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TEXAS v. U.S.: THE REPUBLICAN LAWSUIT AND ITS IMPACTS ON AMERICANS WITH PRE-EXISTING CONDITIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

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[1] The information has been retained in committee files and also is available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=108843.

TEXAS v. U.S.: THE REPUBLICAN LAWSUIT AND ITS IMPACTS ON AMERICANS WITH PREEXISTING CONDITIONS

WEDNESDAY, FEBRUARY 6, 2019

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

The subcommittee met, pursuant to call, at 10:16 a.m., in room 2322, Rayburn House Office Building, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

Members present: Representatives Eshoo, Butterfield, Matsui, Castor, Luján, Cárdenas, Schrader, Ruiz, Kuster, Kelly, Barragán, Blunt Rochester, Rush, Pallone (ex officio), Burgess (subcommittee ranking member), Upton, Guthrie, Griffith, Bilirakis, Bucshon, Brooks, Mullin, Hudson, Carter, Gianforte, and Walden (ex officio).

Also present: Representatives Veasey and O'Halleran.

Staff present: Jeffrey C. Carroll, Staff Director; Elizabeth Ertel, Office Manager; Waverly Gordon, Deputy Chief Counsel; Zach Kahan, Outreach and Member Service Coordinator; Saha Khatezai, Professional Staff Member; Una Lee, Senior Health Counsel; Kaitlyn Peel, Digital Director; Tim Robinson, Chief Counsel; Samantha Satchell, Professional Staff Member; Andrew Souvall, Director of Communications, Outreach, and Member Services; C. J. Young, Press Secretary; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel, Health; Margaret Tucker Fogarty, Minority Staff Assistant; Caleb Graff, Minority Professional Staff Member, Health; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; J. P. Paluskiewicz, Minority Chief Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Danielle Steele, Minority Counsel, Health.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. The Subcommittee on Health will now come to order. The Chair recognizes herself for 5 minutes for an opening statement, and the first thing that I would like to say is, "Welcome."

Welcome back the 116th Congress under the new majority, and I want to thank my Democratic colleagues for supporting me to do this work, to chair the subcommittee.

It is an enormous honor and it is—what is contained in the committee, of course, are some of the most important issues that the American people expressed at the polls in the midterm elections.

To our Republican colleagues, I know that there are areas where we can really work together. In some areas, we are going to have to stretch. But know that I look forward to working with all of you, and to those that are new members of the subcommittee, welcome to each one of you.

I know that you are going to bring great ideas and really be instructive to the rest of us, so welcome to you.

As I said, healthcare was the single most important issue to voters in the midterm elections, and it is a rarity that there would be one issue that would be the top issue in every single congressional district across the country. So this subcommittee is front and center.

We are beginning the Health Subcommittee's work by discussing the *Texas* v. *United States* lawsuit and its implications for the entire healthcare system, both public and private.

For over a hundred years, presidents, including Teddy Roosevelt, Harry Truman, Richard Nixon, and others attempted to reform our Nation's health insurance system and provide access to affordable health insurance for all Americans.

In 2010, through the efforts that began in this committee, the Affordable Care Act was signed into law and bold reforms to our public and private insurance programs were made.

Since the Affordable Care Act was signed into law, over 20 million Americans have gained health insurance that is required to cover preexisting conditions. The law disallows charging sick consumers more, it allows children to stay on their parents' health insurance policy to the age of 26, and provides coverage for preventive health services with no cost sharing.

Last February, 20 attorneys general and Governors sued the Federal Government to challenge the constitutionality of that law. They claimed that, after the individual mandate was repealed by the Republicans' tax plan, the rest of the Affordable Care Act had to go, too.

The Trump administration's Department of Justice has refused to defend the Affordable Care Act in court and in December Judge Reed O'Connor of the Northern District of Texas declared the entire ACA invalid.

Twenty attorneys general, led by the attorney general from California, our former colleague, Xavier Becerra, have appealed Judge O'Connor's ruling.

For those enrolled in the Affordable Care Act, if the Republican lawsuit is successful, the 13 million Americans who gained health insurance through the Medicaid expansion will lose their health insurance.

The 9 million Americans who rely on tax credits to help them afford the insurance plan will no longer be able to afford their insurance and health insurance costs will skyrocket across the country when healthy people leave the marketplace for what I call junk insurance plans that won't cover them when they get sick—another implication leaving the sick and the most expensive patients in the individual market, driving up premiums for so many.

The insurance reforms of the ACA protect every American, including those who get their health insurance through their employer. Every insurance plan today is required to cover 10 basic essential health benefits.

No longer are there lifetime limits. The 130 million patients with preexisting conditions cannot be denied coverage or charged more, and women can no longer be charged more because they are females.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Welcome to the first Health Subcommittee hearing of the 116th Congress, under a Democratic majority, and welcome to the new members of the Health Subcommittee.

Healthcare was the single most important issue to voters in the 2018 election. It is a rarity for one issue to be so important in every Congressional District in the country.

We're beginning the Health Subcommittee's work by discussing the disastrous *Texas* v. *United States* lawsuit and its implications for the entire healthcare system, both public and private.

For over 100 years, presidents including Teddy Roosevelt, Harry Truman, and Richard Nixon attempted to reform our Nation's health insurance system and provide access to affordable health insurance for all Americans.

In 2010, through efforts that began in this committee, the Affordable Care Act was signed into law and bold reforms to our public and private insurance programs were implemented.

Since the Affordable Care Act was signed into law over 20 million Americans have gained health insurance that is required to cover preexisting conditions; disallows charging sick consumers more; allows children to stay on their parent's health insurance until the age of 26 and provides coverage for preventive health services with no cost sharing.

Last February, 20 attorneys general and Governors sued the Federal Government to challenge the constitutionality of that law. They claimed that after the individual mandate was repealed by the Republican's tax plan, the rest of the Affordable Care Act had to go, too.

The Trump administration's Department of Justice refused to defend the Affordable Care Act in court and in December, Judge Reed O'Connor of the Northern District of Texas declared the entire ACA invalid. 20 attorneys general, led by California's Xavier Beccera, have appealed Judge O'Connor's ruling.

For those enrolled in the Affordable Care Act, if the Republican lawsuit is successful, the 13 million Americans who gained health insurance through the Medicaid expansion will lose their health insurance; the 9 million Americans who rely on tax credits to help them afford their insurance plan will no longer be able to afford their insurance; and health insurance costs will sky rocket across the country when healthy people leave the marketplace for junk insurance plans that won't cover them when they get sick, leaving the sick and most expensive patients in the individual market, driving up premiums.

The insurance reforms of the ACA protect every American, even those who get their health insurance through their employer. Every insurance plan today is required to cover ten basic Essential Health Benefits; there are no longer lifetime limits; the 130 million patients with preexisting conditions cannot be denied coverage or charged more; and women can no longer be charged more because they are females.

Judge O'Connor's ruling in *Texas* v. *United States* declared the Affordable Care Act invalid in its entirety, threatening every one of the gains I just described. It is now up to the Democratic House to protect, defend and strengthen the ACA.

Even if legislation to require insurance companies to cover these patients' preexisting conditions is passed, insurers could charge anything they want to cover these services if the ACA is overturned.

On the very first day of this Congress, House Democrats voted to intervene in the *Texas* v. *United States* case as it moves through appeal. The House of Representatives will now represent the Government in this case to defend and uphold the ACA, because this administration refused to do so.

In the majority's work to defend and strengthen the ACA, this subcommittee will explore how the Trump administration's junk insurance plans are affecting the individual insurance market and harming people with preexisting conditions.

These plans aren't required to cover the same Essential Health Benefits as ACA-compliant plans and patients don't know that their health insurance won't pay for their treatments until they've gotten sick and it's too late.

Next week, our subcommittee will explore specific legislation to reverse the Trump administration's actions to expand junk plans. We're also going to discuss legislation that would restore outreach and enrollment funding that has been slashed by the Trump administration so that we can ensure healthcare is more affordable and assessible. And we will also discuss legislation that would reverse the Trump administration's guidance on 1332 waivers that would allow States to undermine the ACA's protections for preexisting conditions and could harm people's access to care.

We will work to reverse the harmful policies that have made healthcare more expensive for individuals who rely on the ACA and deliver on our promises to the American people to lower healthcare and prescription drug costs.

Welcome to our witnesses, and I look forward to your testimony.

Ms. ESHOO. I am going to stop here, and I am going to yield the rest of my time to Mr. Butterfield.

Mr. BUTTERFIELD. Thank you, Chairwoman Eshoo, for holding this very important hearing on the absolute importance of the Affordable Care Act and thank you for giving us an opportunity to expose the poorly written *Texas* case.

I want to talk a few seconds about sickle cell disease. More than one out of every 370 African Americans born with sickle cell disease and more than 100,000 Americans have this disease, including many in my State.

The disease creates intense pain, that patients usually must be hospitalized to receive their care. Without preexisting condition protections, tens of thousands of Americans with sickle cell could be charged more for insurance, they could be dropped from their plans and be prevented from enrolling in insurance plans altogether.

Republicans have tried and tried and tried to repeal the ACA more than 70 times. We, in this majority, have been sent here to protect the Affordable Care Act.

Thank you for the time. I yield back.

Ms. ESHOO. I thank the gentleman.

Next week—I just want to announce this—our subcommittee is going to explore specific legislation to reverse the administration's actions to expand the skinny plans—the junk insurance plans—and we are also going to discuss legislation that would restore outreach in enrollment funding that has been slashed by the administration, so we can ensure that healthcare is more affordable and accessible for all Americans.

We want to thank the witnesses that are here today. Welcome to you. We look forward to hearing your testimony. And now I would like to recognize Dr. Burgess, the ranking member of the Subcommittee on Health, for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Chairwoman Eshoo.

Let me just take a moment to congratulate you. As you are quickly finding out, you now occupy the most important sub-

committee chair in the entire United States House of Representatives, and I know this from firsthand experience.

We were the most active subcommittee in the United States House of Representatives in the last Congress. Hundreds of hours in hearings on health policy, and certainly look forward to that continuing through this term as well.

I want to thank our witnesses all for joining us this morning. We are here to discuss the issue of protecting access to healthcare for individuals with preexisting medical conditions in addition to the *Texas* v. *Azar* case.

So I think you heard the president say this last night in the State of the Union Address. There is broad bipartisan support for providing protections for patients with preexisting conditions.

I am glad we are holding our first hearing of the year. It is the end of the first week of February. So it is high time that we do this. It is unfortunate we are having a hearing that actually doesn't move toward the development of any policies that actually would improve healthcare for Americans.

To that effect, there are numerous options that you could bring before us that could moot the *Texas* v. *Azar* case. But the subcommittee apparently has chosen not to do so. For example, the bill to repeal the individual mandate is one that I have introduced previously.

You can join me on that effort, and if the individual mandate were repealed the case would probably not exist.

You could reestablish the tax in the individual mandate, which would certainly be your right to do so and, again, that would remove most of the argument for the court case as it exists today.

You know, I hear from constituents in north Texas concerned about not having access to affordable healthcare. In the district that I represent, because of the phenomenon known as silver loading, as the benchmark silver plans' premiums continue to increase, well, if you are getting a subsidy—what, me worry? No problem—I got a subsidy so I am doing OK.

But in the district that I represent, a schoolteacher and a policeman couple with two children are going to be covered in the individual market, and they are going to be outside the subsidy window.

So they buy a bronze plan because, like everybody, they buy on price, so that is the least expensive thing that is available to them, and then they are scared to death that they will have to use it because the deductible is so high.

If you get a kidney stone in the middle of the night and, guess what, that $4,500 emergency room bill is all yours. So I take meetings with families who are suffering from high healthcare and prescription drugs costs, and unfortunately we are not doing anything to address that today.

We could be using this time to discuss something upon—to develop policies to help those individuals and families. But, again, we are discussing something upon which we all agreed, but we are taking no substantive action to address.

Look, if you believe in Medicare for All, if you believe in a single-payer, Government-run, one-size-fits-all health system, let us have

a hearing right here in this subcommittee. We are the authorizing committee. That is our job.

Instead, we have the House Budget Committee holding those hearings, and Democrats on that committee are introducing legislation. But these bills belong in the jurisdiction of the Energy and Commerce Committee, and yet we have not scheduled a hearing to discuss this agenda.

Do I agree with the policy or think it would be a good idea for the American people to have Medicare for All or one-size-fits-all health plans? No, I do not, and I would gladly engage in a meaningful dialogue about what such a policy would mean for the American people.

Single-payer healthcare would be another failed attempt at a one-size-fits-all approach. Americans are all different, and a universal healthcare plan that does not meet the varying needs of each and every individual at different stages of their life will probably not be successful.

