to Medicare-eligible residents who needed supplemental coverage. (Appendix Table 1)

STATE HIGH–RISK POOL ENROLLMENT, PROGRAM FEATURES, AND COSTS

Before HIPAA was enacted in 1996, there were 25 state high-risk pools with combined enrollment of 91,054. By the end of 2011, combined enrollment in 35 state high-risk pools reached 226,615, or about 2 percent of the number of non-group health insurance market participants in those states that year. (Appendix Table 2)

The potentially medically eligible population in high-risk pool states was likely much larger. For example, a study by the General Accounting Office (GAO) found between 20% and 60% of non-elderly adults have pre-existing conditions that could result in a health insurer restricting coverage. The range of estimates depended on the list of pre-existing conditions included; the most prevalent conditions included hypertension, mental health disorders, diabetes, pulmonary disease and cancer. In a Kaiser Family Foundation national survey, 50% of respondents said they or a member of their household had a pre-existing condition. Another GAO study reported that in 2010, 19% of applicants for non-group health insurance coverage nationwide were denied. A Kaiser Family Foundation study of medical underwriting practices in the individual health insurance market

High-Risk Pools For Uninsurable Individuals
found applicants with medical conditions as serious as HIV or as mild as seasonal hay fever could have coverage denied or restricted or premiums surcharged when applying for medically underwritten policies. Although no two traditional state-high risk pools were identical, nearly all adopted certain common features that tended to limit enrollment of eligible individuals. These included:

- **Premiums above standard non-group market rates** - All state high-risk pools set premiums at a multiple of standard (i.e., typical or average) rates for medically underwritten coverage in the non-group market, usually 150%-200%. Fifteen pools provided low-income premium subsidies that varied in comprehensiveness. The Oregon pool, for example, discounted premiums 95% for enrollees with income up to 185% of the poverty level, while the New Hampshire pool provided a 20% premium discount for enrollees with income below 200% FPL. Other pools required people to pay the full premium, regardless of income.

- **Pre-existing condition exclusions** - Nearly all state high-risk pools excluded coverage of pre-existing conditions for medically eligible enrollees, usually for 6-12 months. This made coverage less attractive for people who needed coverage specifically for their pre-existing conditions.

- **Lifetime and annual limits** - Thirty-three pools imposed lifetime dollar limits on covered services, most ranging from $1 million to $2 million. In addition, six pools imposed annual dollar limits on all covered services while 13 others imposed annual dollar limits on specific benefits such as prescription drugs, mental health treatment, or rehabilitation.

- **High deductibles** - Most pools offered a choice of plan options with different deductibles; in 25 programs, the plan option with the highest enrollment had a deductible of $1,000 or higher. (Appendix Table 3)

A small number of states capped or closed enrollment to limit program costs, though enrollment caps were not allowed for HIPAA-eligible individuals. Limiting enrollment, directly or indirectly, was a key strategy to limit the cost of high-risk pools to states. By design, all state high-risk pools experienced net losses—that is, expenses greater than premium revenue. In 2011, net losses for 35 state high-risk pools combined were over $1.2 billion, or $5,510 per enrollee, on average. (Appendix Table 4) Most states financed net losses through an assessment on private non-group health insurance premiums; however, nearly all state high-risk pool assessments were offset by tax credits so that, in effect, general state revenue funding applied. A few states used other revenue sources—tobacco taxes and hospital assessments—to fund high-risk pool losses. In addition, in 2003-2010 federal grants were available intermittently, subject to appropriations, to help fund qualified state-high risk pools that met certain criteria. For the first two fiscal years (2003-2004) $80 million per year was appropriated; $75 million in grants was next awarded in 2006, followed by $49 million in 2008, $73.5 million in 2009, and $55 million in each of 2010 and 2011. In some years, a portion of federal grant funds was reserved for states that adopted supplemental consumer benefits such as low-income premium subsidies. Federal grants comprised between 2% and 12% of program expenses in states that received them.7

**Federal Pre-existing Condition Insurance Program (PCIP)**

The ACA established a temporary, national high-risk pool program, implemented in 2010, to offer coverage for uninsured individuals with pre-existing conditions until 2014, when private non-group policies would be available under new market rules prohibiting insurance discrimination based on health status. The law
required PCIP enrollees to pay premiums and appropriated $5 billion to fund expected net losses during the program’s duration. Twenty-seven states opted to administer PCIP for their residents; the federal government operated PCIP for 23 states and D.C.

**PCIP Enrollment, Program Features, and Costs**

Program features under PCIP varied from state high-risk pools in several significant respects. Under the law, PCIP premiums were set at 100% of the standard risk rate for non-group health insurance in each state, meaning rates varied by age but were otherwise equivalent to what a typical person without a pre-existing condition would pay. Low income premium subsidies were not offered. PCIP did not impose annual or lifetime dollar limits on covered benefits. Annual out-of-pocket-cost sharing was capped at the level set for tax-favored high-deductible health plans ($6,050 in 2012) and a minimum actuarial value of 65% was established for program coverage (meaning patients were expected to pay, on average, 35% of their health expenses). In 42 states, the lowest deductible option offered in 2012 was at least $1,000. PCIP did not impose pre-existing condition exclusions. However, to prevent “crowd out” from existing state pools and other private insurance, PCIP eligibility was limited to individuals who had been uninsured for at least 6 months immediately prior to enrolling.

PCIP was operational in all 50 states by the fall of 2010. By late 2012, just over 100,000 individuals were enrolled and program expenses had consumed nearly half of the $5 billion appropriation. For the final 12-month period for which PCIP expense data were reported, net losses for the program were over $2 billion. (Table 1)

**Table 1: PCIP Enrollment and Net Expenses, 2011-2013**

<table>
<thead>
<tr>
<th>Date</th>
<th>Enrollment as of date</th>
<th>Cumulative expenditures net of premiums</th>
<th>Quarterly increase in net expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 31, 2011</td>
<td>24,712</td>
<td>$0.180 billion</td>
<td></td>
</tr>
<tr>
<td>Sep. 30, 2011</td>
<td>37,824</td>
<td>$0.386 billion</td>
<td>$207 million</td>
</tr>
<tr>
<td>Dec. 31, 2011</td>
<td>48,879</td>
<td>$0.618 billion</td>
<td>$232 million</td>
</tr>
<tr>
<td>Mar. 31, 2012</td>
<td>61,819</td>
<td>$0.963 billion</td>
<td>$334 million</td>
</tr>
<tr>
<td>June 30, 2012</td>
<td>77,877</td>
<td>$1.401 billion</td>
<td>$439 million</td>
</tr>
<tr>
<td>Sep. 30, 2012</td>
<td>90,347</td>
<td>$1.861 billion</td>
<td>$460 million</td>
</tr>
<tr>
<td>Dec. 31, 2012</td>
<td>103,160</td>
<td>$2.406 billion</td>
<td>$545 million</td>
</tr>
<tr>
<td>Mar. 31, 2013</td>
<td>114,959</td>
<td>$2.978 billion</td>
<td>$571 million</td>
</tr>
<tr>
<td>June 30, 2013</td>
<td>104,966</td>
<td>$3.602 billion</td>
<td>$625 million</td>
</tr>
<tr>
<td>Sep. 30, 2013</td>
<td>89,438</td>
<td>$3.956 billion</td>
<td>$354 million</td>
</tr>
</tbody>
</table>

In 2012, average per enrollee claims costs for PCIP were $32,108, or more than 2.5 times higher than average per enrollee claims costs ($12,471) under traditional state high-risk pools, all of which continued to operate that year. Compared to traditional state high-risk pool enrollees, PCIP enrollees tended to have more immediate and intensive health care needs, including higher hospital admissions, likely due to the six-month prior uninsurance requirement and lack of pre-existing condition exclusions. By contrast, many traditional state pool enrollees were HIPAA-eligible, meaning they had to have been continuously covered and were less likely to have put off needed treatment prior to joining the pool. Pre-existing condition exclusions would have limited traditional pool coverage of initial treatment costs (or enrollment by) other non-HIPAA-eligible individuals.

In addition, PCIP premiums were based on standard rates for underwritten non-group coverage, while under traditional state pools, premiums were set at 150%-200% of standard market rates. As a result, enrollees under traditional state pools paid a greater share of their claims costs compared to PCIP enrollees. This meant that the loss ratio—the ratio of claims costs to premiums—would naturally be higher in PCIP compared to the traditional state pools. In 2011, claims under traditional state high-risk pools averaged 181% of pool premiums; that year, PCIP claims averaged 417% of premiums. By late 2013, the PCIP loss ratio had reached 600%.

In the face of growing expenses, PCIP adopted a series of changes to limit program costs. In 2012 federally-administered programs switched to a less expensive provider network and negotiated additional discounts with targeted hospitals that treated large numbers of PCIP enrollees. State-run programs were required to achieve similar cost savings or transition to federal administration; 17 state programs transitioned in mid-2013. The federal PCIP program also consolidated plan options for 2013, eliminating those offering the lowest patient cost sharing. Even with these changes, program expenses were still projected to exceed appropriated funds before the end of 2013. In March 2013, new PCIP enrollment was suspended to ensure sufficient funds to pay claims for people already enrolled. PCIP enrollment peaked at nearly 115,000 in March 2013, then declined below 90,000 six months later.

**Discussion**

Nearly four decades of experience with high-risk pools suggests they have the potential to provide health coverage to a substantial number of people with pre-existing conditions. State high-risk pools that existed prior to passage of the ACA covered over 200,000 people at their peak, and the temporary PCIP pool created as part of the ACA covered over 100,000 individuals.

These high-risk pools likely covered just a fraction of the number of people with pre-existing conditions who lacked insurance, due in part to design features that limited enrollment. State pools typically excluded coverage of services associated with pre-existing conditions for a period of time and charged premiums substantially in excess of what a typical person would pay in the non-group market. PCIP had fewer barriers to enrollment—charging standard premiums with no pre-existing condition exclusions—but it did restrict signups to people who had been uninsured for at least six months.

Even with these limitations, the government subsidies required to cover losses in these high-risk pools were substantial—over $1 billion per year in the state pools and about $2 billion in the final year of PCIP. A high-risk pool that had minimal barriers to enrollment could cost substantially more.
### Appendix Tables

<table>
<thead>
<tr>
<th>State</th>
<th>Uninsurable</th>
<th>HIPAA Eligible</th>
<th>ACA Eligible</th>
<th>Medicare Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nevada</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>34</td>
<td>24</td>
<td>19</td>
</tr>
</tbody>
</table>

Source: NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012
<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment as of December 31, 2011</th>
<th>Non-group market participants, 2011</th>
<th>Pool enrollment as percent of non-group market</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>2,113</td>
<td>216,884</td>
<td>0.1%</td>
</tr>
<tr>
<td>Alaska</td>
<td>525</td>
<td>20,940</td>
<td>2.5%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>2,401</td>
<td>116,501</td>
<td>2.4%</td>
</tr>
<tr>
<td>California</td>
<td>6,314</td>
<td>2,293,043</td>
<td>0.2%</td>
</tr>
<tr>
<td>Colorado</td>
<td>13,859</td>
<td>396,950</td>
<td>3.5%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1,603</td>
<td>158,581</td>
<td>1%</td>
</tr>
<tr>
<td>Florida</td>
<td>208</td>
<td>914,604</td>
<td>0.02%</td>
</tr>
<tr>
<td>Idaho</td>
<td>1,658</td>
<td>123,742</td>
<td>1.3%</td>
</tr>
<tr>
<td>Illinois</td>
<td>19,998</td>
<td>589,454</td>
<td>3.4%</td>
</tr>
<tr>
<td>Indiana</td>
<td>7,302</td>
<td>190,011</td>
<td>3.9%</td>
</tr>
<tr>
<td>Iowa</td>
<td>3,268</td>
<td>155,988</td>
<td>1.7%</td>
</tr>
<tr>
<td>Kansas</td>
<td>1,528</td>
<td>149,443</td>
<td>1%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>4,758</td>
<td>170,835</td>
<td>2.8%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>1,723</td>
<td>161,923</td>
<td>1%</td>
</tr>
<tr>
<td>Maryland</td>
<td>20,646</td>
<td>271,473</td>
<td>7.0%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>26,859</td>
<td>264,370</td>
<td>10.2%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>3,328</td>
<td>135,913</td>
<td>2.4%</td>
</tr>
<tr>
<td>Missouri</td>
<td>4,099</td>
<td>345,408</td>
<td>1.2%</td>
</tr>
<tr>
<td>Montana</td>
<td>2,878</td>
<td>82,021</td>
<td>3.5%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>4,021</td>
<td>159,251</td>
<td>2.9%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>2,580</td>
<td>68,840</td>
<td>3.5%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>8,442</td>
<td>84,667</td>
<td>9.9%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>8,160</td>
<td>408,517</td>
<td>2%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1,446</td>
<td>61,539</td>
<td>2.3%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>2,422</td>
<td>154,818</td>
<td>1.0%</td>
</tr>
<tr>
<td>Oregon</td>
<td>12,152</td>
<td>240,724</td>
<td>5%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>1,799</td>
<td>189,469</td>
<td>1%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>645</td>
<td>61,672</td>
<td>1%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>3,255</td>
<td>320,607</td>
<td>1%</td>
</tr>
<tr>
<td>Texas</td>
<td>24,792</td>
<td>955,857</td>
<td>2.6%</td>
</tr>
<tr>
<td>Utah</td>
<td>3,946</td>
<td>158,000</td>
<td>2.5%</td>
</tr>
<tr>
<td>Washington</td>
<td>3,862</td>
<td>357,130</td>
<td>1.1%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>1,152</td>
<td>26,466</td>
<td>4.4%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>21,317</td>
<td>313,149</td>
<td>6.8%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>945</td>
<td>28,191</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>226,615</strong></td>
<td><strong>10,266,121</strong></td>
<td><strong>2.2%</strong></td>
</tr>
</tbody>
</table>


---

**High-Risk Pools For Uninsurable Individuals**

8
### State-by-State Analysis, 2011/2012

<table>
<thead>
<tr>
<th>State</th>
<th>Annual Maximum</th>
<th>Pre-existing Condition Exclusions</th>
<th>Deductible or Coinsurance</th>
<th>Lifetime Benefit Maximum</th>
<th>Annual Pre-existing Benefit Maximum</th>
<th>Low-Income Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>200%</td>
<td>High-Risk Individuals: N/A</td>
<td>$2,500</td>
<td>$1 million</td>
<td>$10,000</td>
<td>X</td>
</tr>
<tr>
<td>Alaska</td>
<td>150%</td>
<td></td>
<td>$5,000</td>
<td>$2 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>150%</td>
<td></td>
<td>$1,000</td>
<td>$1 million</td>
<td>$4,000*</td>
<td></td>
</tr>
<tr>
<td>California</td>
<td>125-137.5%</td>
<td></td>
<td>$500</td>
<td>$75,000</td>
<td>$75,000</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>150%</td>
<td></td>
<td>$1,000</td>
<td>$1 million</td>
<td>$3,000*</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>150%</td>
<td></td>
<td>$1,300</td>
<td>$1.5 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>250%</td>
<td></td>
<td>$1,000</td>
<td>$5 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>150%</td>
<td></td>
<td>$3,000</td>
<td>$1 million</td>
<td>multiple*</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>150%</td>
<td></td>
<td>$500</td>
<td>$2 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>200%</td>
<td></td>
<td>$500</td>
<td>none</td>
<td>$50,000*</td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>150%</td>
<td></td>
<td>$2,500</td>
<td>$3 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>150%</td>
<td></td>
<td>$5,000</td>
<td>$2 million</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>150%</td>
<td></td>
<td>$1,250</td>
<td>none</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>200%</td>
<td></td>
<td>$5,000</td>
<td>$625,000</td>
<td>$125,000</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>200%</td>
<td></td>
<td>$500</td>
<td>$2 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>125%</td>
<td></td>
<td>$2,000</td>
<td>$5 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>175%</td>
<td>6-12 months*</td>
<td>$3,000</td>
<td>$1 million</td>
<td>$100,000*</td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>150%</td>
<td>6-12 months*</td>
<td>$5,000</td>
<td>$1 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>200%</td>
<td>12 months</td>
<td>$5,000</td>
<td>$2 million</td>
<td>multiple*</td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>150%</td>
<td></td>
<td>$2,000</td>
<td>$1 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>150%</td>
<td>9 months</td>
<td>$1,200</td>
<td>$2.5 million</td>
<td>multiple*</td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>150%</td>
<td>6 months</td>
<td>$500</td>
<td>none</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>200%</td>
<td>12 months</td>
<td>$5,000</td>
<td>$1 million</td>
<td>$100,000*</td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>125%</td>
<td>6-9 months*</td>
<td>$500</td>
<td>$1 million</td>
<td>$6,000*</td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>150%</td>
<td>12 months</td>
<td>$2,000</td>
<td>$1 million</td>
<td>$4,000*</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>125%</td>
<td>6 months</td>
<td>$500</td>
<td>$2 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>200%</td>
<td>6 months</td>
<td>$1,500</td>
<td>$1 million</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>150%</td>
<td>6 months</td>
<td>$1,000</td>
<td>$2 million</td>
<td>multiple*</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>150%</td>
<td>6-9 months*</td>
<td>$1,000</td>
<td>$1 million</td>
<td>$200,000*</td>
<td>X</td>
</tr>
<tr>
<td>Texas</td>
<td>125%</td>
<td>12 months</td>
<td>$2,500</td>
<td>$2 million</td>
<td>multiple*</td>
<td>X</td>
</tr>
<tr>
<td>Utah</td>
<td>200%</td>
<td>6 months</td>
<td>$500</td>
<td>$1.5 million</td>
<td>$300,000</td>
<td>X</td>
</tr>
<tr>
<td>Washington</td>
<td>150%</td>
<td>6 months</td>
<td>$500</td>
<td>$2 million</td>
<td>none</td>
<td>X</td>
</tr>
<tr>
<td>West Virginia</td>
<td>150%</td>
<td>6 months</td>
<td>$2,000</td>
<td>$1 million</td>
<td>$200,000</td>
<td>X</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>200%</td>
<td>9 months</td>
<td>$2,500</td>
<td>$3 million</td>
<td>none</td>
<td>X</td>
</tr>
<tr>
<td>Wyoming</td>
<td>200%</td>
<td>12 months</td>
<td>$1,000</td>
<td>$750,000</td>
<td>none</td>
<td>X</td>
</tr>
</tbody>
</table>

**Notes:**
- Pre-existing condition exclusions.
- *No pool closed to new enrollees in 1991, pre-ex not applicable.
- Mississippi pool imposed separate 6-month pre-ex exclusion period for pharmacy benefits, 9 months for pregnancy-related benefits, 12 months for physician and hospital services for all other conditions.
- North Dakota imposed separate 6-month pre-ex exclusion for pharmacy-related benefits.
- New Hampshire pool imposed separate 6-month pre-ex exclusion for pharmacy benefits.
- New Mexico pool imposed separate 6-month pre-ex exclusion for pharmacy benefits.
- North Dakota pool imposed separate 6-month pre-ex exclusion for pharmacy-related benefits.

**Annual Maximums:**
- "NA: $10,000 for pharmacy benefits; N/A: $4,000 for mental health/substance abuse benefit; N/C: $3,000 for DME benefit; N/D: $4,000 for rehab benefits; N/E: $2,000 for hospice benefit; N/S: $10,000 for skilled nursing benefit; N/M: $10,000 applies to pharmacy benefit; N/SS: $2,000 applies to DME benefit; N/M: $10,000 applies to DME benefit; N/E: $100,000 applies to mental health/substance abuse, various day limits apply to skilled nursing, rehab, hospice, and mental health-related services."
- "NC: $1,000 applies to injectable drugs; various day limits apply to skilled nursing, rehab, hospice, and mental health-related services."
- "ND: $3,000 applies to DME benefit; N/T: $100,000 applies to DME benefit; N/E: $100,000 applies to DME benefit; N/E: $100,000 applies to skilled nursing, rehab, hospice, and mental health-related services."
- "NH: $6,000 applies to DME benefit; N/M: $10,000 applies to pharmacy benefit; N/E: $100,000 applies to DME benefit; N/E: $100,000 applies to DME benefit; N/E: $100,000 applies to skilled nursing, rehab, hospice, and mental health-related services."

**High-Risk Pools For Uninsurable Individuals**

Source: NASHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012
<table>
<thead>
<tr>
<th>State</th>
<th>Premiums ($ millions)</th>
<th>Expenses ($ millions)</th>
<th>Net Losses ($ millions)</th>
<th>Per-Enrollee Net Losses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>$15.3</td>
<td>$21.8</td>
<td>$6.7</td>
<td>$3,147</td>
</tr>
<tr>
<td>Alaska</td>
<td>$3.7</td>
<td>$14.3</td>
<td>$10.6</td>
<td>$20,255</td>
</tr>
<tr>
<td>Arkansas</td>
<td>$18.0</td>
<td>$26.4</td>
<td>$8.4</td>
<td>$2,999</td>
</tr>
<tr>
<td>California</td>
<td>$47.6</td>
<td>$70.3</td>
<td>$22.7</td>
<td>$3,579</td>
</tr>
<tr>
<td>Colorado</td>
<td>$67.3</td>
<td>$127.2</td>
<td>$60.1</td>
<td>$4,322</td>
</tr>
<tr>
<td>Connecticut</td>
<td>$19.4</td>
<td>$29.0</td>
<td>$9.6</td>
<td>$5,993</td>
</tr>
<tr>
<td>Florida</td>
<td>$1.3</td>
<td>$3.6</td>
<td>$2.3</td>
<td>$10,894</td>
</tr>
<tr>
<td>Idaho</td>
<td>$6.1</td>
<td>$11.4</td>
<td>$5.3</td>
<td>$3,197</td>
</tr>
<tr>
<td>Illinois</td>
<td>$118.9</td>
<td>$224.0</td>
<td>$103.1</td>
<td>$5,255</td>
</tr>
<tr>
<td>Indiana</td>
<td>$64.2</td>
<td>$134.2</td>
<td>$70</td>
<td>$9,335</td>
</tr>
<tr>
<td>Iowa</td>
<td>$20.2</td>
<td>$42.1</td>
<td>$21.9</td>
<td>$6,690</td>
</tr>
<tr>
<td>Kansas</td>
<td>$13.2</td>
<td>$27.9</td>
<td>$14.7</td>
<td>$9,626</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$34.6</td>
<td>$67.9</td>
<td>$33.2</td>
<td>$6,025</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$9.0</td>
<td>$20.8</td>
<td>$11.8</td>
<td>$6,808</td>
</tr>
<tr>
<td>Maryland</td>
<td>$97.9</td>
<td>$203.8</td>
<td>$106</td>
<td>$5,133</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$133.3</td>
<td>$294.8</td>
<td>$101.5</td>
<td>$6,008</td>
</tr>
<tr>
<td>Mississippi</td>
<td>$18.0</td>
<td>$36.3</td>
<td>$18.3</td>
<td>$5,501</td>
</tr>
<tr>
<td>Missouri</td>
<td>$33.9</td>
<td>$49.2</td>
<td>$15.4</td>
<td>$3,852</td>
</tr>
<tr>
<td>Montana</td>
<td>$17.6</td>
<td>$29.5</td>
<td>$11.9</td>
<td>$4,128</td>
</tr>
<tr>
<td>Nebraska</td>
<td>$32.0</td>
<td>$55.2</td>
<td>$27.2</td>
<td>$6,774</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$13.3</td>
<td>$21.3</td>
<td>$8</td>
<td>$3,102</td>
</tr>
<tr>
<td>New Mexico</td>
<td>$27.1</td>
<td>$123.0</td>
<td>$95.9</td>
<td>$11,358</td>
</tr>
<tr>
<td>North Carolina</td>
<td>$38.3</td>
<td>$48.3</td>
<td>$10</td>
<td>$1,225</td>
</tr>
<tr>
<td>North Dakota</td>
<td>$8.5</td>
<td>$13.6</td>
<td>$5.1</td>
<td>$3,499</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>$11.9</td>
<td>$36.5</td>
<td>$24.6</td>
<td>$10,165</td>
</tr>
<tr>
<td>Oregon</td>
<td>$87.3</td>
<td>$170</td>
<td>$82.6</td>
<td>$6,799</td>
</tr>
<tr>
<td>South Carolina</td>
<td>$25.3</td>
<td>$77.7</td>
<td>$52.4</td>
<td>$1,320</td>
</tr>
<tr>
<td>South Dakota</td>
<td>$4.6</td>
<td>$8.0</td>
<td>$3.4</td>
<td>$5,313</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$31.7</td>
<td>$43.4</td>
<td>$11.7</td>
<td>$3,586</td>
</tr>
<tr>
<td>Texas</td>
<td>$207.4</td>
<td>$322.7</td>
<td>$115.3</td>
<td>$4,649</td>
</tr>
<tr>
<td>Utah</td>
<td>$23.0</td>
<td>$38.3</td>
<td>$15.4</td>
<td>$3,897</td>
</tr>
<tr>
<td>Washington</td>
<td>$31.0</td>
<td>$95.8</td>
<td>$64.8</td>
<td>$16,753</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$5.3</td>
<td>$7.1</td>
<td>$1.8</td>
<td>$1,562</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$104.2</td>
<td>$186.2</td>
<td>$82</td>
<td>$3,847</td>
</tr>
<tr>
<td>Wyoming</td>
<td>$5.5</td>
<td>$8.9</td>
<td>$3.4</td>
<td>$3,611</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,395.7</strong></td>
<td><strong>$2,644.5</strong></td>
<td><strong>$1,248.7</strong></td>
<td><strong>$9,510</strong></td>
</tr>
</tbody>
</table>

Source: NASCHIP, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 2011/2012

High-Risk Pools For Uninsurable Individuals 10
Endnotes


2 In the Maryland pool, for example, the list of eligible conditions included behavioral health conditions (bipolar disorder, chemical dependency, dementia, psychotic disorder); blood disorders (aplastic anemia, hemochromatosis, hemophilia, sickle cell disease); cardiovascular conditions (angina pectoris, cardiomyopathy, congestive heart failure, coronary occlusion); endocrine disorders (Addison’s disease, cystic fibrosis, diabetes, hyperthyroidism, Wilson’s disease); gastrointestinal disorders (liver cirrhosis, stomach cancer, hepatitis B and C, ulcerative colitis); infectious diseases (HIV/AIDS); musculoskeletal/connective disorders (ankylosing spondylitis, sarcoidosis); pulmonary disorders (chronic obstructive pulmonary disease, emphysema); neoplasms (cancer treated or diagnosed within 5 years, Hodgkin’s disease, leukemia, multiple myeloma, muscular dystrophy, myasthenia gravis, anaplastic thyroid cancer, non-Hodgkin’s lymphoma, Wilms’ tumor); neurologic conditions (Alzheimer’s disease, ALS, Friedreich’s Ataxia, Huntington’s disease, hydrocephalus, multiple sclerosis, myasthenia gravis, myotonia, palsy, paraplegia, Parkinson’s disease, quadriplegia, stroke, Tay-Sachs disease); also major organ transplant and pregnancy.

3 Commissioning for Agriculture, Comprehensive Health Insurance for High-Risk Individuals, 1996.

4 All but eight traditional state high-risk pools have since suspended new enrollment.

5 The total number of applications included those made in states, such as New York, which required non-group coverage to be offered on a guaranteed issue basis.


10 For example, in Colorado, enrollees in the state PCIP experienced 592 hospital admissions per 1,000 and used 5,374 inpatient days per 1,000, while enrollees in Colorado’s traditional high-risk pool experienced 137 hospital admissions per 1,000 and used 735 inpatient days per 1,000. See PCIP Annual Report, 2012.


The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the February 1, 2017 hearing before the House Subcommittee on Health entitled “Patient Relief from Collapsing Health Exchanges.”

As the nation’s oldest and largest health policy and public health organization working with Asian American, Native Hawaiian and Pacific Islander (AA and NHPI) communities, APIAHF provides a voice in the nation’s capital for AA and NHPI communities. APIAHF works toward health equity and health justice for all by influencing policy, mobilizing communities, and strengthening programs and organizations to improve the health of the over 20 million AAs and nearly 1 million NHPIs in the United States.

This hearing seeks to address concerns about the effect the Affordable Care Act (ACA) has had on the individual health insurance market. The record of evidence demonstrates that the ACA has successfully done what it was designed to do – reduce the number of uninsured persons in the U.S. To date, 20 million Americans have coverage they can afford and rely upon, including nearly 2 million AAs and NHPIs who are eligible for coverage under the ACA.1

APIAHF has worked to protect and implement the ACA since its passage. Since 2012, APIAHF and partners have worked to outreach, educate and enroll nearly 1 million consumers through Action for Health Justice, a national collaborative of more than 70 AA and NHPI national and local organizations.