Today, we should be focusing on the parts of the health insurance market that are working for Americans. Seventy-one percent of Americans are satisfied with employer-sponsored health insurance, which provides robust protections for individuals with preexisting conditions.

Quite simply, the success of employer-sponsored insurance markets—it is not worth wiping that out with the single-payer healthcare policy. Yet, the bill that was introduced last term, that is exactly what it did.

But today, there are a greater percentage of Americans in employer health coverage than at any time since the year 2000.

Since President Trump took office, the number of Americans in employer health coverage has increased by over 2½ million. Given that the United States economy added more than 300,000 jobs in January, the number of individuals and families covered by employer-sponsored plans is likely even greater still.

Instead of building upon the success of our existing health insurance framework, radical single-payer, Government-run Medicare would tear it down. It would eliminate the employer-sponsored health insurance, private health insurance, Indian health insurance, and make inroads against taking away the VA.

Again, I appreciate that we have organized and we are holding our first hearing. I believe we could be using our time much more productively. There is bipartisan support for protecting patients with preexisting conditions. I certainly look forward to hearing the testimony of our witnesses.

Thank you, I yield back.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Good morning, everyone, and thank you for joining us this morning for our first Health Subcommittee hearing of the 116th Congress. I would like to take a moment to congratulate our new Chair, Anna Eshoo. I look forward to partnering with you throughout this Congress.

Today, we are here to discuss the issue of protecting access to healthcare for individuals with pre-existing medical conditions in addition to the *Texas* v. *U.S.* court case. Let me be clear: This is an issue for which there is broad bipartisan support.

While I am glad that we are finally holding our first hearing of the year, I am disappointed that we are holding a passive hearing that doesn't move toward the development of any policies to improve healthcare for Americans. To that effect, there are numerous options that you could bring before us that could moot the *Texas* v. *U.S.* case, but you have chosen not to do so.

My constituents in North Texas are consistently concerned about not having access to affordable healthcare. In my district, that is the policeman and the schoolteacher with two children who have a bronze plan and cannot afford their high deductible. I take countless meetings with families suffering from high healthcare and prescription drug costs, but unfortunately that's not why you've convened us here today. We could be using this valuable time to develop policies to help those individuals and families, yet we are here discussing something upon which we all agree but are taking no substantive action to address.

If you believe in Medicare for All, a single-payer, Government-run, "one-size-fits-all" healthcare system, we should have a hearing on it right here in this subcommittee. The House Budget Committee and others are having hearings on this, and Democrats are introducing legislation. These bills belong in the jurisdiction of Energy and Commerce, and yet we have not scheduled a hearing to discuss this agenda. Do I agree with the policy or think it would be good for the American people? No, I do not; however, I would gladly engage in a meaningful dialogue about what such a policy would mean for the American people.

Single-payer healthcare would be another failed attempt at a one-size-fits-all approach to healthcare. Americans are all different and a universal healthcare plan will not meet the varying needs of each and every individual. Single-payer is not one-size-fits-all, it is really one-size-fits-no-one.

Today, we should be focusing on the parts of the health insurance market that are working for Americans. For example, 71 percent of Americans are satisfied with their employer-sponsored health insurance, which provides robust protections for individuals with preexisting conditions. Quite simply, the success of the employer-sponsored insurance market is not worth wiping out with single-payer healthcare. In fact, today there is a greater percentage of Americans in employer health coverage than at any time since 2000.

Since President Trump took office, the number of Americans in employer health coverage has increased by more than 2.5 million. Given that the United States economy added more than 300,000 jobs in January, the number of individuals and families covered by employer-sponsored plans is likely even greater.

Instead of building upon the successes of our existing health insurance framework, radical, single-payer, Government-run Medicare for All policy would tear it down. It would eliminate employer-sponsored health insurance, private insurance, the Indian Health Service, and Medicaid and CHIP, and pave the road to the elimination of the VA. Existing Medicare beneficiaries would not be exempt from harm, as the policy would raid the Medicare Trust Fund, which is already slated to go bankrupt in 2026.

Again, while I appreciate that we have organized and are holding our first hearing, I believe that we could be using our time much more productively. There is bipartisan support for protecting individuals with preexisting conditions, and I look forward to future hearings where we can have substantive, bipartisan policy-based discussions. With that, I yield back.

Ms. ESHOO. I thank the ranking member, and let me just add a few points. You raised the issue of employer-sponsored healthcare. Our employer is the Federal Government, and we are covered by the Affordable Care Act.

Number two, we on our side support universal coverage, and so—but what the committee is going to be taking up is, and you pointed out some of the chinks in the armor of the Affordable Care Act—we want to strengthen it, and what you described relative to your constituents certainly applies to many of us on our side as well. So we plan to examine that, and we will.

Mr. BURGESS. Will the gentlelady yield on the point on employer coverage for Members of Congress?

Ms. ESHOO. Mm-hmm.

Mr. BURGESS. I actually rejected the special deal that Members of Congress got several years ago when we were required to take

insurance under the Affordable Care Act and we all were required to join the DC exchange.

But we were given a large tax-free monthly subsidy to walk into that exchange. I thought that was illegal under the law. I did not take that. I bought a bronze plan—an unsubsidized bronze plan at healthcare.gov, the most miserable experience I have ever been through in my life.

And just like constituents in my district, I was scared to use my health insurance because the deductible was so high.

I yield back.

Ms. ESHOO. I thank the gentleman. It would be interesting to see how many Members have accepted the ACA, they and their families being covered by it.

And now I would like to recognize the chairman of the full committee, Mr. Pallone, who requested that this hearing be the first one to be taken up by the subcommittee—the *Texas* law case—and I call on the gentleman to make his statement.

Good morning to you.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Madam Chair, and thank you for all you have done over the years to help people get health insurance, to expand insurance, to address the price of prescription drugs and so many other things, and I am glad to see you in the chair of this subcommittee hearing.

Now, I was going to try to be nice today. But after I listened to Mr. Burgess, I can't be. You know, and I am sure this is—he is going to see this as personal, but I don't mean it that way.

But I just have to speak out, Mr. Burgess. Look, you were the chairman of this subcommittee the whole time that the Republicans tried unsuccessfully to repeal the Affordable Care Act.

I have had so many meetings where I saw you come in and take out your copy of the hearings on the Affordable Care Act and repeatedly tell us that the Affordable Care Act was bad law, terrible law, it needs to be repealed.

I saw no effort at all in the time that you were the chairman to try to work towards solutions in improving the Affordable Care Act. What I saw were constant efforts to join with President Trump to sabotage it.

And the reason that this hearing is important—because the ultimate sabotage would be to have the courts rule that the ACA is unconstitutional, which is totally bogus.

You found this, you know, right-wing judge somewhere in Texas—I love the State of Texas, but I don't know where you found him—and you did forum shopping to find him, and we know his opinion is going to be overturned.

But we still had to join a suit to say that his opinion was wrong and it wasn't based in any facts or any real analysis of the Constitution, and the reason we are having this hearing today is because we need to make the point that the Republicans are still trying to repeal the Affordable Care Act.

They are not looking to work with us to improve it. There were many opportunities when the senators—Senator Lamar Alexander and others—were trying to do things to improve the Affordable Care Act, to deal with the cost sharing that was thrown out by the president, to deal with reinsurance to make the market more competitive, and at no point was that brought up in this subcommittee under your leadership.

You know, you talk about the employer-sponsored system. Sure, we all agree 60 percent of the people get their insurance through their employer.

But those antidiscrimination provisions that you said are protected with employer-sponsored plans they came through actions of the Democrats and the Affordable Care Act that said that you could not discriminate—that you could not discriminate for preexisting conditions, that you had to have an essential benefit package. Those are a consequence of the ACA.

So don't tell us that, you know, somehow that appeared miraculously in the private insurance market. That is not true at all.

Talk about Medicaid expansion, your State and so many other Republican States blocked Medicaid expansion. So there is so many people now that could have insurance that don't because they refuse to do it for ideological reasons.

You mentioned the Indian Health Service. I love the fact that the gentleman from Oklahoma had that Indian healthcare task force. Thank you. I appreciate that.

But I asked so many times in this subcommittee to have a hearing on the Indian Health Care Improvement Act which, again, was in the Affordable Care Act, otherwise it would never have passed, and that never happened.

We will do that. But talk about the Indian Health service—you did nothing to improve the Indian Health Service. And I am not suggesting that wasn't true for the gentleman of Oklahoma. He was very sympathetic.

But, in general, we did not have the hearing and we would not have had the Indian Health Service Improvement Act but for the ACA.

And finally, Medicare for All—who are you kidding? You are saying to us that you want to repeal the ACA and then you want to have a hearing on Medicare for All. You sent me a letter asking for a hearing on Medicare for All.

When does a Member of Congress, let alone the chairman or the ranking member, I guess, in this case, ask for a hearing on something that they oppose? I ask for hearings on things that I wanted to happen, like climate change and addressing climate change.

I don't ask for hearings on things that I oppose. I get a letter saying, "Oh, we should have a hearing on Medicare for All but, by the way, we are totally opposed to it. It is a terrible idea. It will destroy the country."

Oh, sure. We will have a hearing on something that you think is going to destroy the country. Now, don't get me wrong. We will address that issue. I am not suggesting we shouldn't.

But the cynicism of it all—the cynicism of coming here and suggesting that somehow you want—you have solutions? You have no

solutions. I am more than willing to work with you. I am sure that Chairman Eshoo is willing to as well.

But don't tell us that you had solutions. You did not, and you continue not to have solutions. And I am sorry to begin the day this way, but I have no choice after what you said. I mean, it is just not—it is just not—it is disingenuous.

Thank you, Madam Chairwoman.

Ms. ESHOO. Thank you.

And now I will recognize the ranking member. Good morning.

Mr. WALDEN. Good morning.

Ms. ESHOO. The ranking member of the full committee, my friend Mr. Walden.

Mr. WALDEN. Thank you, Madam Chair. Congratulations on taking over the subcommittee.

Ms. ESHOO. Thank you very much. I appreciate it.

Mr. WALDEN. I always enjoyed working with you on telecommunications issues, and I know you will do a fine job leading this subcommittee.

Ms. ESHOO. Thank you.

Mr. WALDEN. I look forward to working with you. As we—I cannot help but respond a bit.

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

Mr. WALDEN. I do wish we were meeting to pass bipartisan legislation and protect Americans with preexisting health conditions from losing their coverage, given the pending court case. And let me speak on behalf of Republicans because we fully support protecting Americans with preexisting conditions.

We have said this repeatedly, we have acted accordingly, and we mean it completely. We could and should inject certainty into the system by passing legislation to protect those with preexisting conditions, period.

On the opening day of the 116th Congress, House Republicans brought a powerful but simple measure to the floor that called on this body to legislate on what we all agree needs to be done, and that is to lock in protections for patients with preexisting conditions.

Unfortunately, that went down on a party-line vote. Our amendment was consistent with our long-held views with respect to the American Health Care Act, which our Democratic colleagues, frankly, in some cases, continue to misrepresent.

We provided protections for those with preexisting conditions under the AHCA. Insurance companies were prohibited from denying or not renewing coverage due to a preexisting condition, period.

Insurance companies were banned from rescinding coverage based on a preexisting condition, period. Insurance companies were banned from excluding benefits based on a preexisting condition, period.

Insurance companies were prevented from raising premiums on individuals with preexisting conditions who maintain continuous coverage, period.

The fact is, this is something we all agree on, and we should and could work together to expeditiously guarantee preexisting condi-

tion protections for all Americans and do so in a manner that can withstand judicial scrutiny. That is something I think we could find common ground on.

And while a status check on the ACA lawsuit is interesting and important, the ruling has been stayed. The attorneys general across the country have filed appeals. Speaker Pelosi has moved to intervene in the case I think three times and Americans' premiums and coverage for this year are not affected.

But what really does affect American consumers is out-of-control costs of healthcare. That is what they would like Congress to focus on and something I think we need to tackle as well.

The fact of the matter is that for too many Americans health insurance coverage exists solely on paper because healthcare costs and these new high deductibles are putting family budgets in peril.

When the Affordable Care Act passed, Democrats promised people that their insurance premiums would go down $2,500. Unfortunately, the exact opposite has occurred for many Americans, and not only have premiums gone up, not down, but think of what out-of-pocket costs have done. They have skyrocketed.

The latest solution from my friends on the other side of the aisle is some sort of Medicare for All proposal. And yes, we did ask for a hearing on it because I think it's something that Democrats ran on, believe in fully, and we should take time to understand it.

We know this plan would take away private health insurance from more than 150 million Americans. We are told it would end Medicare as we know it and would rack up more than $32 trillion in costs, not to mention delays in accessing health services.