---

1 Department of Health and Human Services, 20 million people have gained health insurance coverage because of the Affordable Care Act, new estimates show, March 3, 2016, available at: https://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates.

local community-based organizations and health centers. These community-based partner organizations are located in over 20 states and hear the real effects of AAs and NHPIs gaining coverage through the ACA.

**The ACA Has Expanded Access to Essential Care for AAs and NHPIs**

The ACA's coverage expansions reduced the overall rate of uninsured AAs from 15.7 to 7.8 percent and the percentage of NHPIs without insurance fell from 17.4 to 9.9 percent. Health coverage is critical for AAs and NHPIs who experience a number of barriers to accessing affordable health insurance and care. The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line. Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

Eight in 10 AAs and NHPIs qualify for financial assistance under the ACA. Prior to the ACA, high costs caused many AAs and NHPIs to either forgo care entirely or sell everything they had to afford care. People like Trieu, a young adult from Pennsylvania, had to forgo care and hoped he did not get sick until he got coverage thanks to the ACA's financial help.

The ACA's financial assistance saved the life of Jirapon in Georgia. Jirapon is a single mom with three children who works as a cook. Thanks to a local community based organization, she was able to enroll in health care for the first time. She qualified for subsidies as well as Medicaid for her youngest child. After getting covered, Jirapon went for a general screening and was diagnosed with breast cancer. She was able to access affordable surgery, reconstruction, and long-term care because of the ACA.

Falani and his wife, Teuloi, from Utah went uninsured for 15 years prior to the ACA, even though Falani was battling stomach cancer and diabetes. Without coverage, he resorted to home remedies and emergency care when things got really bad. The ACA changed their lives when they realized they could afford a plan for $45 a month and finally get much needed dialysis.

---


The ACA’s consumer protections and financial assistance have given 4.3 million Asian Americans access to free routine preventive care. This is especially important for diagnosing and treating chronic conditions amongst AAs and NHPIs. The risk of diabetes for AAs is 18% higher than for Whites. Additionally, AAs and NHPIs are the only racial group for whom cancer is the leading cause of death. Early routine care is essential for treating these chronic conditions. Lup, a senior-citizen in Louisiana, got coverage for the first time because of the ACA. She and her husband can now rely on preventive care to stay healthy and she no longer has to live with the constant anxiety that a huge medical emergency would ruin them.

The Health Insurance Market is Strong Under the ACA

Under the ACA, 10.2 million Americans are eligible to enroll in qualified health plans. Marketplace enrollment has grown every year since the ACA was enacted, resulting in a larger and more diverse risk pool. Despite concerns about increasing premiums, a report by Standard & Poor found that the individual market is headed toward stabilization at the end of 2016, with a study projecting more improvement in 2017. This suggests that the premium increases in some states are the result of insurers correcting course as they adjust to a more diverse risk pool compared to pre-ACA underwriting. Nationally, the ACA has lowered overall health expenditures and slowed the growing cost of health care.

Proposed Replacements for the ACA Would Not Provide Access to Comprehensive Care

The ACA provides consumer protections, the financial means to afford coverage, and mandates to ensure protection for the market. APIAHF opposes repealing the ACA without a replacement. Any replacement plan must, at minimum, do not harm and maintain comprehensive, affordable coverage for the 20 million Americans currently enrolled and those eligible for coverage under the ACA and maintain consumer protections and civil rights.

---

The replacements offered in the four proposed bills are not comprehensive coverage and not a replacement for the ACA. Special enrollment periods (SEP) are not being abused, but rather underutilized and are a necessary component for individuals facing changes in life circumstances. Only five percent of SEP eligible consumers enrolled in 2015.\(^{13}\) Adding an additional burden to accessing coverage would hinder eligible people from enrolling.\(^{14}\)

Three-month grace periods are important for low and moderate income families whose finances fluctuate regularly. A study from 2016 showed that these families had a twenty-five percent income drop for 2.7 months of the year and an income increase for another 2.7 months of the year.\(^{15}\) These families would lose health coverage under the shortened grace period simply because they struggle on a monthly basis.

Additionally, when lower income families’ finances drop, they could be forced off of coverage by a reduced grace period. They would then also fall prey to the proposed continuous coverage limitation if they have a preexisting condition. In addition, protecting consumers from preexisting condition exclusions is not sufficient to guarantee access to coverage without financial assistance. This is why the ACA’s consumer protections and guaranteed issue provisions are coupled with financial help for the majority of persons eligible for coverage.

In summary, the ACA has substantially improved access to both coverage and care for 20 million Americans, including millions of AAs and NHPIs. These coverage gains benefit the entire nation, providing life-saving care and financial security for those who would otherwise have no or limited coverage. APIAHF opposes repealing the ACA without a replacement plan that allows all enrolled and eligible people to maintain their coverage with financial help and maintains consumer and civil rights protections.

---


\(^{14}\) Id.

Statement for the Record
House Committee on Energy and Commerce
Subcommittee on Health
“Patient Relief from Collapsing Health Markets”
February 2, 2017

The American Heart Association appreciates the opportunity to submit this testimony for the House Committee on Energy and Commerce, Subcommittee on Health related to the Pre-existing Conditions Protection and Continuous Coverage Incentive Act of 2017. We strongly support maintaining protections for the millions of Americans with pre-existing conditions, including cardiovascular (CVD) conditions; and we are concerned that any requirement of continuous coverage will not maintain these protections. Our concerns are detailed below.

The American Heart Association is the nation’s oldest and largest voluntary organization dedicated to building healthier lives free from heart disease and stroke – the two leading causes of death in the world. Our non-profit and non-partisan organization includes more than 30 million volunteers and supporters. The American Heart Association and our American Stroke Association division fund innovative research to accelerate advances in preventing heart disease and stroke. We also work to advance strong public health policies, and provide critical tools and information to health care providers, patients and families to prevent and treat these deadly diseases.

As measured by prevalence, death, disability, and costs, CVD is the most burdensome disease in the United States. An estimated 92.1 million US adults have at least one type of CVD. By 2030, 43.9% of the US adult population is projected to have some form of CVD, including hypertension, coronary heart disease, stroke, and congestive heart failure. Protections for people with pre-existing conditions are vitally important to patients with CVD. An analysis of some of the largest for-profit health insurance companies in the country found that between 2007 and 2009, one out of every seven applicants was denied coverage based on a health condition. Lists of so-called “declinable conditions” included many cardiovascular conditions such as congestive heart failure, coronary artery/heart disease, bypass surgery and stroke. Applicants were also denied if they were taking drugs on issuers’ lists of “declinable...
medications." Without the protections put in place by the Affordable Care Act, over a quarter of nonelderly adults would again be subject to denials, exclusions, and exorbitant rates.

We support the goal of the Pre-existing Conditions Protection and Continuous Coverage Incentive Act of 2017 to protect health insurance access for people with preexisting conditions. However, we are concerned about the potential for unintended consequences if provisions requiring continuous coverage as a condition of retaining those protections are not crafted to recognize and allow for certain extenuating circumstances, including those we described in more detail in subsequent paragraphs.

While continuous coverage is optimal for individuals and for the risk pool, the reality is that patients can face gaps in coverage for many reasons, including the inability to keep up with premiums, the loss of a job, or a change in family circumstances. For patients with chronic conditions these challenges can be compounded by job instability linked to the demands of managing their health. We hear regularly from patients and family members about the burden of dealing with CVD and stroke. The burden is so high that it may require the patient or family member, often the parent of a child facing CVD or stroke, to miss time from a job or even lose the job entirely. These extenuating circumstances are real—particularly for low-income individuals.

An AHA survey of CVD patients from January 2010 demonstrates the challenges that many with heart disease or stroke face that make continuous coverage a challenge for many. Key findings included:

- Approximately 16% of non-elderly adults surveyed did not currently have health insurance. And even among those who do have insurance, 24% of CVD patients (and 36% of stroke patients) said they've gone without health insurance at some time since their diagnosis.
- Of those CVD patients without insurance coverage, the high cost of the insurance premium was cited as the major reason why (48%), followed by losing insurance coverage because of job loss (37%), their employer doesn’t offer coverage or the employee doesn’t qualify, the insurance company wouldn’t cover their condition, or the insurance company refused coverage due to a pre-existing medical condition.
- Patients identified lack of money or insurance coverage as the leading barrier to taking action to improve their health (25% total CVD patients, 32% stroke). Nearly one-third of total CVD patients (30% total and 39% of stroke patients) said they didn’t have access to affordable preventive screenings for their illness prior to their diagnosis.
• Of those who said they had difficulty paying medical expenses, 50% said it was because they couldn’t afford their co-pays, deductibles or other cost-sharing, 41% said it was because their insurance plan didn’t cover it, and 17% said it was because they had to pay higher costs because their provider was out-of-network.

• Of those who had difficulty paying medical expenses, nearly half (48%) said they had difficulty paying bills, 39% said they used up all or most of their savings, 30% said they had incurred thousands of dollars of medical debt, 25% said they had been unable to pay for basic necessities like food, housing, or heat, and 9% had declared bankruptcy.

A study released in 2016 by the American Heart Association revealed that more than six million adults at risk for CVD and 1.3 million who suffered from heart disease, hypertension or stroke gained health insurance between 2013 and 2014. That figure is likely much higher today. We know that merely having coverage does not guarantee access to quality or affordable care— and we are once again surveying our patients to see what their experience has been to date with the Affordable Care Act and what improvements still need to be made to our health care system to serve the needs of individuals with preexisting conditions— like cardiovascular disease.

We appreciate that the committee is still gathering input and information as they work to construct the specifics of this provision and the second reserved title on continuous coverage, and welcome this opportunity to provide comment on subsequent proposals. As you move forward, the American Heart Association/American Stroke Association urges the subcommittee to consider the following:

• Nongroup health plans should not be able to deny coverage to applicants because of a pre-existing health condition.

• Health plans providing nongroup coverage should not be able to charge people with pre-existing health conditions higher premiums based on their health.

• Nongroup and group health plans (both insured and self-funded) should not be able to exclude coverage for benefits for a defined period of time for new enrollees if the benefit relates to a pre-existing health condition (called pre-existing condition exclusions (PECE)).

• Insured people with pre-existing health conditions should not face barriers when they want or need to change health plans.
The millions of people with CVD that we serve are among the many Americans with pre-existing conditions. Ensuring meaningful health insurance coverage for these individuals is critical to our mission. We look forward to working with the members of this subcommittee to identify strong policy solutions for individuals with preexisting conditions in need of affordable health insurance coverage.
The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

February 2, 2017

Dear Chairman Walden and Congressman Pallone:

We are writing to express our strong opposition to any changes under consideration in insurance rules that would loosen the current 3:1 age-rating band ratio under current law. This limit is a crucial consumer protection that ensures that older adults—specifically those ages 50-64 who are not yet eligible for Medicare—have access to affordable coverage. Consideration of moving to a 5:1 ratio will push premiums up, further exacerbating the affordability of insurance for older adults and result in many becoming uninsured.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

A study by RAND Corporation1 concluded that switching to a 5:1 band would reduce premiums for young adults by much less than it would boost premiums for older enrollees. For a 64-year-old, the annual premium for a typical silver plan would grow from about $8,500 to $10,600. A 24-year-old enrollee would see premiums fall from $2,800 to $2,100. The higher premiums for older, low-income enrollees would cost the federal government an additional $9.3 billion a year in federal premium subsidies. Moreover, RAND estimates about 400,000 older adults who don’t qualify for subsidies would drop coverage. Surely the intent of the Committee is not to increase uninsurance rates nor raise costs to the federal government. The changes made in 2010 to share risk and stop medical underwriting for those with pre-existing conditions have gone a long way to making insurance accessible and affordable to millions previously left out. If the Committee agrees

1 http://www.commonwealthfund.org/publications/blog/2015/sept/charging-older-adults-higher-premiums-could-cost-taxpayers
that a goal is to eliminate discrimination based on health status, then any loosening of the
current rules would undermine that goal and would significantly harm the health and
economic security² for millions of older adults, especially those with multiple health
conditions.

The ACA’s federal age-rating protection should be maintained and strengthened, not
weakened or eliminated. We appreciate the opportunity to submit our comments for the
record.

Sincerely,

Rob Restuccia, Executive Director

Cc: Members of the Committee on Energy and Commerce

---

² According to a March 2013 study by the Urban Institute, looser rate bands would significantly increase out-
of-pocket rates paid by the oldest purchasers, who are substantially less likely than young adults to be eligible
for subsidies. Blumberg, L. and Buettgens, M. “Why the ACA Limits on Age-Rating will not Cause "Rate-Shock":
Distributional Implications of Limited Age Bands in Non-Group Health Insurance”, March 2013
http://www.urban.org/sites/default/files/publication/412757-Why-the-ACA-Limits-on-Age-Rating-Will-Not-Cause-
quote-Rate-Shock-quote-Distributional-Implications-of-Limited-Age-Bands-in-Nongroup-Health-Insurance.PDF
February 2, 2017

The Honorable Greg Walden
Chairman, Committee on Energy and
Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
Ranking Member, Committee on Energy
and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden and Ranking Member Walden:

The National Partnership for Women & Families (National Partnership) represents women across the country who rely on the Affordable Care Act (ACA) for access to essential health care services and who are counting on continued successful implementation of the law. The ACA is working and has already helped millions of women gain access to both health coverage and care. We are deeply troubled by Congressional efforts to repeal this groundbreaking and essential law. Any vote to repeal the law – or significant portions of it – puts the health, wellbeing and economic security of women in dire jeopardy. This is especially true in the absence of any meaningful proposal that ensures continued access to the ACA’s women’s health protections and coverage gains.

Repealing the ACA risks going back to a time when women struggled to find affordable health coverage in the individual market, were routinely charged more than men for the same policies, and often found that health coverage did not cover their essential health care needs. This effort, combined with Congressional efforts to defund and close Planned Parenthood health centers, demonstrates a full-fledged attack on women’s lives and health.

For millions of women, repealing the ACA means stripping away their health insurance and leaving them without affordable coverage options. Since the enactment of the ACA, 9.5 million previously uninsured women have gained affordable, comprehensive health coverage. For 2016, 6.8 million women and girls chose health coverage through the health insurance marketplace. If the law is repealed, millions of women and families will lose their tax credits and cost-sharing reductions. For many, this will force them to go without health insurance and many will not be able to afford essential care.