So, Madam Chairwoman, other committees in this body have announced plans to have hearings on Medicare for All. Speaker Pelosi has said she is supportive of holding hearings on this plan, and Madam Chairwoman, I think I read you yourself said such hearings would be important to have.

A majority of House Democrats supported Medicare for All in the last Congress. In fact, two-thirds of the committee—Democrats' 20 Members, 11 whom are on this subcommittee—have cosponsored the plan.

I think it is important for the American people to fully understand what this huge new Government intervention to healthcare means for consumers if it were to become law.

Yesterday, Dr. Burgess and I did send you and Chairman Pallone a letter asking for a hearing on Medicare for All and we think, as the committee of primary jurisdiction, that just makes sense.

So as you're organizing your agenda for the future, we thought it was important to put that on it. The American people need to fully understand how Medicare for All is not Medicare at all but actually just Government-run, single-payer healthcare.

They need to know about the $32 trillion price tag for such a plan and how you pay for it. They need to know that it ends employer-sponsored healthcare, at least some versions of it do, forcing the 158 million Americans who get their health insurance through their job or through their union into a one-size-fits-all, Government-run plan.

So if you like waiting in line at the DMV, wait until the Government completely takes over healthcare. Seniors need to fully under-

stand how this plan will affect the Medicare trust fund that they've paid into their entire lives and the impacts on access to their care.

Our Tribes need to understand how this plan could impact the Indian Health Service and our veterans deserve to know how this plan could pave the way to closing VA health services.

So the question is, when will we see the bill and when we will have a hearing on the legislation? Meanwhile, we need to work together to help States stabilize health markets damaged by the ACA.

Cut out-of-pocket costs, promote access to preventive services, encourage participation in private health insurance, and increase the number of options available through the market.

And I want to thank Mr. Pallone for raising the issue involving Senator Lamar Alexander. He and I and Susan Collins worked very well together to try and come up with a plan we could move through to deal with some of these issues.

Unfortunately, we could not get that done. So let us work together to lock in preexisting condition protections. Let's tackle the ever-rising healthcare costs and help our States offer consumers more affordable health insurance, and if you are going to move forward on a Medicare for All plan, we would like to make sure we have a hearing on it before the bill moves forward.

So with that, Madam Chair, thank you and congratulations again, and I yield back.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Good morning, Madam Chair. Congratulations on taking over the helm of this very important subcommittee. I only wish we were meeting today to pass bipartisan legislation to protect Americans with preexisting health conditions from losing coverage. Let me speak on behalf of Republicans: We fully support protecting Americans with preexisting conditions. We've said this repeatedly, we we've acted accordingly, and we mean it completely. We could-and should-inject certainty into the system by passing legislation to protect those with preexisting conditions.

On the opening day of the 116th Congress, House Republicans brought a powerful but simple measure to the floor that called on this body to legislate on what we all agree needs to be done—locking in protections for patients with preexisting conditions. Unfortunately, House Democrats voted it down.

Our amendment was consistent with our long-held views. With respect to the American Health Care Act, which our Democratic colleagues continue to mispresent, we provided protections for those with preexisting conditions. Under the AHCA:

- Insurance companies were prohibited from denying or not renewing coverage due to a preexisting condition. Period.
- Insurance companies were banned from rescinding coverage based on a preexisting condition. Period.
- Insurance companies were banned from excluding benefits based on a preexisting condition. Period.
- Insurance companies were prevented from raising premiums on individuals with preexisting conditions who maintain continuous coverage. Period.

The fact is, we agree on this issue. And we can work together expeditiously to guarantee preexisting condition protections for all Americans and do so in manner that can withstand judicial scrutiny.

And while a status check on the ACA lawsuit is interesting, the ruling has been stayed, Attorneys general across the country have filed appeals, Speaker Pelosi has moved to intervene in the case, and Americans' premiums and coverage for this year are not affected.

But what really does affect American consumers is the out-of-control costs of healthcare. That's what they would like Congress to focus on. When will we tackle the high cost of healthcare?

The fact of the matter is that for too many Americans health insurance coverage exists solely on paper because healthcare costs and high deductibles are putting family budgets in peril. When the Affordable Care Act passed, Democrats promised people their insurance premiums would go down $2500. Unfortunately, the exact opposite has occurred for many Americans. And not only have premiums gone up-not down-but also out-of-pocket costs have skyrocketed.

The latest "solution" from the Democratic Party is a Government takeover of healthcare, called Medicare for All. We know that this plan would take away private health insurance from more than 150 million Americans, end Medicare as we know it, and rack up more than $32-trillion in costs, not to mention delays in accessing health services.

Madam Chairwoman, other committees in this body have announced plans to have hearings on Medicare for All. Speaker Pelosi has said she is supportive of holding hearings on this radical plan. Madam Chairwoman, in fact, you yourself called for such hearings.

A majority of House Democrats supported Medicare for All in the last Congress—in fact, two-thirds of committee Democrats, 20 Members, 11 of whom serve on the Health Subcommittee, cosponsored the plan.

I think it is important for the American people to fully understand what this huge, new, Government intervention into healthcare means for consumers. Yesterday, Dr. Burgess and I sent a letter to you and Chairman Pallone asking for a hearing on Medicare for All, as we are the committee with primary jurisdiction over healthcare issues.

The American people need to fully understand how Medicare for All is not Medicare at all, but actually just Government-run, single-payer healthcare. They need to know about the $32 trillion price tag for such a plan, and the tax increases necessary to pay for it. They need to know that it ends employer-sponsored healthcare, forcing the 158 million Americans who get their healthcare through their job or union into a one-size-fits-all, Government-run plan. If you like waiting in line at the DMV, wait until the Government completely takes over healthcare.

Seniors need to fully understand how this plan does away with the Medicare Trust Fund that they have paid into their entire lives, and the impacts on their access to care. Our tribes need to understand how this plan impacts the Indian Health Service, and our veterans deserve to know how this plan paves the way to closing the VA.

So the question is, When will we see the bill, and when will we have a hearing on the legislation?

Meanwhile, we need to work together to help States stabilize health markets damaged by the ACA, cut out-of-pocket costs, promote access to preventive services, encourage participation in private health insurance, and increase the number of options available through the market.

So let's work together to lock in preexisting condition protections, tackle ever-rising healthcare costs, and help our States offer consumers more affordable health insurance. And if Democrats must move forward on a complete Government takeover of healthcare, please pledge to give the American people a chance to read the bill so that we'll all know what's in it before we have to vote on it.

Ms. ESHOO. I thank the ranking member of the full committee for his remarks. Several parts of it I don't agree with, but I thank him nonetheless.

Now we will go to the witnesses and their opening statements. We will start from the left to Ms. Christen Linke Young, a fellow, USC–Brookings Schaeffer Initiative for Health Policy.

Welcome to you, and you have 5 minutes, and I think you know what the lights mean. The green light will be on, then the yellow light comes on, which means 1 minute left, and then the red light.

So I would like all the witnesses to stick to that so that we can get to our questions of you, expert as you are. So welcome to each one of you and thank you, and you are recognized.

STATEMENTS OF CHRISTEN LINKE YOUNG, FELLOW, USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY; AVIK S. A. ROY, PRESIDENT, THE FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY; ELENA HUNG, CO-FOUNDER, LITTLE LOBBYISTS; THOMAS P. MILLER, RESIDENT FELLOW IN HEALTH POLICY STUDIES, AMERICAN ENTERPRISE INSTITUTE; SIMON LAZARUS, CONSTITUTIONAL LAWYER AND WRITER

STATEMENT OF CHRISTEN LINKE YOUNG

Ms. YOUNG. Good morning, Chairwoman Eshoo, Ranking Member Burgess, members of the committee. Thank you for the opportunity to testify today.

I am Christen Linke Young, a fellow with the USC–Brookings Schaeffer Initiative on Health Policy. My testimony today reflects my personal views.

The Affordable Care Act has brought health coverage to millions of Americans. Since the law was passed, the uninsured rate has been cut nearly in half. The ACA's marketplaces are functioning well and offering millions of people comprehensive insurance.

Thirty-seven States have expanded Medicaid, and many of the remaining States are considering expansion proposals. Beyond its core coverage provisions, the ACA has become interwoven with the American healthcare system.

As just a few examples, the law put in place new consumer protections in employer-provided insurance, closed Medicare's prescription drug doughnut hole, changed Medicare reimbursement policies, reauthorized the Indian Health Service, authorized biosimilar drugs, and even required employers to provided space for nursing mothers.

One of the core goals of the ACA was to provide healthcare for Americans with preexisting conditions, and I would like to spend a few minutes discussing how the law achieves the objective.

By some estimates, as many as half of nonelderly Americans have a preexisting condition, and the protections the law offers to this group cannot be accomplished in a single provision or legislative proclamation.

Instead, it requires a variety of interlocking and complementary reforms threaded throughout the law. At the center are three critical reforms.

Consumers have a right to buy and renew a policy regardless of their health needs, have that policy cover needed care, and be charged the same price. Further, the ACA prohibits lifetime limits on care received and requires most insurers to cap copays and deductibles.

Crucially, the law ensures that insurance for the healthy and insurance for the sick are part of the single risk pool and it provides financial assistance tied to income to help make insurance affordable.

However, a recent lawsuit threatened this system of protections. In *Texas* v. *United States*, a group of States argue that changes made to the ACA's individual mandate in 2017 rendered that provision unconstitutional.

Therefore, they puzzlingly argue that the entire ACA should be invalidated, stripping away protections for people with preexisting conditions and everything else in the law.

The Trump administration's Department of Justice has agreed with the claim of a constitutional deficiency, and they further agree that central pillars of the preexisting condition protection should be eliminated.

But, unlike the States, DOJ argues that the weakened remainder of the law should be left to stand. Other scholars can discuss the weakness of this legal argument. I would like to discuss its impacts on the healthcare system.

DOJ's position, that the law's core protections for people with preexisting conditions should be removed, would leave Americans with health needs without a reliable way to access coverage in the individual market.

Insurers would be able to deny coverage and charge more based on health status. In many ways, the market would look like it did before the ACA. Components of the law would formally remain in place, but it is unclear how some of those provisions would continue to work.

The States' position would wreak even greater havoc and fully return us to the markets that predated the ACA. In addition to removing central protections for those with preexisting conditions, the financial assistance for families purchasing coverage, and the ACA's funding for Medicaid expansion would disappear.

The Congressional Budget Office has estimated the repeal of the ACA would result in as many as 24 million additional uninsured Americans, and similar results could be expected here.

In addition, consumer protections for employer-based coverage would be eliminated, changes to Medicare would be undone, the Indian Health Service would not be reauthorized, the FDA couldn't approve biosimilar drugs. Indeed, these are just some of the many and far-reaching effects of eliminating a law that is deeply integrated into our healthcare system.

Before I close, I would like to briefly note that *Texas* v. *United States* is not the only recent development that threatens Americans with preexisting conditions. Recent policy actions by the Trump administration also attempt to change the law in ways that undermine the ACA.

As just a few examples, guidance under Section 1332 of the ACA purports to let States weaken protections for those with health needs. Nationwide, efforts to promote short-term coverage in association health plans seek to give healthy people options not available to the sick and drive up costs for those with healthcare needs.

Additionally, new waivers in the Medicaid programs allows States to place administrative burdens in front of those trying to access care.

To summarize, the Affordable Care Act has resulted in significant coverage gains and meaningful protections for people with preexisting conditions. *Texas* v. *U.S.* threatens those advances and could take us back to the pre-ACA individual market where a person's health status was a barrier to coverage and care.

The lawsuit would also damage other healthcare policies, and this litigation coincides with administrative attempts to undermine the ACA's protections for people with preexisting conditions.

Thank you.

[The prepared statement of Ms. Young follows:]

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Testimony of Christen Linke Young, J.D.
Fellow, USC-Brookings Schaeffer Initiative on Health Policy

U.S. House of Representatives
Committee on Energy & Commerce Subcommittee on Health
Hearing on "*Texas v. U.S.*: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions"

February 6, 2019

Chairwoman Eshoo, Ranking Member Burgess, members of the committee, thank you for the opportunity to testify today. I am Christen Linke Young, a Fellow with the USC-Brookings Schaeffer Initiative on Health Policy. My research focuses on private insurance, access to coverage, and the intersection between state and federal policy making. I am honored to have the opportunity to speak with you today about recent developments in health policy and their impact on consumers with pre-existing conditions. My testimony this morning reflects my personal views and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

The Impact of the Affordable Care Act

The Affordable Care Act (ACA) has brought health coverage to millions of Americans. Since the law was passed in 2010, the uninsured rate has been cut nearly in half.[1] The ACA's Health Insurance Marketplaces are serving millions of consumers.[2] Insurance markets are functioning well and are offering people comprehensive insurance with robust consumer protections.[3]

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[1] *See, e.g.*, Kaiser Family Foundation, Key Facts About the Uninsured Population, December 7, 2018, https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

[2] *See, e.g.*, Center for Medicare & Medicaid Services, Final Weekly Enrollment Snapshot for the 2019 Enrollment Period, January 3, 2019, https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period; Center for Medicare & Medicaid Services, Effectuated Enrollment for the First Half of 2018, November 28, 2018, https://www.cms.gov/newsroom/fact-sheets/effectuated-enrollment-first-half-2018.