Even women and families who could continue to afford health insurance could find themselves without the important protections they have under the ACA. The ACA ended outrageous, predatory practices that allowed insurers to refuse to cover women who had breast cancer or cesarean sections, received medical treatment due to domestic violence or who have chronic conditions like high blood pressure or diabetes. Now, under the law, women can no longer be denied coverage just because they are sick or have a pre-existing condition – nor can they be charged more because of their health status. The ACA also
prohibits plans in the individual and small group markets from charging women higher premiums simply because of their gender (a common practice before the ACA called "gender rating").

To date, proposals for replacing the ACA have fallen short of ensuring that women and families would be guaranteed these same protections if the ACA was repealed. For example, the "Preexisting Conditions Protection and Continuous Coverage Incentive Act of 2017" offers a hollow promise that individuals will retain the same level of protection against discrimination on the basis of health status or gender that they currently enjoy. While this bill provides that any legislation to repeal the ACA must include a bar on exclusions for pre-existing conditions, it noticeably does not prohibit medical underwriting for health status or gender. Thus, while coverage may be available to people with pre-existing conditions, that coverage will likely only be offered at high premium rates—making health coverage unaffordable or inaccessible to those who need it most. The bill would also result in a return to the days when women were consistently charged more for health insurance than men simply because of their gender.

In addition to ensuring the availability of affordable coverage, the ACA also sets nationwide standards for benefits that women and families can expect their health insurance to offer. For example, women purchasing insurance in the individual or small group markets are guaranteed access to critical essential health benefits including maternity and newborn care. The ACA also requires most health insurance plans to cover vital preventive services, including well-woman visits, birth control, and interpersonal and domestic violence screening and counseling, without copayments, deductibles or other out-of-pocket costs. These are just some of the many protections that have helped improve the health and lives of women across the country.

Repealing the ACA would leave women and families without the quality, affordable health care they need. It not only endangers advances in women’s health care access, but also puts women’s economic security at risk. We urge Congress to deeply consider the effects repeal would have on individuals and families across the country, and to end all efforts to repeal this groundbreaking and successful law.

Sincerely,

Debra L. Ness, President


Testimony Submitted for the Record

Gretchen Borchelt
Vice President for Reproductive Rights and Health
National Women’s Law Center

Hearing on “Patient Relief from Collapsing Health Markets”

U.S. House of Representatives Energy and Commerce Committee
Subcommittee on Health

February 2, 2017
The National Women’s Law Center (“Center”) has worked for more than 40 years to advance and protect equality and opportunity for women and girls in every aspect of their lives, including health care and economic security. The Center submits this testimony in strong opposition to the “Preexisting Conditions Protection and Continuous Coverage Incentive Act.”

The “Preexisting Conditions Protection and Continuous Coverage Incentive Act” is a false promise of protection. The end result would be to return women to the days of discrimination in the health care market.

As the Center demonstrated in our 2008 report, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women*, prior to the Affordable Care Act, insurance companies used health status and health history, including pre-existing conditions, in order to determine whether an individual received coverage and if so, to determine what premium to charge the individual applicant or what limits to put on that coverage.

Women often fared worst because of conditions unique to them, which insurers deemed “pre-existing conditions.” For example, women have greater health needs than men and are more likely than men to suffer from a chronic condition requiring ongoing treatment, like asthma or arthritis. These conditions could lead to rejection of coverage or higher premiums. In addition, if during the medical underwriting process the insurer discovered that an applicant underwent a past Cesarean delivery, the company might have charged her a higher premium, imposed an exclusionary period during which it refused to cover another Cesarean delivery or pregnancy, or even rejected her for coverage altogether unless she had been sterilized or was no longer of childbearing age. Insurers in DC and nine states were allowed to deny coverage to domestic violence survivors. In addition, news reports at the time documented the practice of insurance companies obtaining prescription drug histories as a basis to reject applicants for health coverage. Women were more likely than men to be potentially affected by this practice— at any age they are more likely than men to take prescription medications on a regular basis.

In other words, before the Affordable Care Act, just being a woman amounted to being treated like a pre-existing condition. Because of “pre-existing conditions,” women seeking coverage in the individual market faced limits that made coverage meaningless, such high premiums that they could not afford coverage, or outright rejection from coverage.

The Affordable Care Act changed these practices. Right now, under the health care law, insurers can no longer charge more or deny coverage to an individual because of a pre-existing condition. Insurers cannot limit benefits for that coverage either. Once individuals have coverage, insurers cannot refuse to cover treatment for a pre-existing condition. Approximately 65 million women with pre-existing conditions can no longer be denied or charged more for their health coverage thanks to the Affordable Care Act.

The “Preexisting Conditions Protection and Continuous Coverage Incentive Act” fails to protect individuals seeking coverage in these ways, leaving them once again vulnerable to the same unfair practices that existed prior to the Affordable Care Act. Although the bill prohibits pre-existing condition exclusions, it does not address the other problems associated with health status underwriting. Specifically, it does not prohibit issuers from charging an individual more for
health insurance coverage based on a pre-existing condition. This means that although health insurance coverage may be theoretically available to a woman with a pre-existing condition, the insurance company could price the premium in such a way that she is effectively denied coverage. Nor does this bill include provisions requiring that insurers cover treatment related to the pre-existing condition. So even if a woman could get coverage, she could be denied coverage for treatments she needs related to the underlying condition. There is no reason to think insurers would not revert to these prior tactics, and in fact, there are incentives for insurers to do so, given that the other parts of the Affordable Care Act that discouraged such practices are absent.

Furthermore, the “Preexisting Conditions Protection and Continuous Coverage Incentive Act” includes an incomplete “placeholder” for a “continuous coverage incentive.” This indicates that the pre-existing condition exclusion is tied to an individual having health insurance and having been insured without a gap for a specified period of time. There are numerous scenarios under which a woman could lose continuous coverage, like losing a job, going back to school, or choosing to pay for groceries one month instead of paying a premium bill. If that were to happen, she would lose the pre-existing condition protection and once again face insurance coverage denials.

Because the “Preexisting Conditions Protection and Continuous Coverage Incentive Act” would return women to being considered a pre-existing condition, we urge you to reject it. No woman should again be denied insurance coverage or charged more because she has had a prior pregnancy or Cesarean delivery, because she received fertility treatment, had breast or cervical cancer, is a survivor of domestic violence, or because she had medical treatment following a sexual assault. The Affordable Care Act made sure that these practices were no longer allowed. Despite claims to the contrary, the “Preexisting Conditions Protection and Continuous Coverage Incentive Act” does not, and would allow insurance companies to return to these harmful and discriminatory practices.

Health insurance policies sold in Wisconsin often include "mandated benefits." These are benefits that an insurer must include in certain types of health insurance policies. Some mandated benefits apply only to group policies. Some apply both to policies sold to individuals and to groups. Most apply only to policies issued or renewed after a certain date. Except for health maintenance organizations (HMOs) organized as cooperatives under ch. 185, Wis. Stat., HMOs are required to provide the same benefits as traditional insurers. Cooperative HMOs are subject to the mandates regarding chiropractors, optometrists, professional health care services, dental services, nurse practitioners, newborns, adopted children, HIV drugs, dentists, temporomandibular (TMJ) disorders, breast reconstruction, and hospital and ambulatory surgery center charges, anesthesiologists for dental care, coverage of certain health care costs in cancer clinical trials, and coverage of student on medical leave.

This brochure gives a brief description of current mandated benefits.

Professional Health Care Services

- Board Certified Behavior Analyst—Behavior analysts are added to the list of providers that may provide physician-prescribed services for the treatment of autism spectrum disorders required to be covered by disability insurance policies and self-insured governmental and school district health plans. Paraprofessionals working under a behavior analyst's supervision are also covered. The Department of Regulation and Licensing (DRL) provides licensure and regulation of behavior analysts engaging in the practice of behavior analysis.

- Chiropractors—All health insurance policies must cover services provided by a chiropractor if the policy would provide coverage for the same services if performed by a physician or osteopath. Policies may not require the insured to be referred to a chiropractor by a physician to receive benefits.

Insurers may apply the same deductible and copayment provisions to chiropractic care that apply to all other benefits. In addition, insurers may apply cost containment or quality assurance measures to chiropractic care if it applies those provisions to nonchiropractic benefits. For example, an HMO can limit chiropractic care for its enrollees to those chiropractors who are either employed by or under contract to the HMO. [s. 632.87(3), Wis. Stat.]

- Dentists—All health insurance policies are required to provide coverage for diagnoses or treatment of a condition or complaint performed by a licensed dentist if the policy covers diagnoses and treatment of the condition if performed by any other health care provider. [s. 632.87(4), Wis. Stat.]

- Nonphysician Providers—Unless the policy provides otherwise, insurers may not refuse to pay for services by certain nonphysician providers if the service is covered by the policy even though a social worker is licensed to provide services covered under the contract. Insurers may refuse to pay for services given by certain providers if the policy clearly states that this is the case. For example, insurers could refuse to pay for services provided by a social worker in private practice even though a social worker is licensed to provide services covered under the contract. This applies both to group and to individual policies. [s. 632.87(1), Wis. Stat.]

- Nurse Practitioners—Health insurance policies that provide coverage for Papanicolaou (PAP) tests, pelvic examinations, and associated laboratory work if performed by a physician must also provide coverage for these services when performed by a nurse practitioner acting within the scope of his or her license. This applies to all insured policies, all plans offered by the Group Insurance Board, and all self-funded plans offered by school districts or municipalities. [s. 632.87(1) and (5), Wis. Stat.]
Covered Persons

- **Optometrists**—Insurers may not exclude coverage for services provided by an optometrist if the contract covers the same service when it is provided by another health care provider. Insurers may exclude all vision care services and procedures from coverage. This applies to both individual and group policies. [s. 632.87(2) and (3), Wis. Stat.]

- **Adopted Children**—All health insurance policies that provide coverage for dependent children must cover adopted children and children placed for adoption on the same terms and conditions as natural children. Policies may not exclude or limit coverage of a disease or physical condition of the child because the disease or condition existed before coverage under the policy began. This applies to all policies, including plans offered by the state to its employees, cities, counties, school districts, cooperative sickness care plans, and prepaid plans. [s. 632.896, Wis. Stat.]

- **Dependents**—Insurers that offer individual or group health insurance policies (including vision and dental plans) and self-insured health plans of the state or of a county, city, village, town, or school district that provide dependent coverage of children are required to provide coverage if requested by an adult child of the applicant or insured as a dependent of the applicant or insured if the child is under the age of 26. Coverage must also be provided to an adult child regardless of age if the child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education and the child returns to school as a full-time student within 12 months of fulfilling his or her active duty obligation.

- **Grandchildren**—Health policies that provide coverage for any child of the insured shall provide the same coverage for all children of that child until that child reaches the age of 18. [s. 632.895(5m), Wis. Stat.]

- **Handicapped Children**—Hospital or medical expense policies that cover dependent children may end coverage when the child reaches maturity. However, coverage of a dependent child cannot end while the child continues to be both:
  - Incapable of self-sustaining employment because of a mental retardation or physical handicap; and
  - Chiefly dependent upon the person insured under the policy for support and maintenance.

This applies both to group and individual policies. Insurers can require notice of continued dependence after a child reaches the maximum age under the policy. [s. 632.88, Wis. Stat.]

- **Newborn Infants**—All health insurance policies must provide coverage from the moment of birth for a newborn child of the insured. The newborn shall receive the same coverage that the policy provides for any children covered or eligible for coverage under the policy. The only exception is that waiting periods do not apply. If a pregnant person or a person whose spouse is pregnant applies for a policy providing hospital or medical expense benefits, insurers may not issue a policy that excludes or limits benefits for the expected child. Insurers must issue the policy without exclusions or limitations or decline or postpone the application. Coverage for newborn children must include congenital defects and birth abnormalities as an injury or sickness under the policy.

The payment of a specific premium or subscription fee is required to provide coverage for a child. Policies may require that notification of a child's birth and payment of the required premiums or fees be furnished to the insurer within 60 days after the date of birth. Insurers may refuse to continue coverage beyond the 60-day period if such notification is not received, unless within one year after the birth of the child the insured makes
all past due payments with interest at the rate of 5-1/2% per annum.

If the payment of a specific premium or subscription fee is not required to provide coverage for a child, the policy or contract may require notification of the birth of a child but may not deny or refuse to continue coverage if such notification is not furnished. Benefits may exclude costs associated with a normal delivery. [s. 632.895(5), Wis. Stat.]

- **Student on Medical Leave**—Every disability insurance policy and every self-insured health plan of the state or of a county, city, town, village, or school district that provides coverage for a person as a dependent of the insured because the person is a full-time student shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full-time student.

A student is required to submit documentation and certification from the person's attending physician stating the medical necessity of the leave of absence.

This applies to insurance policies issued or renewed on or after July 1, 2008, and self-insured health plans of the state or of a county, city, town, or school district, established, extended, modified, or renewed on or after July 1, 2008. However, if an insurance policy covers employees under a collective bargaining agreement containing provisions inconsistent with this provision, it first applies to a policy issued or renewed on the earlier of: (a) the date the collective bargaining agreement expires; or (b) the date the collective bargaining agreement is extended, modified, or renewed. If a self-insured plan covers employees under a collective bargaining agreement containing provisions inconsistent with this provision, it first applies to a plan established, extended, modified, or renewed on or after July 1, 2008.

If an insurance policy covers employees under a collective bargaining agreement containing provisions inconsistent with this provision, it first applies to a policy issued or renewed on the earlier of: (a) the date the collective bargaining agreement expires; or (b) the date the collective bargaining agreement is extended, modified, or renewed.

- **Mandatory Benefits**

- **Autism Spectrum Disorder**—All disability insurance policies and self-insured health plans of the state or of a county, city, town, village, or school district are required to provide coverage for the treatment of autism spectrum disorders which includes autism disorder, Asperger's syndrome, and pervasive developmental disorder not otherwise specified. This provision does not apply to a disability policy that covers only certain specified diseases, a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan, a long-term care insurance policy, or a Medicare replacement or a Medicare supplement policy.

Coverage must be provided for the treatment of autism spectrum disorders if the treatment is prescribed by a physician and provided by qualified providers. Coverage required includes at least $25,000 for non-intensive level services per insured per year with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years and at least $25,000 for non-intensive level services per insured per year. For calendar year 2012, insurers must provide coverage of at least $61,700 for intensive-level services and $25,850 for non-intensive-level services. The adjusted coverage amounts are effective for newly issued policies or on the first date of a modified, extended or renewed policy or certificate after January 1, 2012.

Coverage may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered by the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

The above provisions take effect for health insurance policies that are issued or renewed and governmental or school district self-funded health plans that are established, extended, modified, or renewed on or after November 1, 2009. [s. 632.895 (12m), Wis. Stat.]

- **Breast Reconstruction**—Health insurance policies that provide coverage for a mastectomy are required to provide coverage of breast reconstruction of the affected tissue incident to a mastectomy.

This applies to both group and individual policies, including HMOs, PPsAs, and LSHOs, and every self-funded county, municipality and school district health plan. [s. 609.77 and 632.895 (13), Wis. Stat.]

- **Coverage of Certain Health Care Costs in Cancer Clinical Trials**—Health care policies, plans, and contracts are prohibited from excluding coverage for certain health care services, items, or drugs administered to an insured in a cancer clinical trial in certain situations that would be covered under the policy, plan, or contract if the
The coverage is subject to all terms, conditions and restrictions that apply to other coverage under the policy, including the treatment and services performed by participating and nonparticipating providers. This includes policy requirements that the cancer clinical trial services be performed by a participating provider.

This applies to all health insurance policies and self-insured health plans of the state or of a county, city, village, town, or school district. However, if an insurance policy covers employees under a collective bargaining agreement containing provisions inconsistent with these changes, the changes first apply to a policy issued or renewed on or after January 1, 2010. The following coverage is provided:

- The cost of hearing aids, cochlear implants, and related treatment for infants and children. This applies to group and individual disability policies and to self-insured health plans of the state or of a county, city, town, village, or school district newly issued or renewed on or after January 1, 2010.

- Cochlear Implants—Coverage is required for hearing aids, cochlear implants, and related treatment for infants and children. This applies to group and individual disability policies and to self-insured health plans of the state or of a county, city, town, village, or school district newly issued or renewed on or after January 1, 2010.

- The cost of hearing aids and cochlear implants is required to cover the cost of one hearing aid per ear per child more than once every three years.

- The cost of hearing aids is not subject to any cost-sharing provisions, limitations, or exclusions, other than a preexisting condition exclusion, that apply generally under the disability insurance policy or self-insured health plan.

These provisions do not apply to a disability policy that covers only certain specified diseases, a disability policy or self-insured health care plan that provides only limited-scope dental or vision benefits, a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan, a long-term care insurance policy, a Medicare replacement or a Medicare supplement policy, or a short-term individual health benefit plan.

This applies to all insured policies and all self-funded plans offered by school districts or municipalities.

- Contraceptive Coverage—All disability insurance policies and self-insured health plans of the state or of a county, city, town, village, or school district that provide coverage for outpatient health care services, preventive treatments and services, or prescription drugs and devices are required to also provide coverage for contraceptives prescribed by a health care provider, and outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive if covered under the policy. Coverage may only be subject to the exclusions, limitations, or cost-sharing provisions that apply generally to the coverage of outpatient health care services, preventive treatments and services, prescription drugs and devices that are provided under the policy or self-insured health plan.

These provisions do not apply to a disability policy that covers only certain specified diseases, a disability policy or self-insured health care plan that provides only limited-scope dental or vision benefits, a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan, a long-term care insurance policy, or a Medicare replacement or a Medicare supplement policy.

- Colorectal Cancer Screening—All disability insurance policies and self-insured health plans of the state or of a county, city, town, village, or school district that cover any diagnostic or surgical procedures are required to cover colorectal cancer examinations and laboratory tests for any insured or enrollee who is 50 years of age or older...
or any insured or enrollee who is under 50 years of age and at high risk for colorectal cancer.

Coverage may be subject to any cost-sharing provisions, limitations, or exclusions that apply generally under the disability insurance policy or self-insured health plan.

These provisions do not apply to a disability policy that covers only certain specified diseases other than cancer; a disability policy or self-insured health care plan that provides only limited-scope dental or vision benefits, or a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan.

The Commissioner of Insurance, in consultation with the Secretary of the Department of Health Services and after considering nationally validated guidelines, including guidelines issued by the American Cancer Society for colorectal cancer screening, is required to promulgate rules that:

- Specify guidelines for colorectal cancer screening that must be covered under the law.
- Specify the factors for determining whether an individual is at high risk for colorectal cancer.
- Periodically update the guidelines and factors, described above.

This applies to all insured policies, and all self-funded plans offered by school districts or municipalities. [s. 632.895 (16m), Wis. Stat.]

**Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care**—Health insurance policies are required to cover hospital or ambulatory surgery center charges and anesthetics provided in conjunction with dental care if any of the following applies:

1. The individual is a child under the age of 5.
2. The individual has a chronic disability that meets all the conditions in s. 230.04 (9)(a) (2) a., b., and c., Wis. Stat.
3. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

This applies to both group and individual policies, including HMOs, PPPs, and LSHOs, and every self-funded county, municipality and school district health plan. [s. 605.76 and 632.895 (12), Wis. Stat.] The requirement does not apply to dental-only plans.

**Diabetes**—Policies that cover expenses for the treatment of diabetes shall provide coverage for insulin infusion pumps, other equipment and supplies, including insulin, and diabetic self-management education programs. Insurers may apply the same deductible and coinsurance provisions that apply to other covered expenses. Coverage may be limited to the purchase of one pump per year, and the insured may be required to use the pump 30 days before purchase.

All health insurance policies that provide coverage of expenses incurred for the treatment of diabetes shall also provide coverage for expenses incurred for prescription medication used in the treatment of diabetes. Insurers may apply the same exclusions, limitations, deductibles and coinsurance provisions that apply to other covered expenses. [s. 632.895(d), Wis. Stat.]

**Genetic Testing**—Insurers, other than insurers writing life or income continuation coverage, are prohibited from:

- Requiring an individual or a member of the individual’s family to obtain a genetic test using DNA from the person’s blood to determine the presence of a genetic disease or disorder.
- Requiring an individual to reveal if he or she or a member of the family has had a genetic test and revealing the results of that test.
- Requiring or requesting a health care provider to reveal whether an individual or family member had a genetic test or the results of a genetic test.
- Conditioning coverage on whether a person or member of a person’s family has had a genetic test.
- Basing premium rates or other aspects of insurance coverage on whether a person or a person’s family member has had a genetic test and revealing the results of the test.

Insurers that write life or income continuation coverage who obtain genetic test information about an individual or family member are prohibited from:

- Using the information in writing any type of insurance other than life or income continuation.
- Setting rates or coverage conditions that are not reasonably related to the risk involved. [s. 631.89, Wis. Stat.]

**Drugs for Treatment of HIV Infection**—All health insurance policies that provide coverage of prescription medicine shall provide coverage for each drug that satisfies all of the following:
• Child Immunizations—All health insurance policies and every self-insured health plan of the state or of a county, city, town, village, or school district that provides coverage for a dependent of an insured, must provide coverage of appropriate and necessary immunizations from birth to the age of 6 years for a dependent who is a child of the insured. The coverage may not be subject to any deductibles, copayments or coinsurance under the policy or plan, except that a managed care plan is prohibited from applying such cost-sharing only with respect to services provided by network providers.

The mandate does not apply to health insurance policies that provide coverage of only certain specified diseases, policies that cover only hospital and surgical charges, policies offered by a limited service health organization, long-term care policies, and Medicare supplement or Medicare replacement policies. [s. 632.895(14), Wis. Stat.]

• Kidney Disease—Policies that cover hospital and surgical charges, policies offered by a limited service health organization, long-term care policies, and Medicare supplement or Medicare replacement policies. [s. 632.895(14), Wis. Stat.]

• Lead Screening—All health insurance policies and all self-insured plans offered by a city, village, school district are required to provide coverage for blood lead tests for children under 6 years of age, according to screening protocols established by the Department of Health Services.

This requirement does not apply to a policy that covers only certain specified diseases, policies offered by a limited service health organization, long-term care insurance policies, Medicare supplement policies, or Medicare replacement policies. [ss. 609.85 and 632.898 (10), Wis. Stat.]

• Mammography—All health insurance policies except specified disease, Medicare supplement, long-term care policies, must provide women between the ages of 45 and 49 two examinations by low-dose mammography. Insurers may refuse to provide coverage for an examination by low-dose mammography for a woman aged 45 to 49 if she has had such an examination within the previous two years. Insurers may apply any mammogram obtained during that age period, even if it obtained prior to coverage under the policy, toward the two mandated examinations. Women who are age 50 to 65 must be covered for annual mammograms.
Coverage is required regardless of whether the woman shows any symptoms. Policies may not apply exclusions or limitations that do not apply to other radiological examinations covered under the policy. The mammography examinations shall be performed at the direction of a licensed physician or nurse practitioner unless all of the following apply:

- The woman does not have an assigned or regular physician or nurse practitioner when the examination is performed.
- The woman designates a physician to receive the results.
- Any previously obtained mammography examination was obtained at the direction of a licensed physician or nurse practitioner.

Maternity Coverage—If a group health policy provides maternity coverage for anyone covered under the policy, it must provide coverage for all persons covered under the policy. Insurers may not apply exclusions and limitations to the mandated maternity coverage that do not apply to other maternity coverage provided under the policy.

Mental Health Parity—Wisconsin’s current mandate is amended to remove the minimum coverage amounts for the treatment of mental and nervous disorders and substance use disorders. Group health benefit plans and self-insured health plans of the state or of a county, city, town, village, or school district that provides coverage for inpatient hospital treatment or outpatient treatment must provide coverage of inpatient hospital services, outpatient services, and transitional treatment arrangements for the treatment of nervous and mental disorders and substance use disorders.

Individual health plans are not required to cover mental health or substance use disorder services; however, if coverage is provided, it must be at a parity level.

Treatment limitations for mental health and substance use disorder services shall be no more restrictive than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan.

These provisions do not apply to a health care plan offered by a limited service health organization or by a preferred provider plan that is not a defined network plan or to a hospital indemnity, income continuation, accident only, long-term care, or Medicare supplement policy.

An exemption is provided for small employers who provide health coverage for their employees through a group health benefit plan if the employer has fewer than 10 eligible employees on the first day of the plan year. Employers who qualify for and elect the small employer exemption under s. 632.89(2), Wis. Stat., must first notify the insurer who in turn will inform the employer to notify all enrollees under the plan within 30 days that they have elected an exemption.

A cost exemption also applies for employer plans where the increase exceeds 2% in the first plan year or 1% in any plan year thereafter. Specifically, an insurer offering a group health benefit plan shall have a qualified actuary determine whether the employer is eligible for a cost exemption based on the actual group claims experience in accordance with s. 632.89(3), Wis. Stat. Additionally, insurers may require employers to provide at least 90 days’ advance notice to the insurer from the employer’s renewal date for obtaining the determination.

Despite exemptions from the state nervous and mental disorders and substance use disorder coverage requirement, state law requires compliance with the minimum mandated coverage requirements and limitations contained in s. 632.89(2), 2007 Wis. Stat., for treatment of services for nervous and mental disorders and substance use disorders.

Coverage may be subject to any exclusions and limitations: deductibles; co-payments; coinsurance; annual and lifetime payment limitations; out-of-pocket limits; out-of-network charges; day, visit, or appointment limits; limitations regarding referrals to nonphysician providers and treatment programs; and duration or frequency of coverage limits if no more restrictive than the most common or frequent type of treatment limitations applied to substantially all other coverage under the plan. Any overall deductible amount or annual or lifetime limit or out-of-pocket limit for the plan shall include expenses incurred for the treatment of nervous and mental disorders and substance use disorders.

Health plans that provide coverage for the treatment of mental health and substance use disorders are required to make available the criteria for determining medical necessity under the plan with respect to that coverage. The criteria must be made available to any current or potential insured, participant, beneficiary, or contracting provider. Also, health plans that provide coverage for mental health and substance use disorders and deny coverage for services for treatment
shall, upon request, make the reason for the denial available to the insured, participant, or beneficiary.

Mandated coverage for mental health and substance use disorders does not apply to treatment for autism spectrum disorders.

Federal law may provide additional coverage under provisions included in the Patient Protection and Affordable Care Act (PPACA) and Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

The above provisions apply to health benefit plans that are issued or renewed and governmental self-insured health plans that are established, extended, modified, or renewed on December 1, 2010. [s. 632.89, Wis. Stat.]

Skilled Nursing Care—Policies that cover hospital expenses must cover at least 30 days of skilled nursing care to patients who enter a licensed skilled nursing facility within 24 hours after discharge from a hospital. Coverage may be limited to care that is medically necessary as certified by the attending physician every seven days and that is for the same condition treated in the hospital. Skilled nursing care is narrowly defined. Many people in nursing homes are not receiving skilled care. [s. 632.895(3), Wis. Stat.]

TMJ Disorders—All group and individual health insurance policies that provide coverage of any diagnostic or surgical procedure involving a bone, joint, muscle, or tissue are required to provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular (TMJ) disorders.

This applies to both group and individual policies, except dental-only and Medicare supplement policies, including HMOs, PPOs, and SHOs, and every self-funded county, municipality, or school district health plan. [s. 605.78 and 632.855(11), Wis. Stat.]

Health insurance policies may cap coverage of nonsurgical diagnosis and treatment of TMJ at $1,250 per year. Plans are permitted to impose a prior authorization requirement on surgical or nonsurgical TMJ services, but not diagnosis.

If you have a specific complaint about your insurance, refer it first to the insurance company or agent involved. If you do not receive satisfactory answers, contact the Office of the Commissioner of Insurance (OCI).

For information on how to file insurance complaints call:
(608) 266-0103 (In Madison) or 1-800-236-8517 (Statewide)
Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
Electronic Mail
ocicomplaints@wisconsin.gov
Please indicate your name, phone number, and e-mail address.

Deaf, hearing, or speech impaired callers may reach OCI through WI TRS

A copy of OCI's complaint form is available on OCI's Web site. You can print it, complete it, and return it to the above mailing address.

Copies of OCI publications are available online on OCI's Web site.

Disclaimer

This guide is not a legal analysis of your rights under any insurance policy or governmental program. Your insurance policy, program rules, Wisconsin law, federal law, and court decisions establish your rights. You may want to consult an attorney for legal guidance about your specific rights.

OCI does not represent that the information is complete, accurate or timely in all instances. All information is subject to change on a regular basis, without notice.

Printed copies of publications are updated annually unless otherwise stated. In an effort to provide more current information, publications available on OCI's Web site are updated more frequently to reflect any necessary changes. Visit OCI's Web site at oci.wi.gov.
Chairman Burgess and Ranking Member Green, thank you for having me here this morning and thank you to our three witnesses here today.

Each of us on this dais has heard from hardworking constituent families who are facing fewer choices and staggering price hikes in insurance markets with ever dwindling coverage options.