[3] *See* Matthew Fiedler, USC-Brookings Schaeffer Initiative for Health Policy, How Would Individual Market Premiums Change in 2019 in a Stable Policy Environment?, August 2018, https://www.brookings.edu/wp-content/uploads/2018/08/Individual-Market-Premium-Outlook-20191.pdf.

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Thirty-seven states, including DC, have expanded Medicaid,[4] and many of the remaining states are considering expansion proposals.

Beyond its core coverage expansion provisions, the ACA has become interwoven with the American health care system. The law included a variety of new standards for employer-provided health insurance to improve workers' coverage. It enhanced Medicare benefits by closing the prescription drug "donut hole" and expanding coverage of preventive services, and made many changes to reimbursement that are now baked into the way Medicare pays providers and issuers. It created new tools for tackling fraud and abuse in federal health care programs. And to highlight a few of the many additional provisions, the ACA funded a variety of public health and health care workforce programs, reauthorized the Indian Health Service, created a pathway for the approval of biosimilar equivalents for biologic drugs, and required employers to provide space for nursing mothers to express breastmilk.

The ACA and Americans with Pre-Existing Conditions

One of the core goals of the ACA was to provide health care coverage for Americans with pre-existing conditions (many of whom had been denied coverage, charged more, or had their condition excluded from coverage prior to the ACA's passage), and I'd like to begin by discussing how the law achieves that objective. By some estimates, as many as half of non-elderly Americans have a pre-existing health condition,[5] and the protections the law offers to this group cannot be accomplished in a single provision or simple legislative proclamation. Instead, it requires a variety of interlocking and complementary reforms threaded throughout the law.

At the center are three critical protections: consumers have a right to 1) buy and renew a policy regardless of their health care needs; 2) have that policy cover the care they need, including care

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[4] Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, January 23, 2019, https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

[5] Emily Gee, Center for American Progress, Number of Americans with Pre-Existing Conditions by Congressional District, April 5, 2017, https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/. *See also* Gary Claxton et al, Kaiser Family Foundation, Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA, December 12, 2016, https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca (estimating 27 percent of non-elderly Americans have a pre-existing condition).

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associated with their pre-existing conditions as well as new conditions; and 3) be charged the same price regardless of health status. These protections work together and are the law's essential starting point, but the law takes necessary additional steps. The ACA also prohibits annual and lifetime limits on the dollar value of care received and requires most insurers to impose a maximum out-of-pocket limit on copays, deductibles, and other cost-sharing. Crucially, the law ensures that insurance for the healthy and insurance for the sick are part of a single risk pool. With these critical consumer protections, robust risk adjustment is essential for enabling insurance markets to pool and share risk. Further, the law provides financial assistance tied to income to help make health insurance more affordable to Americans with pre-existing conditions at all income levels.

***Texas v. U.S.* and the ACA**

However, a recent lawsuit threatens the system of protections put in place under the ACA. In *Texas v. United States*, a group of state attorneys general argue that changes made to the ACA's individual mandate in 2017 legislation render that provision in the law unconstitutional. Therefore, because of the supposed constitutional problem with a single provision, they puzzlingly argue that the entire ACA should be invalidated – stripping away its protections for people with pre-existing conditions and everything else included in the law. The Trump Administration's Department of Justice has agreed with the claim of a constitutional deficiency, and they further agree that central pillars of the pre-existing condition protections – the ability to buy and renew a plan and not be charged more – should be eliminated. But, unlike the state attorneys general, the Department of Justice argues that the weakened remainder of the law should be left to stand.

Other scholars can discuss the weakness of this legal argument; I'd like to discuss its impact on the health care system. The position articulated by the Department of Justice – that the law's core protections for people with pre-existing conditions should be removed – would leave Americans with health needs without a reliable way to access coverage in the individual market. Insurers would be able to deny coverage and charge more based on enrollees' health status. In many ways, the market would look like the pre-ACA individual market. Some components of the ACA would formally remain in place, but it is unclear how that would work in practice. With individuals required to complete medical underwriting screens and prices varying for every consumer, those broader ACA policies – like financial assistance, risk adjustment, and a standardized Marketplace – would struggle.

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The position of the state attorneys general would wreak even greater havoc and fully return us to the markets that predated the ACA. In addition to removing central protections for those with pre-existing conditions, the financial assistance for individuals and families purchasing coverage and the ACA's funding for states' Medicaid expansions would also disappear. The Congressional Budget Office has estimated that repeal of the ACA would result in as many as 24 million additional uninsured Americans,[6] and similar results could be expected here.

The impact would also extend far beyond Medicaid and the individual market. The ACA's consumer protections for employer-based coverage, affecting more than 150 million Americans,[7] would be eliminated. The ACA's changes to Medicare would be undone, reinstating copays on preventive services and re-opening the prescription drug "donut hole." It would also create major confusion in Medicare payment, as the ACA policies that are today fully integrated into the Medicare payment rules would suddenly lack a legislative basis. The reauthorization of the Indian Health Service would no longer be in force. The FDA would not be authorized to approve the sale of biosimilar versions of biologic drugs, needlessly holding back new drugs that would lower costs. Indeed, these are just some of the many and far-reaching effects of suddenly eliminating a law that is deeply integrated into the health care system nearly nine years after its passage.

Other Concerns for Americans with Pre-Existing Conditions

Before I close, I would like to briefly note that *Texas v. United States* is not the only recent development that threatens protections for Americans with pre-existing conditions. Recent policy actions by the federal Department of Health and Human Services also attempt to change the law in ways that would undermine the ACA's protections.

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[6] Congressional Budget Office, Budgetary and Economic Effects of Repealing the Affordable Care Act, June 19, 2015 https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf. *See also* Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables From CBO's March 2016 Baseline, March 2016, https://www.cbo.gov/sites/default/files/recurringdata/51298-2016-03-healthinsurance.pdf.

[7] *See, e.g.,* Kaiser Family Foundation, Health Insurance Coverage of the Total Population, 2017, https://www.kff.org/other/state-indicator/total-population/.

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As just a few examples: Guidance addressing State Innovation Waivers under Section 1332 of the ACA purports to let states weaken the ACA's protections. It attempts to permit states to provide less comprehensive coverage that would not meet the needs of those with pre-existing conditions, and to reduce the number of state residents with high quality coverage. Nationwide, efforts to promote short-term health coverage and Association Health Plans seek to fragment the risk pool so that healthy people have options that are not available to the sick, thus raising the cost of coverage for the sick. Additionally, new waivers in the Medicaid program allow states to place administrative burdens in front of those trying to access care, which can pose distinct barriers for those with disabilities or significant health needs.

Conclusion

To summarize, the Affordable Care Act has resulted in significant coverage gains and meaningful protections for people with pre-existing conditions. *Texas v. United States* threatens those protections and could take us back to the pre-ACA individual market – a time when a person's health status was a barrier to coverage and care. The lawsuit would also damage the broader health care policy environment, and this litigation coincides with other attempts to undermine the ACA's protections for people with pre-existing conditions.

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Ms. ESHOO. Thank you very much.

Next, Mr. Avik Roy, president of the Foundation for Research and Equal Opportunity. Welcome.

STATEMENT OF AVIK S. A. ROY

Mr. ROY. Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee of the House Energy and Commerce Committee, thanks for inviting me to speak with you today.

I am Avik Roy and I am the president of the Foundation for Research on Equal Opportunity, a nonpartisan nonprofit think tank focussed on expanding economic opportunity to those who least have it.

When we launched in 2016, our first white paper showed how universal coverage done the right way can advance both the progressive and conservative values at the same time, expanding access while reducing Federal spending and burdensome regulations.

In my oral remarks, I am going to focus on a core problem that, respectfully, Congress has failed to solve: how to protect Americans with preexisting conditions while also ensuring that every American has access to affordable health insurance.

Thirty-two million U.S. residents go without coverage today. Fewer than half of those eligible for subsidies in the ACA exchanges have enrolled in ACA-based coverage.

This failure is the result of the flawed theory first articulated by MIT economist Jonathan Gruber underlying Title 1 of the Affordable Care Act—that if Congress requires that insurers offer coverage to those with preexisting conditions and if Congress forces insurers to overcharge the healthy to undercharge the sick, Congress must also enact an individual mandate to prevent people from jumping in and out of the insurance market.

We should all know by now that Professor Gruber is not omniscient. After all, in 2009, Gruber said, what we know for sure about the ACA is that it will, quote, "lower the cost of buying nongroup health insurance."

In reality, premiums have more than doubled in the ACA's first 4 years, and the ACA subsidies only offset those increases for those with incomes near the poverty line.

There are two flaws with Gruber's theory, sometimes called the three-legged stool theory. First, the two ACA provisions that have had the largest impact on premiums have nothing to do with preexisting conditions.

Second, the ACA's individual mandate was so weak with so many loopholes that its impact on the market was negligible. Guaranteeing offers of coverage for those with preexisting conditions has no impact on premiums because the ACA limits the enrollment period for guaranteed issue plans to six weeks in the fall or winter.

The limited enrollment period, not the mandate, ensures that people can't game the system by dropping in and out. While community rating by health status does cause some adverse selection by overcharging healthy people who buy coverage, thereby discouraging healthy people from signing up, among enrollees of the same age this is not an actuarially significant problem.

The largest impact is from the ACA's 3-to-1 age bans which on their own double the cost of insurance for Americans in their 20s and 30s, forcing many to drop out of the market because younger people consume one-sixth of the healthcare that older people do.

In the court cases consolidated as *NFIB* v. *Sebelius*, President Obama's Solicitor General, Neal Katyal, repeatedly argued that if the individual mandate were ruled to be unconstitutional, much of the ACA should remain but that the ACA's guaranteed issue and health status community rating provisions, the ones that impact those with preexisting conditions, should also be struck from the law.

The Trump Justice Department has merely echoed this belief. Both administrations are more correct than the district judge in *Texas* v. *Azar*, who, in an egregious case of judicial activism, argued that the entirety of the ACA was inseparable from the mandate.

However, it is clear that both Justice Departments are also wrong. The zeroing out of the mandate penalty has not blown up the insurance market. Indeed, it has had no effect.

To be clear, it is not just ACA enthusiasts who have bought into Gruber's flawed theories. Many conservatives have as well. A number of conservative think tank scholars have argued that, because they oppose the individual mandate, we should also repeal the ACA's protections for those with preexisting conditions—that is, guaranteed issue and community rating by health status.

These scholars have argued that a better way to cover those with preexisting conditions is to place them in a separate insurance pool for high-risk individuals.

I want to state this very clearly: Those scholars are wrong. The most market-based approach for covering those with preexisting conditions is not to repeal the ACA's guaranteed issue and health status provisions but to preserve them and to integrate the principles of a high-risk pool into a single insurance market through reinsurance.

I have been pleased to see Republicans in Congress support legislation that would ensure the continuity of preexisting condition protections irrespective of the legal outcome in *Texas* v. *U.S.* I hope both parties can work together to achieve this.

Both parties can further improve the affordability of individual insurance by enacting a robust program of reinsurance and restoring 5-to-1 age bans.

On these and other matters, I look forward to working with all members of this committee both today and in the future to ensure that no American is forced into bankruptcy by high medical bills.

Thank you.

[The prepared statement of Mr. Roy follows:]

FREOPP.org
The Foundation *for* Research *on* Equal Opportunity

TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Committee on Energy & Commerce

TEXAS v. U.S.