A provision to extend grace periods for nonpayment in the Affordable Care Act has exacerbated this by creating a scenario where some patients with exchange plans are only paying 9 months of premiums, yet receiving 12 months of coverage.

These premium payment defaults are producing an imbalance in the risk pool, and in turn, raising premiums for hardworking American families that were promised lower health care costs.

The Health Coverage State Flexibility Act, before us today, corrects this simply by better aligning the grace period for nonpayment of premiums with grace periods provided for under state laws prior to the adoption of the ACA.

I look forward to working with this committee on these four commonsense bills that will help stabilize premiums and help patients get covered and stay covered.

Again, I thank the Chairman and Ranking Member and I yield back.
Statement for the Record to:

COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

Hearing on Patient Relief from Collapsing Health Markets

Submitted by:
Blue Cross and Blue Shield Association

February 1, 2016
The Blue Cross and Blue Shield Association (BCBSA) appreciates the opportunity to comment on legislative proposals under consideration by the House Energy and Commerce Subcommittee on Health.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 107 million members – one-in-three Americans. BCBS Plans offer coverage in every zip code across the United States and provide coverage in the vast majority of the Exchange Marketplaces today. BCBS Plans have an 85 year history providing coverage across all markets in their local communities.

BCBSA commends Chairmen Burgess and Walden for considering changes to improve the individual health insurance market with these stabilizing bills that will encourage people to get the ongoing health care they need to stay healthy and manage their chronic illnesses.

BCBSA strongly supports the three bills recently introduced to address existing policies that allow some people to buy health insurance only when they need care, threatening the sustainability of the market. We believe these bills would help balance the overall risk pool and stabilize the market by:

- Ensuring individuals are eligible for a Special Enrollment Period before enrolling
- Aligning grace periods for non-payment of premium with state requirements
- Modifying age variation in premium rates to 5:1 or a rate set by a state

A system where people can get health insurance regardless of preexisting conditions can only be viable if people maintain continuous coverage and there are appropriate incentives for all Americans to participate. Experience from the past two and a half years shows that the newly enrolled individuals are older than originally projected; have higher rates of certain conditions (e.g., hypertension, diabetes, depression, coronary artery disease, HIV and Hepatitis C); use more medical services; and have much higher costs. 1 In addition, medical costs continue to increase with significant growth in prescription drug costs.

BCBSA supports these legislative proposals that would help ensure that the individual market is stable, affordable and encourages people to get the ongoing care they need:

1. Eligibility for Special Enrollment Periods (SEPs) should be determined up front before coverage is effective.

Special enrollment periods (SEPs) play a key role in promoting continuity of coverage during important life transitions, such as job changes, relocations, marriage, and births. However, CMS allows SEPs for more events than either Medicare Advantage or employer coverage. It is important that CMS verifies that consumers are eligible for SEPs in order to avoid "just in time" insurance which undermines the stability of the market. We support Congressman Blackburn's re-introduction of H.R. 706 that will ensure a strong verification process.

Individuals who gain coverage through SEPs are a substantial and growing percentage of the Exchange population, and they incur significantly higher medical claims than others. CMS data show only 40% of those ever covered in the federal exchange in 2015 had

---

coverage for 12 months, and that about 25 percent 2015 enrollment came in through SEPs. Moreover, these enrollees typically incur higher costs than those individuals who enroll during the open enrollment period. In fact, the actuarial firm Oliver Wyman found those individuals enrolling in coverage through SEPs amassed 24% more in health care costs over their first three months of coverage in 2014 than those coming in during the open enrollment period. Oliver Wyman found strong evidence that the relative cost of the enrollees signing up for coverage during SEPs was even higher in 2015.

2. Grace periods for non-payment of premiums should be shortened to 30 days as required by almost all states.

We commend Congressman Flores for re-introducing H.R. 710, which will incentivize individuals to stay covered. The ACA required a 3-month grace period for certain individuals to continue receiving coverage without paying their health insurance premiums. The ACA requirement far exceeds state grace periods which are typically 30 days, allowing some individuals to stop paying premiums in October but continue to get medical services through December, causing premiums to go up for everyone. A recent national consumer survey shows that more individuals are using the grace period than before. It found that 18% of consumers stopped paying their premium in 2015 and then reenrolled again in 2016. Further, half of these consumers returned to the same plan they stopped paying for in 2015. Of the consumers that stopped paying premiums last year, 45% said they had stopped payments in 2014.

3. Allow states to determine the age rating factors to ensure appropriate incentives to enroll younger, healthier people.

The ACA limited the amount premiums for adults can vary based on age to a 3 to 1 band. This has made premiums for younger people much more expensive than their actual medical costs and resulted in fewer people age 25-44 obtaining health insurance. In fact, the uninsured rate is much higher than was originally projected for those ages 25-44. We applaud Congressman Bucshon for re-introducing legislation, H.R. 708, which will allow states more flexibility while encouraging younger and healthier individuals to enroll.

CONCLUSION

Keeping premiums affordable for everyone is crucial to increasing participation and coverage among healthier individuals who help balance the overall risk pool and stabilize the market. The current risk pool is out of balance – with a disproportionate number of people who need significant healthcare services – making health insurance more expensive for everyone. The bipartisan legislation under consideration by the Committee provides a needed course correction to ensure greater market stability and more affordable coverage. BCBSA encourages immediate passage of these bills.

2 https://academyhealth.confex.com/academyhealth/2016arm/mediafile/Presentation/Session4923/Keri%20Apostle.pdf
3 Oliver Wyman, “Special Enrollment Periods and the Non-Group, ACA-Compliant Market”.
Chairman Burgess, Ranking Member Green, and distinguished members of the Subcommittee on Health, thank you for giving the American Congress of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners in women’s health, the opportunity to submit written testimony in response to your February 2, 2017 hearing titled “Patient Relief from Collapsing Health Markets.” We look forward to working closely with you to preserve landmark women’s health gains, and to improve the ACA for patients and providers. We hope you will view ACOG as a resource and trusted partner as you continue to examine our nation’s health care system.

As the nation’s leading organization of women’s health providers, ACOG is keenly aware of many of the benefits, and shortfalls, of the Patient Protection and Affordable Care Act (ACA). ACOG has a strong history of supporting access to coverage and care for all women. While ACOG engaged extensively with Congress during the development of the ACA, we reluctantly opposed the final bill because of the inclusion, and exclusion, of several provisions that we believed undermined health reform’s great promise.

However, ACOG does not support full repeal of the ACA. We stand strongly behind the landmark women’s health gains achieved through the ACA, and urge the Congress not to turn back the clock on women’s health.

ACOG’s health reform principles (attached) serve as our guide to measuring the adequacy of all ACA reform proposals. Any reforms must preserve:

- Guaranteed maternity coverage for all women in all plans. This essential health benefit righted a wrong in our healthcare system, helping pregnant women access prenatal care and leading to healthier pregnancies and healthier babies. Every $1 spent on prenatal care saves $3.38, primarily in cost of low birthweight and preterm infants. Preterm birth costs our nation $26 billion annually – more than $50,000 for every infant born prematurely.
- Coverage with no cost sharing for women’s preventive health services. More than 55 million women gained access to evidence-based preventive services under the ACA, including mammograms, immunizations, and contraception. This provision saved women $1.4 billion on out-of-pocket costs for contraception in one year, and has helped drive down the rate of unintended pregnancies.
- Direct access to ob-gyn care. Ob-gyns deliver primary and preventive care to women, and are often the only doctor a woman sees on a regular basis. This patient-centered protection guarantees our patients the ability to see their preferred physician.
- No pre-existing condition exclusions. Before the ACA, insurers dodged coverage in too many ways, including by refusing coverage of roughly 65 million women with pre-existing conditions, including prior C-section or having been the victim of domestic violence, can no longer be denied coverage. This important patient-centered protection must be maintained.
• No gender rating. Before the ACA, insurers charged women approximately $1 billion more annually and a 25-year old woman could pay 81% more than a man for identical coverage. Let’s continue to make insurers play fair.

• No insurance coverage annual or lifetime limits or rescissions. Before the ACA, 39.5 million women were subject to coverage limits, leaving our patients with serious health issues vulnerable to losing coverage mid-treatment. This patient-centered protection is critical to our ability to care for our sickest patients.

• No excessive waiting periods (defined as longer than 90 days). Before the ACA, insurance companies could impose excessive waiting periods, such as 9-months or two years, before beneficiaries could use their coverage, including maternity coverage. That practice was the exact opposite of patient-centered, allowing insurers to collect monthly premiums and deny coverage for needed care.

ACOG supports thoughtful improvements to current law. We hope to work closely with the Subcommittee to reduce administrative burdens on patients and physicians, address unaffordably high deductible plans, correct the narrowing of networks, reform the medical liability system, and abolish the Independent Payment Advisory Board (IPAB).

Thank you for your consideration of these key provisions, which are imperative to the health of our patients. We look forward to continuing to engage with you and provide guidance as you further evaluate our nation’s health care system and consider potential reforms.
ACOG Health Reform Principles

January 2017

Affordable access to care improves health and reduces health system and employer costs.

ACOG is a strong supporter of the landmark women's health gains made in the Affordable Care Act. Any attempt to reform our nation's health care system must not compromise or reduce these health insurance guarantees and protections. Alternative proposals must:

Maintain critical benefits

• Guarantee maternity coverage for all women in all plans. This coverage, leading to healthier outcomes and lower costs, was routinely excluded from private insurance plans prior to the ACA.
  ✓ As estimated 8.7 million American women gained maternity services under the ACA. Previously, only 12% of individual market plans covered these services. 1
  ✓ Every $1 spent on prenatal care saves $3.38, primarily in reduced spending for low birthweight and preterm infants. 2
• Ensure full coverage and no cost-sharing for women's preventive health services under all plans, including the full range of FDA-approved contraceptives.
  ✓ More than 55 million women gained access to preventive services, including mammograms, flu shots, and contraception without a copay or a deductible.
  ✓ Women saved $1.4 billion on out-of-pocket costs for contraception in one year. 3
  ✓ Currently, 49% of US pregnancies are unintended; unintended pregnancies resulted in approximately $12.5 billion in government expenditures in 2008. 4
• Continue Medicaid coverage for tobacco cessation services to pregnant women, leading to better care and lower costs.
  ✓ Smoking during pregnancy is associated with intrauterine growth restriction, preterm birth, low birthweight, perinatal mortality, and ectopic pregnancy.
  ✓ Up to 34% of sudden infant death syndrome (SIDS) cases can be attributed to prenatal maternal smoking. 5
• Maintain the Medicaid state plan option to expand coverage of family planning services for low-income women.
  ✓ Medicaid accounted for 75% of 2010 expenditures on publicly-funded family planning. 6
  ✓ In 2010, every $1 invested in publicly-funded family planning services saved $7.09 in Medicaid expenditures that would have otherwise been needed to pay the medical costs of maternity and infant care. 7

Preserve market protections

• Prohibit pre-existing condition exclusions, gender rating, coverage rescissions, and annual and lifetime benefit caps.
  ✓ Roughly 65 million women with pre-existing conditions, such as a prior C-section or a history of domestic violence, must not be denied coverage.
  ✓ Prior to the ACA, gender rating cost women approximately $1 billion annually. 8
  ✓ Insurers must guarantee renewability and availability of coverage.
• Ensure direct access to ob-gyn care.
  ✓ Ob-gyns deliver primary and preventive care services to women. An ob-gyn is often the only doctor a woman sees on a regular basis. Reforms must not impose a barrier to this care.
• Allow individuals through age 26 to maintain coverage on their parents' health insurance.
• Continue prohibition on excessive waiting periods.
  ✓ Prior to the ACA, insurance companies could impose waiting periods ranging from 9 months to 2 years before maternity coverage could be used. 9
• Ensure **premium subsidies** are available to help small employers and low-income individuals purchase private health insurance.
  ✓ In 2011, nearly 40% of uninsured women had incomes between 139%-399% of the federal poverty level, making them eligible for subsidies. Alternative proposals must ensure continued affordability.

**Strengthen the health care safety net**

• **Continue Medicaid expansion**, ensuring a public safety net for no-income and low-income non-pregnant women, and encourage all states to expand their Medicaid programs to cover this population. Thanks to Medicaid expansion:
  ✓ Between 2010 and 2015, the uninsured rate among women ages 18-64 decreased from 19.3% to 10.8%, nearly half.  
  ✓ Hospital uncompensated care costs dropped by $10.4 billion in 2015.”

• **Preserve the changes to the Medicaid and CHIP application process and allow states to continue to give real-time determinations for non-disabled adults and children, to ensure that women, including pregnant women, can enroll in health insurance and begin accessing care in a timely manner.**

• **Continue identification and development of Medicaid quality measures with multi-stakeholder input.**

  ✓ Continued development and testing of quality measures, including those concerning maternity care, will further efforts to enhance the quality of health care delivered through Medicaid and lead to better outcomes.

• **Maintain permanent authorization of the Indian Health Care Improvement Act.**

  ✓ The cornerstone legal authority for the provision of health care to American Indians and Alaska Natives, the Act modernized and improved health care provided to American Indian/Alaska Native populations, who generally experience lower health status and disproportionate disease burden.

**Protect public health**

• **Provide break time and a place at work for breastfeeding women to express milk.**

  ✓ One study estimates that $3.6 billion would be saved annually in the cost of treating some childhood illnesses if breastfeeding rates were increased.

  ✓ Children who were breastfed as infants have fewer childhood illnesses and fewer visits to the pediatrician’s office, which leads to decreased parental absenteeism from work and lower health system costs.”

• **Continue the Patient-Centered Outcomes Research Institute (PCORI)** to advance the evidence on health outcomes through research.

  ✓ The work of PCORI improves the quality of care and speeds implementation of evidence-based practices, positively impacting the rising rates of health care costs.

  ✓ PCORI’s work in women’s health ranges from maternity patient reported outcomes, uterine fibroid management, reduction of preterm birth, contraceptive counseling, and maternal mental health.

• **Continue the Prevention and Public Health Fund.**

  ✓ The Prevention Fund helps states keep communities healthy and safe via immunization programs, epidemiology and laboratory capacity grants, breast and cervical cancer screenings, smoking cessation programs, etc.

  ✓ Every $1 invested in evidence-based prevention programs saves $5.60.”

• **Continue the Center for Medicare and Medicaid Innovation (CMMI)** to support the advancement of innovative payment and delivery system models.

  ✓ The Strong Start for Mothers and Newborns initiative seeks to reduce preterm birth and other adverse birth outcomes.