Its Impacts on Americans With Pre-Existing Conditions

AVIK S. A. ROY

President
The Foundation for Research on Equal Opportunity

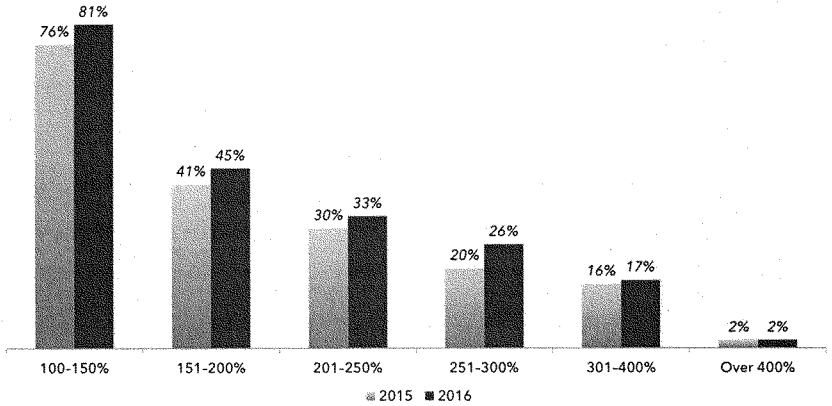
February 6, 2019

The Foundation for Research on Equal Opportunity (FREOPP) is a non-partisan, non-profit, 501(c)(3) organization dedicated to expanding economic opportunity to those who least have it. FREOPP does not take institutional positions on any issues. The views expressed in this testimony are solely those of the author.

INTRODUCTION

Ensuring that every American—rich or poor, healthy or sick—has access to affordable health insurance is one of the most important policy goals Congress could have. The Foundation for Research on Equal Opportunity has, since its founding, been an unwavering advocate of the central relationship between universal health insurance and equality of economic opportunity.

Figure 1. Percentage of Eligible Individuals in Exchange Plans, by Income
(% of Federal Poverty Level)

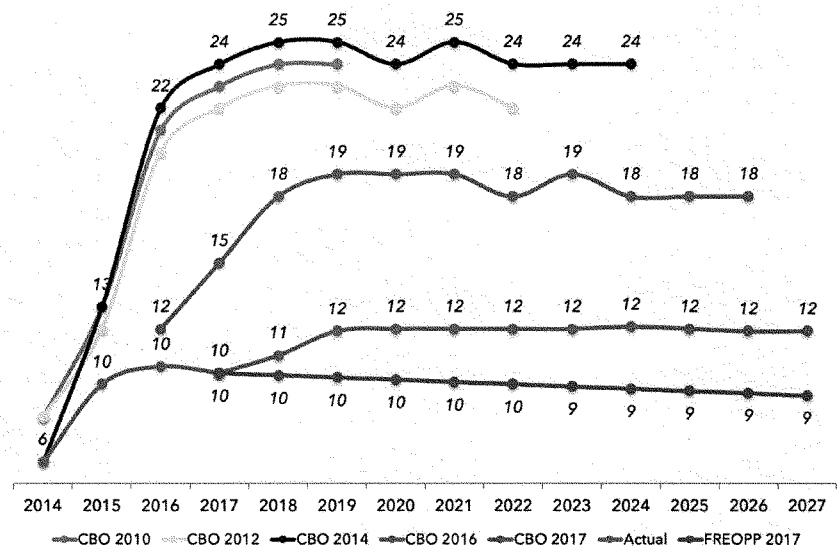


ACA premium subsidies are not sufficient to compensate for higher ACA gross premiums. The ACA's premium increases, driven by the law's extensive regulations of the individual insurance market, exceed the subsidies that most Americans are eligible for. As a result, as one ascends the income scale, net premiums are costlier today than they were prior to the debut of the exchanges in 2014. *(Sources: Avalere Health, HHS Assistant Secretary for Planning and Evaluation)*

It is widely known that the United States spends more than any other country in the world on health care. Indeed, the two most important problems with American health care stem from its high cost. The high cost of U.S. health care is the reason that tens of millions go without health insurance. In addition, the unsustainable trajectory of the federal deficit and debt are driven by growth in public spending on health care, a problem primarily driven by growth in the unit price of health care goods and services. If unsustainable public debt forces the United States to engage in aggressive fiscal austerity at some point in the future,

it will be those most dependent on public health expenditures—the poor, the elderly, and the vulnerable—who will have the most to lose.

Figure 2. CBO Exchange Enrollment Projections Over Time (Millions of Enrollees)



2018 enrollment was 15 million short of CBO's 2010 estimates. The Congressional Budget Office has significantly reduced its estimates of exchange enrollees. The CBO's March 2016 baseline remained optimistic that enrollment would increase substantially in 2017 and 2018, but that did not materialize. *(Source: Congressional Budget Office)*

The Affordable Care Act of 2010 sought to solve the first problem—tens of millions going without health insurance—by deliberately ignoring the high unit price of health care goods and services. Instead, the ACA sought to fund the cost of covering some uninsured Americans through three mechanisms: (1) raising taxes by $1.2 trillion over a decade; (2) reducing Medicare spending by $800 billion over a decade; and (3) overcharging uninsured Americans who are young and/or healthy.

The third approach—overcharging uninsured Americans who are young and/or healthy—is central to the policy concerns of the Committee on this occasion.

THE ACA'S 'THREE-LEGGED STOOL' HAS ALWAYS BEEN HIGHLY UNSTABLE

The Affordable Care Act's reforms of the individual market for health insurance—i.e., the market for those who purchase insurance on their own, and do not receive it from their employers, or from Medicare, Medicaid, or other federal programs—were based on a flawed understanding of the economics of health insurance.

Congress sought to enact two worthwhile and important reforms. The first was to require insurers in the individual market to offer coverage to everyone, irrespective of pre-existing conditions: what in insurance parlance is called *guaranteed issue.* The second was to require insurers to charge equal premiums to everyone, regardless of prior health status; i.e., to overcharge the healthy in order to undercharge the sick: what insurers call *community rating according to health status.*

Some advocates of the ACA argue—illogically—that these two reforms required the enactment of 2,000 pages of other reforms; that is, the Affordable Care Act in its entirety. But this illogical on its face. For example, as noted above, Congress sought to fund the Affordable Care Act in part by reducing Medicare spending by $800 billion over a decade; Congress could have enacted the ACA's Medicare provisions independently of whether or not the ACA included guaranteed issue and community rating according to health status in the individual market for health insurance—a market that, at the time, served less than 10 percent of the U.S. population.

The District Court ruling in *Texas v. Azar* adheres to the same indefensible logic as that of ACA supporters who argue that the law *in its entirety* is a necessary consequence of its provisions regarding pre-existing conditions. No credible economist or health policy expert believes this to be true.

A more reasonable argument is that certain other provisions of Title I of the ACA are connected to its guaranteed issue and health status community rating provisions. The theories of MIT economist Jonathan Gruber have been influential in this regard. Gruber, widely considered the "architect" of the ACA, has long argued that regulating the individual health insurance market should be thought of as a "three-legged stool," in which the three legs are:

- *Guaranteed issue* and *community rating by health status*, which overcharges healthy uninsured individuals;
- Forcing healthy people to buy costlier coverage with an *individual mandate*; and
- Distributing taxpayer-funded *subsidies* to those forced, by the individual mandate, to purchase otherwise unaffordable coverage.

Most relevant to *Texas v. Azar* is the theory that the ACA's *individual mandate*—its requirement that nearly everyone in America purchase health insurance, or face a financial penalty—is a necessary consequence of requiring that insurers offer coverage to everyone, regardless of preexisting conditions, and of the ACA's requirement that healthy uninsured individuals be overcharged for coverage in order to reduce premiums for those who are sick.

Gruber theorized that if individuals were guaranteed an offer of coverage, irrespective of their health status, they would only buy insurance when sick, increasing premiums for everyone else (because insurance premiums are calculated by taking the total health care claims of a given pool of individuals, divided by the number of people in the risk pool, plus administrative costs).

In addition, Gruber believed that because community rating by health status forces insurers to overcharge healthy enrollees in order to undercharge sick enrollees, under such a system many healthy individuals would choose to forego coverage rather than pay inflated prices. These individuals, he thought, could be forced back into the system with an individual mandate.

This "three-legged stool" formulation sounds reasonable in theory, but in the case of the ACA, has been unstable in practice. To abuse the analogy, the problem with the ACA is that the three "legs" of the stool are of different length and varying angles, making the "stool" impossible to sit upon.

The ACA's bevy of insurance regulations—including, but not limited to, guaranteed issue and community rating by health status—are the longest leg of the stool, as they more than doubled the average cost of individually-purchased health insurance from 2014 to 2018. Additional ACA provisions that drove up the cost of individually-purchased health insurance include *community rating by age*, which overcharges young people for coverage,[1] and *actuarial value* mandates, which force individuals to buy costlier coverage than they may need or want.[2]

The ACA's individual mandate was and is the shortest leg of the stool, because its penalties, even as originally enacted, were too low, and contained numerous exemptions. In addition, the Obama administration weakly enforced the mandate, effectively allowing healthy people to drop out of the market.[3]

The ACA's subsidies are the stool leg of medium length. The subsidies are robust enough to help many people whose incomes are near the Federal Poverty Level afford the ACA's costly insurance plans. But as those subsidies phase out as one goes up the income scale, fewer and fewer have enrolled. In March of 2010, on the eve of the ACA's passage in Congress, the Congressional Budget Office predicted that 25 million Americans would be enrolled in the ACA's exchanges. The actual number is more likely to be 10 or 11 million.[4]

The flaws in Professor Gruber's three-legged stool theory can be summarized quite simply. In 2009, in an interview with Ezra Klein, then of the *Washington Post*, Gruber said: "What we know for sure the bill will do is that it will lower the cost of buying non-group health insurance" before the impact of subsidies is considered.[5]

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[1] Roy A, "How Obamacare Dramatically Increases The Cost of Insurance for Young Workers." Forbes. 2012 Mar 22; https://www.forbes.com/sites/theapothecary/2012/03/22/how-obamacare-dramatically-increases-the-cost-of-insurance-for-young-workers/#690e4b317e46.

[2] Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep; https://freopp.docsend.com/view/utmr2i6.

[3] Roy A, "Obamacare's Dark Secret: The Individual Mandate is Too Weak." Forbes. 2012 Jul 9; https://www.forbes.com/sites/theapothecary/2012/07/09/obamacares-dark-secret-the-individual-mandate-is-too-weak/#6a4f97df6abf.

[4] Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. The Foundation for Research on Equal Opportunity. 2016 Sep; https://freopp.docsend.com/view/utmr2i6.

[5] Roy A, "Obamacare was built to fail." Vox.com. 2016 Oct 7, https://www.vox.com/the-big-idea/2016/10/7/13191250/obamacare-exchanges-crisis-arrogant-progressives.

THE SEVERABILITY OF THE INDIVIDUAL MANDATE FROM THE ACA

As noted above, in the cases that became consolidated before the Supreme Court as *NFIB v. Sebelius*, a key question that came up is whether or not the individual mandate is *severable* from the rest of the ACA. While the ACA contained no severability provision, long-standing judicial doctrine requires courts to act as surgically as possible in severing unconstitutional provisions from otherwise constitutional statutes.

In considering these issues as it related to the individual mandate, the Supreme Court relied on the statutory text of the ACA. Section 1501(a)(2)(I) of the ACA states, "if there were no requirement [to buy health insurance], many individuals would wait to purchase health insurance until they needed care...the requirement is *essential* to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." (Emphasis added.)

Congress, in other words, made clear its view that the individual mandate, guaranteed issue, and community rating by health status were intricately connected, and that while other parts of the ACA may indeed be severable from the individual mandate, these two provisions were not.

Neal Katyal, the U.S. Solicitor General under President Obama when *NFIB v. Sebelius* was argued before the Supreme Court, made exactly the same argument in oral arguments and briefs, and in media interviews. For example, in a March 2012 interview with National Public Radio, when asked if the individual mandate is severable from the rest of the ACA said,

> I mean, the law is 2,400 pages long and has all sorts of stuff that have nothing to do with the individual mandate, things like funding for abstinence education in classrooms and the like. So certainly a good part of the law could stand. I mean, the government's position in the case has been, well, most of the law could stand, but some of it has to go. If the individual mandate goes so, too, the government says, must the provisions that force insurers to insure everyone at a low cost, the so-called guaranteed issue and community rating provisions.[6]

From a factual standpoint, it is simply not correct that the individual mandate is necessary for the proper functioning of the ACA's policies meant to benefit those with pre-existing conditions, for several reasons.

First, the ACA's individual mandate is too weak. Its financial penalties, prior to the enactment of the Tax Cuts and Jobs Act, were too weak to dissuade healthy individuals from purchasing costly coverage. Many individuals were exempted from the mandate on income or affordability criteria. Still others were able to file for hardship exemptions. And the Obama administration only loosely enforced the mandate, for example by not requiring documentation demonstrating an actual hardship.

Second, the ACA specifies limited enrollment periods for the purchase of individual health insurance. Currently, individuals are given a six week period to purchase health insurance for the following year; if they do not, they are no longer eligible for the ACA's pre-existing condition protections. This provision has done far more to prevent gaming of the system than has the ACA's weak individual mandate.

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[6] Katyal N, "Defending the Affordable Care Act." National Public Radio. 2012 Mar 23; https://www.npr.org/2012/03/23/149222905/defending-the-affordable-care-act.

Third, contrary to the belief of some conservatives, skyrocketing premiums under the ACA are not a result of the ACA's protections of those with pre-existing conditions. Rather, they are the result of two other ACA regulations: the one that requires insurers to overcharge the young, called *community rating by age*, or *age bands*, and the one that eliminates low-premium plans with an *actuarial value* below 60 percent.

This is why the individual market reforms I have proposed would preserve guaranteed issue and community rating by health status, and also the TCJA's zeroing out of the mandate penalty, while reforming age bands and actuarial value requirements, and adding reinsurance, to strengthen the direct subsidy of sicker individual-market patients.

WHAT CONGRESS SHOULD DO NOW

In *Texas v. Azar*, the Trump administration's Department of Justice filed a memorandum that echoed the Obama administration's view. In the memorandum, Justice Department lawyers disagreed with the *Texas v. Azar* plaintiffs' claim that a finding that the individual mandate was unconstitutional necessitated the invalidation of the entirety of the ACA. Instead the lawyers wrote, if the Court found that the mandate was unconstitutional, "this Court should consider...entering a declaratory judgment that the ACA's provisions containing the individual mandate as well as the guaranteed-issue and community-rating requirements will all be invalid beginning on January 1, 2019." The DOJ lawyers also stated that "the remainder of the ACA, however, can stand despite the invalidation of these provisions."[7]

This uncontroversial statement—that the intent of Congress and the Obama administration was that the individual mandate and the guaranteed issue and community rating by health status provisions of the ACA be inextricably linked—has been mischaracterized as implying that the Trump administration opposes protecting Americans with pre-existing conditions. By contrast, President Trump has repeatedly expressed his insistence that any reforms or replacements of the ACA cover those with pre-existing conditions. After the District Court issued its opinion in *Texas v. Azar*, the White House issued a statement that "The Trump Administration looks forward to working with Congress on a bipartisan basis to continue to protect people with pre-existing conditions."

Similarly, after the ruling, I argued that Congress should pass a simple bill reiterating the requirements of guaranteed issue and community rating by health status in the individual market. By doing so, in the extremely unlikely event that the Supreme Court upholds the District Court opinion, Congress would ensure that those with pre-existing conditions remain protected.

I understand that a motion to produce such legislation was proposed by House Republicans during floor debate at the beginning of this Congress—one that would guarantee that no American could be denied coverage, or be charged higher premiums or cost sharing, as a result of a previous or current illness—and that the motion was defeated by the majority.

To me, this is a shame, as such legislation would ensure that Americans with pre-existing conditions would be protected whatever the courts decide. I hope that Congress will reconsider its position.

I have spent my entire career in public policy arguing that all policymakers—including Republicans and conservatives—should embrace the cause of universal coverage. America—the wealthiest country in the history of the world—spends more than enough to

[7] Federal defendants' memorandum in response to plaintiffs' application for preliminary injunction in *Texas v. Azar*.

cover everyone, if we do it the right way and at the right price. I look forward to working with members of both parties to achieve this goal.

Ms. ESHOO. Thank you very much, Mr. Roy.

You have testified here before, and we appreciate you being here again today. I would like to just suggest that, for the benefit of Members, that you get your testimony to us much earlier, all right?

Mr. ROY. I apologize.

Ms. ESHOO. Yes.

Mr. ROY. I was, of course, officially invited to testify before this committee on Monday. I had some personal and professional obligations that limited my ability to get the testimony in a timely fashion.

Ms. ESHOO. Yes.

Mr. ROY. I will be happy to brief any members of this committee or their staffs at another time.

Ms. ESHOO. Well, we thank you. I just—I have a bad habit, I read everything, and it wasn't there. So—but I heard today, and then we will all ask you our questions. Thank you.

The next witness is Ms. Hung, and she is the cofounder of Little Lobbyists. You are recognized for 5 minutes, and welcome.

STATEMENT OF ELENA HUNG

Ms. HUNG. Thank you. Good morning.

Thank you, Chairwoman, Ranking Member, and members of the subcommittee for the opportunity to tell my story and share my concerns with you today.

My name is Elena Hung, and I am a mom. I am a proud mom of an amazing 4-year-old. My daughter, Xiomara, is a happy child. She is kind and smart and funny and a little bit naughty. She is the greatest joy of my life.

She is at home right now, getting ready to go to school. She attends an inclusive special education pre-K program, and I asked her if she wanted to come here today. She said she wanted to go to school instead.

It has been a long road to this moment. Xiomara was born with chronic complex medical conditions that affect her airway, lungs, heart, and kidneys. She spent the first 5 months of her life in the neonatal intensive care unit.

She uses a tracheostomy tube to breathe and a ventilator for additional respiratory support. She relies on a feeding tube for all of her nutrition. She participates in weekly therapies to help her learn how to walk and talk. But I am thrilled to tell you that Xiomara is thriving today.

This past year was her best year yet healthwise, and ironically it was also when her access to healthcare has been the most threatened. I sit before you today because families like mine—families with medically complex children—are terrified of what this lawsuit may mean for our kids.

You see, our lives are already filled with uncertainty—uncertainty about diagnoses, uncertainty about the effects of medications and the outcomes of surgeries. The one certainty we have is the Affordable Care Act and the healthcare coverage protection it provides.

We don't know what Xiomara's future holds, but with the ACA's protections in place we know this: We know Xiomara's 10 pre-

existing conditions will be covered without penalty, even if we switch insurance plans or employers.

We know a ban on lifetime caps means that insurance companies cannot decide that her life isn't worth the cost and cut her off care just because she met some arbitrary dollar amount.

We know we won't have to worry about losing our home as a result of an unexpected hospitalization or emergency. We know Medicaid will provide the therapies and long-term services and supports that enable her independence.

I sit before you today on behalf of families like mine who fear that the only certainty we know could be taken away, pending the outcome of this lawsuit—this lawsuit that seeks to eliminate protections for people with preexisting conditions—and if that happens our children's lives will then depend on Congress where every so-called replacement plan proposed over the last 2 years has offered far less protection for our kids than the ACA does.

I sit here before you today on behalf of Isaac Crawley, who lost his insurance in 2010 after he met his lifetime limit just a few weeks after his first birthday but got it back after the ACA became law;

Myka Eilers, who was born with a preexisting congenital heart defect and was able to obtain health insurance again when her dad reopened his own business after being laid off;

Timmy Morrison, who spends part of his childhood in hospitals, both inpatient and outpatient, because his insurance plan covers what is essential to his care;

Claire Smith, who has a personal care attendant and is able to live at home with her family and be included in her community, thanks to Medicaid;

Simon Hatcher, who needs daily medications to prevent life-threatening seizures, medications which would cost over $6,000 a month without insurance;

Colton Prifogle, who passed away on Sunday and was able to spend his final days pain-free with dignity, surrounded by love, because of the hospice care he received.

These are my friends, my friends that I love. These are Xiomara's friends. This is our life. I cofounded the Little Lobbyists, this group of families with medically complex children, some of whom are here today, because these are stories that desperately need to be told and heard alongside the data and numbers and policy analysis.

There are children like Xiomara in every State. That's millions of children with preexisting conditions and disabilities across the country. I sit before you today on the eve of another trip to the Children's Hospital.

Tomorrow I will hold my daughter's hand as I walk her to the OR for her procedure, and as I have done every time before, I know I will drown in worry, as a mother does.

But the thing that has always given me comfort is knowing that my Government believes my daughter's life has value and that the cost of medical care she needs to survive and thrive should not financially bankrupt us. It is my plea for that to always be true.

Thank you.

[The prepared statement of Ms. Hung follows:]

Testimony of Elena Hung, Co-founder of Little Lobbyists
Hearing: Texas v. U.S.: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions
Subcommittee on Health (Committee on Energy and Commerce)
February 6, 2019

Good morning. Thank you for the opportunity to tell my story and share my concerns with you today.

My name is Elena Hung, and I am a mom. I'm a proud mom of an amazing 4 year old.

My daughter Xiomara is a happy child; she is kind and smart and funny, and a little bit naughty. She is the greatest joy of my life.

She is at home right now, getting ready to go to school. She attends an inclusive, special education Pre-K program. I asked her if she wanted to come with me today, and she said she wanted to go to school instead.

It has been a long road to this moment.

Xiomara was born with chronic, complex medical conditions affecting her airway, lungs, heart, and kidneys.

She spent the first five months of her life in the Neonatal Intensive Care Unit.

She uses a tracheostomy tube to breathe and a ventilator for additional respiratory support. She relies on a feeding tube for all of her nutrition.

She participates in weekly therapies to help her learn how to walk and talk.

I am thrilled to tell you that Xiomara is thriving today.

This past year was her best year yet, health-wise. Ironically, it was also when her access to health care has been the most threatened.

I sit before you today because families like mine -- families with medically complex children -- are terrified of what this lawsuit may mean for our kids.

You see, our lives are already filled with uncertainty -- uncertainty about diagnoses, uncertainty about the effects of medications and the outcomes of surgeries. The one certainty we have is the Affordable Care Act and the health care coverage protections it provides.

We don't know what Xiomara's future holds, but with the ACA's protections in place, we know this:

We know Xiomara's ten pre-existing conditions would be covered without penalty even if we switched insurance plans or employers.

We know a ban on lifetime caps means that insurance companies cannot decide her life isn't worth the cost and cut off her care just because she met some arbitrary dollar amount.

We know we won't have to worry about losing our home as a result of an unexpected hospitalization or emergency.

We know Medicaid will provide the therapies and long-term services and supports that enable her independence.

I sit before you today on behalf of families like mine who fear that the only certainty we know could be taken away pending the outcome of this lawsuit -- this lawsuit that seeks to eliminate protections for people with pre-existing conditions. And if that happens, our children's lives will then depend on Congress, where every so-called "replacement plan" proposed over the past two years has offered far less protection for our kids than the ACA does.

I sit before you today on behalf of:

Isaac Crawley, who lost his insurance in 2010 after he met his lifetime limit just a few weeks after his first birthday, but got it back after the ACA became law.

Myka Eilers, who was born with a pre-existing congenital heart defect and was able to obtain health insurance again when her dad opened his own business after being laid off.

Timmy Morrison, who spends part of his childhood in hospitals (both inpatient and outpatient) because his insurance plan covers what is essential to his care.

Claire Smith, who has a personal care attendant and is able to live at home with her family and be included in her community thanks to Medicaid.

Simon Hatcher, who needs daily medications to prevent life-threatening seizures -- medications which cost over $6,000 a month without insurance.

Colton Prifogle, who passed away on Sunday, was able to spend his final days pain-free, with dignity, surrounded by love, because of the hospice care he received.

These are my friends. These are Xiomara's friends. This is our life.

I co-founded the Little Lobbyists -- this group of families with medically complex children -- because these are stories that desperately need to be told and heard alongside the data and numbers and policy analysis.

There are children like Xiomara in every state -- that's millions of children with pre-existing conditions and disabilities across the country.

I sit here before you today on the eve of another trip to the children's hospital. Tomorrow, I will hold my daughter's hand as I walk her to the OR for her procedure. As I have done every time before, I know I will drown in worry (as a mother does), but the thing that has always given me comfort is knowing that my government believes my daughter's life has value and that the cost of the medical care she needs to survive and thrive should not financially bankrupt us. It is my plea for that to always be true.

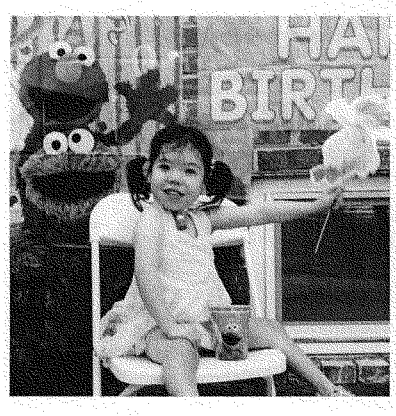
Thank you.

Elena Hung is Xiomara's mom, the co-founder of Little Lobbyists, and a national co-chair of Health Care Voter.

Xiomara, age 4

Submitted by Elena Hung, Mother
Maryland, Silver Spring

LITTLE LOBBYISTS



After spending the first five months of her life in the hospital, Xiomara is eager to explore the outside world. She loves going to the playground, library, school, and grocery store. She enjoys meeting new people and visiting new places. Most of all, she loves watching Sesame Street and playing with her big brother.