  ✓ The Medicare Access and CHIP Reauthorization Act (MACRA) law that repealed the flawed Sustained Growth Rate (SGR) relies on CMMI to test innovative payment models.


January 2, 2017

The Honorable Michael Burgess
Chairman
House Energy & Commerce
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Gene Greene
Ranking Member
House Energy & Commerce
Subcommittee on Health
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Burgess and Ranking Member Greene:

On behalf of the more than 4.4 million Alliance for Retired Americans, I appreciate the opportunity to provide comments to the hearing entitled, "Patient Relief from Collapsing Health Markets." Although the focus of the hearing is on reducing the cost of health care for Americans, Representative Bucshon's proposal to modify the health variations in health insurance premium rates only helps younger adults and would actually increase premiums for older Americans.

Prior to passage of the Affordable Care Act (ACA), the premium for a single 64 year old compared to a 19 year old typically varied by 5-to-1 and, in some markets, as high 11-to-1. This made insurance unaffordable for many early retirees who were not yet Medicare eligible and had to purchase insurance in the individual market. Instituting a 5-to-l age rating would not only destroy the basic principles of the ACA, but it reverts back to previous law and to a broken system.

The Commonwealth Fund found that while the rate of insured would increase among young people if the age rating was changed to 5-to-1, 400,000 older adults would lose coverage. The shift in age rating would also increase costs to the federal government. Because the ACA caps premium contributions for low- and moderate-income marketplace enrollees as a percent of income, many individuals affected by the change in age rating would face higher premiums, reach the cap and the federal government would be required to pick up the cost difference.

We are also concerned about legislation relating to pre-existing conditions. While Representative Walden’s bill promises to protect patients with pre-existing condition, it is our understanding that this would only be the case if the individual had continuous coverage. Should an individual lose coverage at any time, insurers would be allowed to charge much higher premiums.
I am pleased to add my voice to the chorus of individuals and organizations that oppose efforts to expand age rating bands and oppose the modified and narrower protections against pre-existing conditions. Thank you to taking my concerns into consideration and helping to spare older Americans from increased and unaffordable premiums.

Richard Fiesta
Executive Director
February 2, 2017

The Honorable Michael Burgess, M.D.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

Dear Chairman Burgess:

Thank you for your efforts to make healthcare accessible and affordable for all Americans. As the Subcommittee on Health prepares to hold a hearing on improving the health insurance markets, the Healthcare Leadership Council (HLC) welcomes the opportunity to share our thoughts on this important issue.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation’s healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century health system that makes affordable, high quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, pharmacies, post-acute care providers, and information technology companies—are committed to advancing a consumer-centered healthcare system that values innovation, accessibility, and affordability.

HLC believes that the post-Affordable Care Act (ACA) insurance structure must bolster the stability of the marketplace, encourage greater competition, and give all Americans enhanced choice and flexibility in their coverage. Like the Subcommittee, HLC is concerned that loopholes such as the large number of Special Enrollment Periods (SEPs) and the three-month premium payment grace period mean that the individual mandate does not serve its purpose of ensuring that all consumers have continuous coverage and that the coverage is affordable. To address these issues, the number of SEPs should be reduced to align with the large employer insurance market and pre-enrollment verification should be required. In addition, the length of the grace period should align with state law and consumers should be required to pay their outstanding premiums before re-enrolling in coverage.

If the post-ACA insurance structure does not include an individual mandate, then there needs to be a continuous coverage requirement and/or other critical safeguards against adverse selection. For individuals who have not had continuous coverage, insurers should be able to charge them higher premiums, limit their benefit options, or defer them to a federally funded high risk system in order to keep costs affordable for everyone.
A permanent high risk pool for the continuously covered should also be in place and should receive broad-based and stable funding. In addition, risk adjustment mechanisms to account for higher cost enrollees should be improved.

Consumers should be provided with advanceable, refundable tax credits to help them purchase coverage. To attract consumers, flexible plan designs should be encouraged. Decision support tools—including out of pocket cost calculators, smart plan-finder tools, searchable provider networks and drug formularies, and clear cost information for common services—would help consumers to understand their options and choose among the plans.

Thank you for your efforts to improve the health insurance markets. HLC looks forward to continuing to work with you to make health insurance accessible and affordable for all Americans. Should you have any questions, please contact Debbie Witchey at 202-449-3435.

Sincerely,

Mary Grealy
President

cc: The Honorable Gene Green, Ranking Member
    Subcommittee on Health
America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We appreciate this opportunity to comment on a series of bills the committee is examining as part of its effort to develop health reforms for replacing the Affordable Care Act (ACA). As the committee examines these issues, it is clear that certain parts of the ACA have not worked as well as intended, especially for individuals who purchase coverage on their own. In fact, the individual market—which has grown significantly in recent years and currently provides coverage to 18 million Americans—has faced challenges for many years, including prior to the implementation of the health reform law.

For consumers who purchase coverage in the individual market, the more immediate challenges—which have been well-documented—include significant increases in average premiums in 2017 (driven by underlying growth in medical and prescription drug costs, the sunset of the transitional reinsurance program and other factors), fewer health plan choices, lower-than-expected exchange enrollment and risk pool challenges in some states.

While these challenges are real, it is also true that the ACA has expanded coverage to 20 million Americans and the percentage of Americans without health insurance has dropped to historical lows—down from 16.0% in 2010 to 8.6% in 2016. These gains have been achieved through the Medicaid expansion as well as through the ACA exchange marketplace (which has been accomplished through a combination of insurance market reforms, financial assistance via premium subsidies, and the individual mandate).

Draft Bills Under Consideration in Today’s Hearing

We appreciate that today’s hearing will focus on several draft bills that offer promising strategies for addressing some of the challenges in the individual market. We look forward to working with the committee on these and other proposals.

"Plan Verification and Fairness Act"

We support this legislative proposal to implement a pre-enrollment verification process, using available electronic data sources, for special enrollment periods (SEPs). While the Centers for Medicare & Medicaid Services (CMS) has taken steps to address the misuse of SEPs, pre-enrollment verification represents the most effective approach to ensure the appropriate use of SEPs in promoting both affordability for consumers and stability in the new Exchanges.

While most consumers play by the rules, many have misused SEPs—and that raises costs for everyone. Too many Americans have incentives to game the system by applying for coverage only when they need care. We must eliminate opportunities for fraud if we are to make care more affordable for everyone.

In February 2016, AHIP and the Blue Cross Blue Shield Association released a joint policy analysis that raised concerns about the misuse and abuse of SEPs by some individuals and discussed the importance of verifying eligibility for SEPs. Our joint policy analysis stated: “We continue to support ensuring consumers have access to affordable coverage. Special enrollment periods are important to ensure continuity of coverage given changing life situations for consumers and must be implemented through verification processes that do not allow ‘just in time’ insurance which will undermine the stability of the marketplaces. Verification should focus on ensuring program integrity up front because it is a more consumer friendly approach.

2 AHIP-BCBSA, Appropriate Use of Special Enrollment Periods Is Key to Exchange Stability, Affordability for Consumers, February 2016
that avoids issues on the back end that consumers, providers, issuers and exchanges must reconcile."

"Health Coverage State Flexibility Act"
We support this legislative proposal to align the current grace period for recipients of advanced premium tax credits (APTC) with existing state law and regulation. This bill would take another important step toward eliminating opportunities for fraud and making health care more affordable.

Under current law, Exchange enrollees who receive APTC are provided a three-month grace period before coverage is discontinued if they are delinquent on their premium payment, and health plans are required to pay health care claims during the first month of the grace period. We believe current law should be amended to make the grace period requirements consistent with existing state rules, most of which currently allow for a 30-day grace period. This legislation could help promote continuous coverage and consumer affordability by improving risk pool stability.

"State Age Rating Flexibility Act"
We support this legislative proposal to grant states the flexibility to adopt wider age rating bands to promote more affordable coverage and expand participation among younger, healthier individuals.

The ACA established 3:1 age rating bands that led to higher premiums for certain younger consumers, particularly those who purchased individual market coverage prior to the ACA and/or are not currently eligible for subsidies. Providing flexibility for states to adopt wider age bands—combined with other steps, such as modifying the formula for the existing premium assistance tax credits to factor in age bands—could encourage younger and healthier people to enroll in coverage. This, in turn, could improve affordability for consumers by promoting greater stability of the risk pool.

"Preexisting Conditions Protection and Continuous Coverage Incentive Act"
We appreciate that this legislative proposal aims to address the needs of individuals with pre-existing conditions and we look forward to seeing the incentives that will be included in a later version of this bill.

Our members have strongly supported an approach to health reform that brings everyone into the system. Broad coverage can ensure the availability of affordable options. Health insurance only
works when everyone is covered: those who utilize insurance to obtain quality care as well as those who are healthy but have insurance to protect themselves in case they get sick. Both types of consumers must be insured for coverage to remain affordable. To address this priority and achieve a more stable and workable marketplace, it is important for Congress to approve robust policies that encourage people to maintain continuous coverage.

Conclusion

AHIP and the health plans we represent look forward to working with the committee, members of Congress on a bipartisan basis, and the administration as it works to improve health care for all Americans. We can achieve this by working together in a good faith and bipartisan manner to fix critical problems while preserving the expanded coverage and enhanced affordability of coverage for millions of patients and families. Thank you again for the opportunity to work with you on these important issues.
Dr. Doug Holtz-Eakin
President
American Action Forum
1747 Pennsylvania Avenue, N.W.
Fifth Floor
Washington DC, 20006

Dear Dr. Holtz-Eakin:

Thank you for appearing before the Subcommittee on Health on February 2, 2017, to testify at the hearing entitled “Patient Relief from Collapsing Health Markets.”

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on March 3, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

[Dr. Holtz-Eakin did not answer submitted questions for the record by the time of printing.]
Attachment — Additional Questions for the Record

The Honorable Gus Bilirakis

Mr. Holtz-Eakin, the Center for Health and Economy analyzed the Better Way agenda, can you provide details on what they found that the plan broadly accomplishes? What is the impact on premiums? Is there a change to provider access? What would be the impact on the federal budget? Are you able to share the findings on the premium impact Better Way would have on both single and family coverages at each of the coverage levels — catastrophic through platinum — offered by Obamacare?
February 17, 2016

Dr. J. Leonard Lichtenfeld
Deputy Chief Medical Officer
American Cancer Society
250 Williams Street, N.W.
Atlanta, GA 30303

Dear Dr. Lichtenfeld:

Thank you for appearing before the Subcommittee on Health on February 2, 2017, to testify at the hearing entitled “Patient Relief from Collapsing Health Markets.”

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on March 3, 2017. Your responses should be mailed to Jay Gulshen, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to jay.gulshen@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment
The Honorable Frank Pallone, Jr.

1. One important consumer protection that the ACA put in place were the Essential Health Benefits. Before the ACA, many Americans bought insurance only to find out that it did not cover necessary care, such as prescription drugs or hospitalization. Under the ACA, all Qualified Health Plans must cover a basic set of services, known as Essential Health Benefits. Rep. Walden’s discussion draft assumes repeal of the entire ACA, including the Essential Health Benefits. We know that for example, before the ACA, 62 percent of plans lacked maternity coverage and 18 percent lacked coverage for mental health services. Without additional legislation, insurance companies would presumably have to cover anyone who applied, but the coverage could be lacking basic benefits.

Q: Dr. Lichtenfeld, can you talk about the kinds of medical care services patients need when they are in cancer treatment?

• Cancer patients in active treatment need a full range of medical services including but not limited to: hospitalization, specialty cancer care, physician services, prescription drugs, rehabilitative care, and mental health services.
• It’s important to note that the need for care doesn’t end once the cancer is treated. Cancer survivors also need access to a wide range of services for years following their cancer treatment.
• Streamlined “basic” policies that do not include explicitly defined comprehensive benefits put cancer patients and survivors at risk of inadequate treatment, and could jeopardize access to necessary preventive care, treatment and follow-up care.

Q: If the ACA benefit standards were to be repealed, how would cancer patients be affected if insurance policies no longer covered prescription drugs? Or if they only covered generic drugs?

• As I mentioned previously, cancer patients in active treatment, as well as cancer survivors, need access to a full range of medical services.
• Pharmaceutical therapies are an integral part of cancer treatment today. Further, millions of cancer survivors rely on drug therapies to prevent recurrence of their cancer. Without access to drug therapies cancer treatments would be severely limited and the lives of cancer patients and survivors put at risk.
• We support access to lower cost generic versions of cancer drugs. But currently many of the newer and innovative therapies are biologics that do not yet have biosimilars. But even biosimilars – while less costly – will be expensive. Without
adequate insurance coverage these drugs would still be unaffordable for many cancer patients.

- Newer cancer treatments such as immunotherapy are expensive and becoming standards of care for several types of cancer including but not limited to lung cancer and melanoma, for example. These treatments are also expensive and well out of the reach of patients without insurance coverage.

Q: What if policies limited coverage to 3 doctor visits per year?

- Arbitrary coverage limits make no sense – particularly in cancer care.
- Every cancer and every cancer patient is unique and their treatment regimen should be dictated by what patients need in order to beat their cancer – not by a one size fits all limit on coverage.
- The typical cancer patient needs many more than 3 doctor visits per year.

Q: What if policies had annual deductibles of $10,000 or $20,000 per person?

- Access to affordable health care is critical to cancer care. Unreasonably high deductibles are a serious barrier to care. Most people cannot afford to pay $20,000 out of pocket before their health insurance coverage begins.
- For someone with cancer a high deductible that prevents them from getting the care they need could be a matter of life and death.
- Further, some cancers – like colorectal, breast, and cervical – can be prevented or caught very early with access to screening and early detection. Yet unaffordable deductibles could cause people to go without life-saving screening services. And if cancer is detected through screening there must be adequate coverage for prompt treatment to provide the best opportunities for success.

2. The Affordable Care Act allows for certain Special Enrollment Periods (SEPs) for those who are eligible to purchase health insurance outside of the designated open enrollment period. The individual market has always been transitional as people move into and out of sources of coverage, such as job-based plans and Medicaid. Thus life changes triggering an SEP often occur outside of open enrollment leading some people to “churn” into and out of marketplace plans during the year.

We have heard from insurers that SEPs allow patients to game the system and that patients are using SEPs when they are not eligible. We care about program integrity, and we care about having a stable risk pool, and so did the prior administration. This is why CMS took steps to tighten up SEPs by reducing the number of SEPs and requiring that consumers provide proof that they are eligible. CMS has also instituted a requirement for the “permanent move” SEP; under which those applying have to prove they had minimum essential coverage before their move.
H.R. 706 would require that HHS verify eligibility before coverage can start. I’m concerned that this will cause a delay in coverage. CMS is starting a pilot project to see if pre-enrollment verification can work without delays, but I’m skeptical. So is the nonpartisan Congressional Budget Office, who estimates that this policy would result in approximately 1 million patients experiencing a 1 to 2-month delay in coverage.