HEALTHCARE

Tracheobronchomalacia, Chronic Lung Disease, Pulmonary Hypertension, Chronic Kidney Disease, Global Development Delays.

Current Medical Needs

Xiomara uses a tracheostomy to breathe and a ventilator for additional respiratory support. She also relies on a feeding tube for all her nutrition needs.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Despite a healthy pregnancy and uncomplicated birth, Xiomara was born with multiple complex health issues affecting her airway, lungs, heart, and kidneys. Access to quality health care covered by our health insurance means Xiomara received the care she needed during an extended hospitalization in the Neonatal Intensive Care Unit (NICU) without resulting in financial ruin for our family. Medicaid helps provide the care and services that our private insurance does not, like skilled home nursing.

EDUCATION

How do school-based therapies, specialized education, and/or other accommodations help your child? What does the protection provided by Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child and your family?

Xiomara attends an inclusive special education program at the local public school. She receives therapies while at school including physical therapy, occupational therapy, and speech therapy. She is able to interact with her peers while receiving a quality education. A skilled nurse attends school with her to address her medical needs and ensure her safety. Xiomara loves going to school; she especially loves riding the school bus with her friends. It means the world that she is able to pursue her education in an inclusive setting.

COMMUNITY INCLUSION

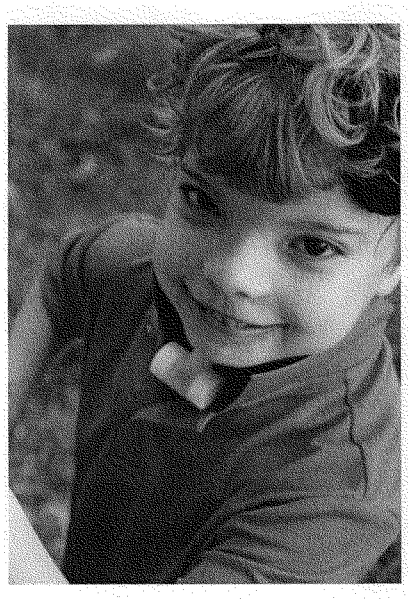
What disabilities impact your child's access to public spaces and services? How does the ADA improve their ability to be included in their community?

Xiomara uses a wheelchair; accessibility in public spaces ensure that she can participate alongside her family and friends. While there is still much work to be done, the ADA helps provide for her inclusion in the community via curb cuts, ramps, elevators, and other accessible means.

Timmy, age 7

Submitted by Michelle Morrison, Mother
Maryland

LITTLE LOBBYISTS



Timmy loves robots and pirates, plays on a local soccer team, and dreams of growing up to become a police officer, firefighter, "ambulance man," garbage collector, or robot repairman. He is exuberant, hilarious, creative, and one of the most resilient children you will ever meet.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Timmy has Opitz G/BBB syndrome, a genetic syndrome that is associated with airway abnormalities and several other medical conditions that affect his lungs, heart, liver, and some other areas.

Timmy breathes through a tracheotomy and has a feeding tube. He relies on several pieces of specialized medical equipment, including a ventilator (at night), a pulse oximeter, a nebulizer, a machine that provides intrapulmonary percussive ventilation, and an oxygen concentrator (when he's sick).

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

We have excellent employer-provided insurance that allows Timmy to thrive at home. That insurance keeps him healthy and provides for the medical supplies and equipment that he relies on; it also allows us to access out-of-state specialists, which is necessary because Timmy's condition is rather rare. Quality healthcare means that Timmy lives a fairly normal life; it also drastically reduces the cost of his medical care because we are able to avoid lengthy in-patient hospital stays.

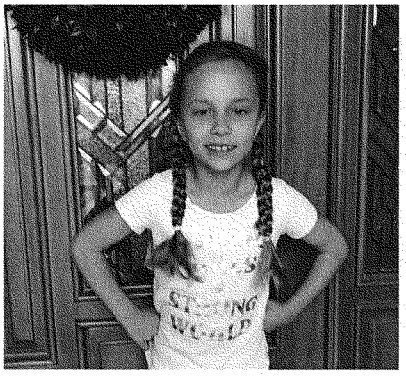
Timmy spent his first six months in the hospital. He was born just six days after the initial provisions of the Affordable Care Act kicked in. Among those was a ban on lifetime maximums. Our insurance policy at the time included a lifetime limit of $1,000,000, which Timmy would have reached by the time he was three months old. Because of the ACA, we didn't lose our insurance. Timmy was born in Ohio and was approved for the Medicaid waiver when we finally brought him home; however soon thereafter we moved to Maryland and have been on the Medicaid waiver waiting list since 2011. We are managing because my employer-sponsored insurance is very good. However, because our insurance does not cover daytime nursing (kids usually access this service through Medicaid), we cannot both work outside the home. If Medicaid cannot even manage current needs, what would happen if Medicaid cuts were implemented??

Timmy is thriving primarily because we have great insurance. Even with the ACA, our employment options are extremely limited because of Timmy's insurance needs. A loss of employment, a change in jobs, or even a decision on the part of my employer to reduce covered benefits would be devastating, both for Timmy's health and for our family's finances.

Myka, age 8

Submitted by Angela Eilers, Mother
California, 92887

LITTLE LOBBYISTS



Myka is a truly special girl. She is so kind, so loving and so curious. She LOVES to play with her friends more than anything. She plays softball, ice skates. She loves to read the Rebel Girl books with her mom. She always thinks of her brothers and their well being. She's a great student always doing her best in class. She's a good friend and a loving daughter.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Myka was diagnosed after birth with pulmonary stenosis, a Congenital Heart Defect. Just recently, she was diagnosed with a neurological disorder that includes a tumor on her optic nerve. Myka has had 2 open heart surgeries before her first birthday. The first surgery was 4 months after her birth and a 3 week NICU stay. Her first surgery also had her in the cardio thoracic intensive care unit for 2.5 weeks. Myka
goes to a cardiologist every year, a neurologist every 6 months, a neurological opthamologist every 6 months, has a MRI under general anesthesia every 6 months.

What health care coverage does your child have?

My husband owns his own company (thanks only to the ACA which allowed him to open his own business because we COULD secure healthcare on our own). We have a small business healthcare plan put together by a broker.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Access to quality healthcare means my child will always be monitored for her ailments. It means she will have access to the doctors who've been treating her literally her entire life keeping her alive.

Losing the protections of the ACA, specifically the pre-existing condition and no lifetime caps, mean my husband being able to continue to be self-employed. We don't have to worry about being denied healthcare for Myka. She will continue to have the same level of care she has always had. Her new diagnoses of a brain glioma is terrifying. Not having healthcare on top of it, would be devastating to our family.

Myka hit $500k in medical costs at 11 months old. Each MRI costs $15k. No lifetime caps means we can continue to receive the level of care she requires.

EDUCATION

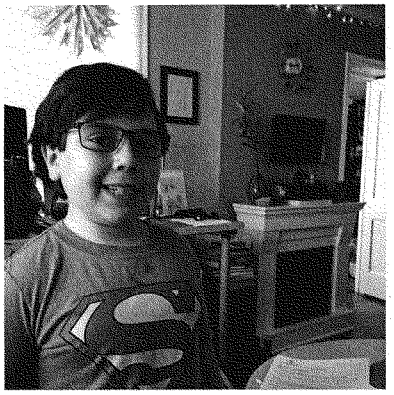
How do school-based therapies, specialized education, or other accommodations help your child? What does Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child?

Myka receives Speech therapy and will eventually require executive skill help.

Simon, age 12

Submitted by Laura Hatcher, Mother
Maryland, 21204

LITTLE LOBBYISTS



Simon loves his friends and family. He has a great sense of humor and the best laugh you've ever heard. Music, horseback riding therapy, everything Disney, the Muppets, and playing Mario Kart with his sister are some of his favorite things. He's won lots of medals in Baltimore's Special Olympics and his hugs are the best ever.

HEALTHCARE

Simon had a stroke in utero which resulted in brain damage creating physical and cognitive disabilities and a variety of medical conditions. He has hydrocephalus, cerebral palsy, a rare form of epilepsy (ESES), osteopenia, moderate vision and hearing loss, and Autism. Simon also has a unique genetic disorder we are trying to learn more about.

Current Medical Needs

Simon sees many specialists (some in different states) and frequently visits the hospital for testing and surgeries. He needs several prescription medicines, and has a shunt placed in his brain. Simon wears braces on his legs, uses a walker and a wheelchair. He needs to wear a pulse oximeter at night to alert to sudden life threatening seizures. Simon also participates in the Undiagnosed Diseases Program at NIH, to learn more about his condition and contribute to future research.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Access to affordable quality health care keeps Simon alive. Without it, we would lose this child we love so much. The ACA gives us peace of mind by ensuring Simon will ALWAYS have access to health care, despite his many pre existing conditions and the high cost of his care. We're on a waiting list for a Medicaid waiver and for many years have been looking forward to the opportunities and cost relief this will provide our family. In the future, as a person with extensive disabilities, Medicaid will be Simon's only option for health care and community inclusion. The quality of this program will directly impact the quality of Simon's life as an adult – maintaining its integrity is crucial. With so many people on waiting lists it's clear we need MORE funding for these critical programs, not less!

EDUCATION

How do school-based therapies, specialized education, and/or other accommodations help your child?

These things make it possible for Simon to learn and grow! They help him with education and everyday life.

What does the protection provided by Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child and your family?

Without these protections Simon would not be able to go to school, and would likely be institutionalized the way our country used to "care" for people with significant disabilities like my son. These legal protections make sure Simon is seen as a person first and has the same access to education as any other child.

COMMUNITY INCLUSION

What disabilities impact your child's access to public spaces and services? How does the ADA improve their ability to be included in their community?

Simon has mobility challenges as well as vision and hearing problems. Elevators, curb cuts, parking and even headphones make the world a manageable place. The ADA gives us the right to expect to access our community and enables our entire family to contribute and be included.

Adrien, age 12

Submitted by Gretchen Kirby, Mother
Massachusetts, 019133734

LITTLE LOBBYISTS

Adrien loves reading, learning about birds & writing stories with animals as the main characters. She's an "older" sister to her twin brother and younger sister who likes to help them find things they cannot and loves to help with laundry or any organizing.

Her favorite activities include writing & drawing. She & her brother & sister regularly write adventure stories in which they are the heroes of the story. She enjoys climbing, running around, and riding her bike while outdoors- and sledding in the winter.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Adrien is an ex-preemie (27 week, Twin A) with Broncho-Pulmonary Dysplasia (chronic lung disease of prematurity), airway obstruction requiring a Tracheostomy Tube for breathing, asthma, severe GERD, Delayed Gastric Emptying, Gastroparesis & GTube. She wears Ankle-Foot Orthotics to address tightness in her legs related to her traumatic early birth. She sees an army of specialists including: ENT/ORL, Pulmonary doctor, GI, a GI motility specialist, Neurologist, Cardiologist, Orthopedist, Physiatrist, Dermatologist & Opthamologist to address ongoing health concerns and for monitoring of conditions (hopefully) resolved.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Without access to healthcare, Adrien would probably suffer a quick decline in her health and have a significantly reduced quality of life. Access to quality healthcare allows her to have medications, specialized equipment, and adequate supplies for her to enjoy a pretty healthy life at home in her community. Because she was born at 27 weeks, as a twin, and currently has both a G-Tube and a Tracheostomy Tube to help her breathe, she has many medical conditions that would prevent her from accessing healthcare on her own later in life if the protections for people with pre-existing conditions and removal of 'lifetime limits' clauses were to be repealed. She has a rich & full life. She excels in ready, writing & science. She hopes to one day work in the field of healthcare and help other kids like herself. Without the equipment, supplies & medications being covered by Medicaid to help her thrive at home, her life would be limited to an inpatient hospital & her hopes & dreams, unreachable.

Louie, age X

Submitted by Kathleen Ide, Mother
Louisiana, 70065-4037

LITTLE LOBBYISTS

Louie is a bright, funny, sweet kid. He loves reading and numbers, painting, Thomas the Tank Engine and playing in water, sand and dirt. He is quick with a hug, and is one of the most determined and sharp kids I have ever met.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Autism spectrum disorder and global developmental delay. Currently he receives more than 30 hours of therapy a week, including speech, occupational, physical and ABA. He also uses a communication device to speak, which is paid for by insurance.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Access to quality, affordable health care means that everyone can get good health insurance and care at a cost they can afford. Frankly, I would consider Louie's health insurance and care to be excellent, but it is not affordable by any means. We sacrifice a lot to pay that bill every month.