Q: Dr. Lichtenfeld, can you explain the impact of a 1 to 2-month delay in coverage on a cancer patient?

- Someone who hears the words “you have cancer” wants and needs their treatment to begin as soon as possible. For many cancer patients delay is not an option—especially when faced with an acute life-threatening condition.
- For later stage cancers, getting treatment underway quickly is especially important. A two-month delay in coverage not only puts a cancer patient through needless stress and anxiety, but it can actually impact the success of their treatment.

3. Mr. Walden’s draft includes a placeholder for a continuous coverage requirement. However, since it’s a placeholder, we don’t know exactly what the policy will look like. Failing to pay your medical bills isn’t always a choice. Sometimes people need the care and want to pay for the care but other circumstances prevent them from doing so. But this sort of policy has the potential to lock people out of the market. Financially vulnerable households in particular might face long-term consequences if insurance is temporarily unaffordable. Job loss often drives the loss of existing health insurance coverage. For families in tough situations, the loss of income combined with the loss of employer-sponsored coverage could cause them to be unable to re-enroll in an insurance plan or lead to a sizable increase in premiums.

I’m worried that the continuous coverage punishment simply does not fit the crime.

Q: Dr. Lichtenfeld, can you please talk about the effect of continuous coverage policies on the cancer community?

- The Kaiser Family Foundation estimates that 27 percent of adult Americans under the age of 65 have a pre-existing condition.
- Prior to January 1, 2014, health insurance issuers were permitted to refuse to cover an individual who had a pre-existing condition; could provide coverage but limit and/or refuse to cover care associated with the individual’s pre-existing condition; or, could charge the individual a higher premium based on her pre-existing condition (thus making insurance unaffordable). A survey conducted before these exclusions were prohibited 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, were charged more, or had a specific health problem excluded from their coverage.

- Depending on how continuous coverage would be implemented it could actually restore the discriminatory practice of pre-existing condition exclusions insofar as individuals with pre-existing conditions could be charged higher premiums.

Q: Can you explain why cancer patients might have a gap in coverage that is beyond their control?

- Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to 6 months depending on the treatment.
- Gaps in coverage also occur as a result of a divorce or death of a spouse when one spouse is no longer covered on the other’s health plan. Moving from one state to another may also result in a gap in coverage.
- All of these examples – and many others – are common reasons why a person may have an unexpected gap in coverage. Penalties imposed on people in these situations may adversely impact access to care, interrupt life-saving treatment and make insurance unaffordable when they attempt to regain coverage.

Q: Do you think that patients should be penalized with higher premiums for gaps in coverage beyond their control?

- A one-size-fits-all approach that imposes penalties for any interruption in coverage fails to recognize the many legitimate reasons that patients have coverage gaps.
- As I mentioned previously, many people may experience a gap in coverage when they lose their job and their employee coverage. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to 6 months depending on the treatment.
- Gaps in coverage also occur as a result of a divorce or death of a spouse when one spouse is no longer covered on the other’s health plan. Moving from one state to another may result in a gap in coverage. All of these examples – and many others – are common reasons why a person may have an unexpected gap in coverage.
- Penalties imposed on people in these situations may adversely impact access to care, interrupt life-saving treatment and make insurance unaffordable when they attempt to regain coverage.


Dr. Lichtenfeld, we are also reviewing a bill today that would reduce the grace periods in the individual market to one month. This means that if someone misses their premium payment and doesn’t make it up in a month, they will be removed from insurance and not be able to enroll again until the next open enrollment period.

Q: Dr. Lichtenfeld, can you talk about the effect of this bill on the cancer community?

- The legislation under consideration by the Subcommittee would retain the three-month grace period for plan years beginning before January 1, 2018, but would eliminate this patient protection for subsequent plan years. States would have the authority to set the appropriate grace period. If a state chooses not to do so, the default period would be one month.

- We are concerned that limiting the grace period would pose an undue burden on individuals who experience sudden or unexpected personal financial changes – such as coping with having to pay large deductibles and out-of-pocket costs associated with a serious disease like cancer. The out-of-pocket costs of a newly diagnosed cancer patient can be beyond the means of many Americans.

- When an individual is diagnosed and initially undergoes cancer treatment she usually incurs a significant portion in out-of-pocket costs between the deductible, and frequent copayments and coinsurance associated with services and/or medications. Nearly half of all American adults report being unable to cover an emergency expense costing $400 without having to borrow or sell something to do so. Yet many standard plans impose deductibles of $2,500 or more.

- Individuals often need additional time in order to try to obtain funds to cover these unexpected medical costs. Enacting legislation that would reduce the grace period would curtail the ability of individuals to retain their health insurance coverage at a time when they need it most (e.g., while they are undergoing treatment for a serious disease or illness).

- Moreover, we are deeply concerned that the legislation fails to provide a minimum protection – a state could conceivably limit the grace period to only a few days. While we would expect few states to take such draconian action, we nevertheless urge the Subcommittee to consider providing a federal floor of patient protections.

- Finally, we are concerned about how this provision will be impacted if the other legislative proposals discussed above were implemented. For example, if an individual failed to pay her health insurance premiums for more than 30 days and her coverage was terminated, she would be uninsured and thus potentially face medical underwriting if she lacked coverage for a period of time provided under the legislation.
4. Several Republicans including President Trump and Speaker Ryan have stated that high risk pools will be put in place for people with preexisting conditions and significant medical expenses. Though we currently don’t have any legislative language to show how they actually plan to implement or fund high risk pools, I’d still like to ask about the concept as I find it incredibly concerning. Past experience with high risk pools tell us that they are incredibly expensive and that individuals in high risk pools face high out of pocket costs and limited benefits.

As we discussed at the hearing the draft bill by Mr. Walden would allow insurance companies to charge individuals with preexisting conditions more. I’m worried that this bill in combination with a high risk pool and the potential repeal of the ACA’s essential health benefits would spell disaster for the sickest Americans.

Q: Mr. Lichtenfeld, could you explain how high risk pools typically work? Have they worked well in the past?

- Between 1976 and 2010, 35 states implemented state high-risk pools that provided health insurance coverage to individuals unable to obtain health insurance in the individual market.
- High risk pools were often the only source of non-group coverage for an individual with a pre-existing condition like cancer because, prior to 2014, health plans in most states were permitted to deny health insurance coverage to an individual because of a pre-existing condition.  
- Eligibility for high risk pools varied by state, but generally in order to qualify an individual had to meet one or more of the following categories:
  - **Medically Eligible:** In order to be medically eligible, an individual would have to demonstrate they had been turned down for private insurance due to a medical condition (e.g., a cancer diagnosis).
  - **HIPAA Eligible:** In order to be HIPAA eligible an individual must have had group health insurance coverage within the past 63 days and that coverage must have lasted longer than 18 months. Individuals must also had exhausted any COBRA coverage (or similar coverage extension provided by the state).
  - **Health Coverage Tax Credit Eligible:** In order to meet this eligibility category an individual must have experienced job loss as a result of foreign trade (e.g., eligible for Trade Adjustment Assistance) or were between the ages of 55 and 64 and received benefits from the Pension and Guarantee Corporation.
  - **Medicare Eligible:** A number of states also offered coverage to individuals eligible for Medicare as a supplemental source of coverage.
- A few states capped enrollment in their state high risk pools in order to limit the overall cost of the program. Eligible individuals were placed on a waiting list until the cap was removed or a spot opened up. People were often on waiting lists for years – leaving them without insurance coverage.
Q: Do high risk pools ever have wait lists?

- Yes – some states had wait lists for individuals who wanted to enroll in the high risk pool plan. Individuals would have to wait until a spot opened up for them in the pool because the state did not have enough funding to cover everyone.
- Some states also imposed waiting periods before covering pre-existing conditions. For instance, an individual with a prior cancer diagnosis would have to wait a period of time after enrolling (usually 6-12 months) before the state high risk pool would cover the costs associated with cancer treatments.

Q: Are the consumer protections in high risk pools as robust as those in the ACA? For example, are there annual or lifetime limits on care?

- In the past, not all state high risk pools had the same kind of protections afforded by the ACA. For instance, states employed a variety of measures to limit or curtail enrollment in high risk pools in order to keep costs down including:
  - **Waiting Periods:** Most states imposed waiting periods before covering pre-existing conditions. For instance, an individual with a prior cancer diagnosis would have to wait a period of time after enrolling (usually 6-12 months) before the state high risk pool would cover the costs associated with cancer treatments.
  - **Limitations on Coverage:** A majority of states imposed limitations on coverage with either lifetime or annual limits. States that imposed annual limits did so by either imposing a cap on total covered benefits or capping particular benefit categories (e.g., prescription drugs, mental health, etc.). A majority of states imposed a lifetime dollar limit, which ranged from $1 million to $2 million.

Q: How would the creation of high risk pools impact cancer patients?

- Cancer patients and survivors need insurance coverage that is affordable, readily accessible, and protects them from pre-existing condition exclusions, annual and lifetime caps on coverage and extraordinary out-of-pocket costs.
- Past experiences have shown us that high risk pools often did not meet the needs of cancer patients, due to high costs and lack of coverage for services cancer patients need.
- ACS CAN will analyze proposals with a required threshold that they provide the same coverage, or better than what is currently provided.
1. One of the bills we are considering today would allow insurers to charge older Americans more than five times as much— or more— as they charge younger consumers. Middle class seniors stand to lose the most. They could be charged over $2,000 dollars more per year. And what's worse is that this bill wouldn't do what Republicans promise. It doesn't encourage young people to get health insurance because the vast majority of them wouldn't see any savings generated from the age rating.

Q: Dr. Lichtenfeld, how does this bill harm seniors, especially those that are fighting against cancer?

- Under current law, health insurance issuers in the individual market are prohibited from charging older adults more than three times the premium charged to younger adults for the same coverage (e.g., 3:1 age rating). The legislation under consideration by the Subcommittee would relax these requirements and permit health insurance issuers to charge older adults five times the amount charged to younger individuals (e.g., a 5:1 age rating). The legislation also would allow states to impose a different ratio— either a higher or a lower ratio.

- 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. Thus, increasing the age rating bands would mean that older individuals (those more at risk of developing cancer) would face significantly higher health care premiums or be priced out of the market completely.

- This problem would be exacerbated in states that choose to go beyond the 5:1 age rating provided in the legislation. Prior to the enactment of the ACA's age rating band restrictions, older adults faced significant problems accessing health insurance coverage, in large part because of age rating restrictions (compounded by the ability of issuers to use health status when setting premiums).

- Research suggests that relaxing the age rating bands would result in a slight reduction in premiums charged to younger cohorts relative to the significant increase in premiums charged to older cohorts. One study estimated that increasing the age bands to 5:1 would result in premiums for a 64-year-old to increase from $8,500 to $10,600 per year (a $2,100 increase), while premiums for a 21-year-old would decrease from $2,800 to $2,100 (a reduction of only $700). In addition, the policy would actually result in higher federal expenditures of an estimated $9.3 billion due to the advance premium tax credits.
Q: Does this bill help younger Americans who need access to affordable healthcare?

- Relaxing the age rating bands may result in a slight reduction in premiums charged to younger cohorts relative to the significant increase in premiums charged to older cohorts.
- It should be noted, however, that the bills under consideration today do not include any financial assistance for anyone to help afford premiums or cost-sharing, including younger Americans. If the ACA tax credits and Medicaid expansion is repealed, it is unclear to me how many younger Americans will be able to afford health insurance, even with changes to age bands.

2. Dr. Lichtenfeld, do cancer patients often spend a lot of time with their doctors and care teams getting treatments to help make them well?

- There are hundreds of different kinds of cancers and each of them requires a different treatment regimen. Cancer patients work with their physicians and care teams to create their treatment protocol and understand their treatment plan. This might include surgery, radiation, chemotherapy, immunotherapy or hormone therapy.
- During the course of these treatments – and well into survivorship – cancer patients will work closely with their doctors. This partnership is critical to the patient’s treatment and long term quality of life.

3. Do cancer treatments like chemotherapy have side effects that make it hard for patients to accomplish daily tasks?

- Many kinds of cancer treatments can cause serious side effects that make it difficult for cancer patients to actively engage in their normal routines, such as nerve pain and changes in heart function.
- It’s one of the reasons why we are concerned about proposals that would exempt individuals from pre-existing condition exclusions only if they maintain continuous coverage.
- Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to 6 months depending on the treatment.
- Under proposals now being considered by the Committee, this kind of gap in coverage could possibly be subject to medical underwriting.
4. Do cancer patients get a “pass” on taking care of their finances... putting food on the table... or taking care of their families? Or do family and friends often have to step in and help with those duties?

- Depending on the severity of their treatment some cancer patients may find it difficult to maintain their normal activities of daily living and may require assistance from family and friends.
- Those cancer patients without a strong support network may find it difficult to maintain their usual routines – working, paying bills, maintaining their home, preparing meals, etc. Caregivers are an incredibly important part of one’s cancer experience.

5. Is it conceivable that with all that a cancer patient has to deal with... or when a loved one is managing their affairs... that one month’s payment may get overlooked?

- As I mentioned previously, depending on the severity of a cancer patient’s treatment and whether or not they have a strong support network that can step in and pick up some of the day to day responsibilities it is plausible that a cancer patient could miss making an insurance payment. Frequently, that support network itself becomes overwhelmed when tending to a patient’s needs—especially during acute crises which are not uncommon in cancer care.

6. If that cancer patient is then kicked off their plan for missing that one payment... what happens to that patient?

- If a cancer patient loses his/her health insurance coverage it may directly impact their ability to successfully fight their cancer.
- Losing access to insurance likely means losing access to their treatment which has a direct bearing on their chances of survival.

7. What if the cancer patient didn’t miss a payment when they were sick... but maybe misses a payment a couple of years into remission? Now the patient has not maintained continuous coverage. If allowed, as one of the policies we are discussing does, would insurance companies take the patient’s previous cancer diagnosis into account when pricing their new plan? What would happen to that patient?

- Cancer survivors who are more likely to report being unable to work because of their health or having employment disability, including more missed work days or additional days spent in bed due to poor health.
- Depending on how a proposal is drafted health insurers could end up charging higher premiums to cancer survivors who experience a gap in coverage.