However, what I lose sleep over isn't the thought of paying for the insurance; it's the fear that my child could lose access to these protections altogether. He would never have been insurable before the ACA. I have spoken to families who were bankrupted trying to keep up with therapy bills. What I want is for my child to have the best possible shot at living a healthy and happy life. But he needs this care for that to happen.

I do worry about cuts to Medicaid. Though we do not currently utilize it, I view it as Louie's safety net if something happens to me.

Olive, age 4

Submitted by Julie Kauffman, Mother
Missouri, 631261341

LITTLE LOBBYISTS

Olive loves to go and do! She loves music, the zoo, ice skating & roller skating in her gait trainer. She loves all things Disney - especially the Slinky Dog roller coaster. She had a true zest for life and is our little thrill seeker.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Olive's diagnosis is Dystonic Spastic Quadriplegia Cerebral Palsy. She also has Reactive Airway Disease. Olive is total care. She requires assistance for eating, feeding, dressing, transitioning, bathing, etc.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Currently Olive is on Missouri Medicaid. Prior to moving to Missouri from Arkansas she had private insurance as her primary and Arkansas Medicaid as her secondary. She was on the wait list to get on the waiver list and I believe she was number 2,000 and something. Now, in Missouri, she cannot apply for the waiver until she is off of Medicaid which is quite worrisome.

My child relies on Medicaid. She relied on Medicaid when she had private insurance. Kids with a certain level of disability have to have Medicaid to pick up the tab where private insurance drops the ball. Repealing the ACA or capping lifetime limits or taking away protections from preexisting conditions for children like Olive would be devastating to families like ours. We fight for everything. Our kids fought to live. They shouldn't have to fight for access to medical care.

EDUCATION

How do school-based therapies, specialized education, and/or other accommodations help your child? What does the protection provided by Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child and your family?

School based therapies compliment what we are doing at home as well as our outpatient hospital therapies. In complex cases like Olive's it helps to have several opinions in order to get different ideas on how best to help her.

IDEA helps Olive to become the best she can be. All kids should be entitled to an education in this country. Some kids require more than the average student but that should be embraced. Not looked at as a burden or an additional expense. Olive benefits so much from going to school and engaging with peers. Other children are her biggest motivator. It's a nice break from the hospital or doctors office. It allows her to be a kid! The other students benefit as well by engaging with someone who may be a little different than they are but at the core us just a child who wants to learn and have fun. It allows them to appreciate diversity at a young age.

COMMUNITY INCLUSION

What disabilities impact your child's access to public spaces and services? How does the ADA improve their ability to be included in their community?

Olive uses a wheelchair to get around. Right now we push her in a manual chair but she is trialing power chairs. Even the smallest threshold is cumbersome in a power chair. Steps aren't possible. And you aren't going to pick up and carry a power chair.

One of the biggest issues we run into with the ADA is the lack of enforcement for van lift accessible parking spots. It seems anyone with a placard can park in a specified van lift spot. Van lift spots are a necessity. Not a luxury.

Isaac, age 9

Submitted by Kim Crawley, Mother
Virginia, 20147

LITTLE LOBBYISTS

Isaac LOVES to sing and dance! He has an incredible smile, it lights up the room. When he's not singing and dancing he can be found dominating his friends and family at Mario Kart.

Isaac is an active member of his church, a scout and most importantly a great friend and big brother.
He is well known in our community for his resilience and bright attitude.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Isaac was born at 31 weeks with Esophageal Atresia (a gap in his esophagus). He spent 8 of his first 11 months in the ICU, part of it in Va, part of it in Minnesota. During this time he was kept in a medically induced sleep for 3 months.

In his first year, Isaac underwent 14 major surgeries. He received a tracheostomy as a result of paralyzed vocal cords, and a feeding tube for nutrition.

He came home for the first time in his life at 13 months.

Since then he has undergone 12 additional major surgeries - mostly out of state. He has had his esophagus replaced with a piece of colon, and started the process to expand his now fused rib cage.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Isaac did lose his insurance, he reached his lifetime maximum at just over a year old, one month before the ACA was signed into law. In one year he used a lifetime ($2 million) in care.

Without access to good insurance Isaac would not be able to travel out of state to the doctors that are best able to treat him.

Additionally, insurance is great, but it doesn't pay for everything. Isaac requires a home health nurse, this is paid for by Medicaid. Without this help I would not be able to work and provide for my family. There are many prescriptions and services that insurance denies, some prescription can cost up to $3000 a refill. When these are denied by health insurance Medicaid picks up the cost.

EDUCATION

How do school-based therapies, specialized education, or other accommodations help your child? What does Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child?

Because Isaac has a tracheotomy, he has communication issues. He receives speech therapy both privately and in school.

Isaac attends his neighborhood school, with a nurse. He is educated with his friends and able to stay in the least restrictive environment because of this.

Claire, age 12

Submitted by Jamie Smith, Mother
Washington DC, 20015-1217

LITTLE LOBBYISTS

Claire loves ice cream, fashion magazines, shoes, anything Disney, swimming, and laughing with her siblings. She has an incredible laugh. She loves books and has earned the nickname "the little Professor" at school.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Claire has a rare genetic disorder, microduplication of Chromosome 2p. Although there are only two known cases in the entire world, many of the resultant medical conditions are more common. Claire has a number of diagnoses, including autism, asthma, epilepsy, hypotonia, and intellectual disability among others. She is completely reliant on others for all of her needs and care.

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Claire was born in 2006, before the ACA was law. We constantly worried that Claire would reach her caps on care or that if my husband were to loose his job Claire would be uninsurable due to the multiple pre-existing conditions with which she was born. Before the ACA, we had to make all of professional and life decisions based on ensuring Claire's access to health insurance.

Claire depends on Medicaid to cover significant costs necessary for her care that are not covered by private insurance. These include home health care necessary to provide both personal care to keep her safe within the home and nursing care, the ABA therapy that has opened up a new world for her, and some durable medical equipment that is not covered by private insurance but that allows her to be a part of her community and live at home. Medicaid even covered the cost of a hearing aid that private insurance denied. Medicaid also covers some of her educational costs, including school-based therapies.

EDUCATION

How do school-based therapies, specialized education, and/or other accommodations help your child? What does the protection provided by Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child and your family?

Claire attends a school for children with complex medical needs and multiple and severe disabilities. She receives multiple therapies at school as well as special education services. Some of the cost of her education is covered by Medicaid. She has a 1:1 aide at school.

COMMUNITY INCLUSION

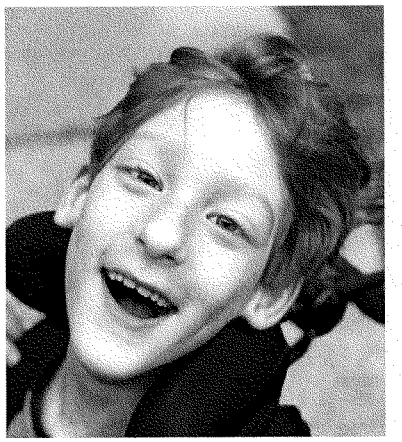
What disabilities impact your child's access to public spaces and services? How does the ADA improve their ability to be included in their community?

Claire uses a wheelchair and relies on ADA protections to access the community. While we appreciate the accommodations that do exist, we see everyday that more needs to be done. Where we live in Washington, DC new playgrounds and schools are being built with budgets in the millions of dollars that do not meet even the minimum standards of the ADA. This makes it difficult for Claire to fully integrate into the community and the lives of her siblings.

Danny, age 6

Submitted by Laura Robeson, Mother
Kansas, 66208

LITTLE LOBBYISTS



Danny is a six year-old who loves school, playing with friends, and reading. Danny was born prematurely and has cerebral palsy, epilepsy, cortical vision impairment, and uses a g-tube for all of his food and nutrition. He also happens to have the best smile around. He loves to go shopping mostly because he likes to chat up everyone in the store. While he is still working on his verbal communication, he has a lot to say and an opinion about everything. He is the whole world to his family and works incredibly hard at everything he does. He has physical therapy three times a week, speech, vision and occupational therapy. He manages to fit in lots of play dates with friends and Lego Club, too. To know Danny is to love him. This kid will move mountains.

HEALTHCARE

What diagnosis/es and medical needs does your child have?

Danny has spastic, quadriplegic cerebral palsy, epilepsy, and cortical vision impairment. Danny needs total support for all of his personal care and living. Danny requires adaptive positioning equipment and uses a wheelchair. He has a g-tube for all of his nutrition. He is on many medications to treat seizures and GERD. He also follows a specialized ketogenic diet to treat his seizures. While at home or school, he requires 1:1 assistance for all activities of daily living and for seizure monitoring.

What health care coverage does your child have?

Employer-based health insurance

Medicaid

Medicaid Waiver

What does access to affordable, quality health care mean to you? How would losing the protections of the ACA impact your child? How might cuts to Medicaid impact your family?

Medical care is a daily activity in our life and we live in fear of losing protections for pre-existing conditions and the return of lifetime caps. Danny's level of disability qualifies him for an institutional level of care and we choose to have his services in our home. Danny receives personal care after school and on weekends. This has allowed both of us to work and for Danny to receive the care he needs. If Medicaid were cut, it would significantly alter Danny's life not only now, but in the future. Danny will depend on Medicaid to provide his care so that he may live a full and independent life. Without Medicaid supports, his health and life would be at risk.

EDUCATION

How do school-based therapies, specialized education, or other accommodations help your child? What does Section 504, IDEA, and access to free and appropriate education in the least restrictive environment mean for your child?

Danny receives full-time 1:1 paraprofessional support, physical and occupational therapy, vision therapy, and assistive technology support. He needs adaptive equipment in the classroom and on the playground. Because of all of the supports, he attends a regular 1st grade class and is academically on grade level. Most of his therapies are provided within the classroom setting and he spends most of his day with his friends and classmates.

COMMUNITY INCLUSION

What disabilities impact your child's access to public spaces and services? How does the ADA improve their ability to be in their community?

Danny needs wheelchair accessible spaces to navigate the world. He requires the use of ramps, elevators, curb cuts, accessible parking and large bathrooms. He needs an accessible changing table in the restroom to change his clothes and attend to his personal care. He needs room for his wheelchair in doorways and in movie theaters.

My son is in hospice and his healthcare matters. By Tonya Prifogle

LITTLE LOBBYISTS

The following is a blog post written by Tonya Prifogle, Colton's mother. Colton passed away on the afternoon of February 3, 2019 at home, surrounded by his family.

My 7-year-old son Colton is in hospice.

Our entire family has been gathered around his bedside for weeks. His health, which had been slowly declining for over a year, rapidly deteriorated the day after Christmas. I'm grateful that he made it to Christmas, my smiling boy's favorite time of year, to give us the gift of one last holiday together as a family.

The time will soon come when his broken body will be at rest, and my constant fight to ensure his access to health care will become a distant memory.

But not yet. Even in these final moments, when I should be able to focus the whole of my broken heart on saying goodbye, our fight is not over. Once again, our health care system has failed us. Once again, I am consumed by the fire of outrage at the suffering our children are needlessly forced to endure.

Obtaining hospice care for a medically complex child like my son is no easy task. The flat rate allocated for home hospice by Medicaid is not enough for a child like Colton; who needs a trach, feeding tube, supplemental oxygen, ventilator, medical supplies, medications, and more (we don't call him our "million dollar kid" for nothing). Negotiating difficult contracts with agencies to set up care was complicated and stressful, to say the least.

As Colton became more ill, he needed more pain medication to remain comfortable. The prescription was written, but when we tried to fill it the medication was denied. Over the next few days, the script was denied four times. No matter what our physicians and pharmacists tried, it would not go through. As we ran out of medication, my greatest fear as a mother was coming true - my child would die a painful death and there was nothing I could do to help him. The health care system in our country is so broken that it prevented my child from accessing the medicine he needed to ease his suffering in his final moments.

I refused to accept this. I turned to the Little Lobbyists community I have been advocating alongside and my fellow mommas went into action. Through Twitter and Facebook, we shared Colton's story. Generous friends and strangers donated funds and clicks alike. We cried out to the world for help and our voices were amplified by collective compassion and matching outrage. No family should have to endure this. Not here, not now, not ever.

Fortunately we were heard by the people who needed to hear us. We finally got the attention of the pharmacy responsible. They explained they'd made a mistake due to confusion over a new law in our state and were correcting the situation. After over a week of worry, pain, and distraction, Colton got the medication he needed.

I'm filled with relief and gratitude that my beautiful little boy will not have to endure unnecessary suffering at the end of his life. But I cannot stop thinking about all the other mothers who are facing the death of their child. We should not have to fear the loss of health care coverage while we are trying to say goodbye. This is excruciating enough -- without fighting for hospice, without needing a "GoFundMe," without exposing ourselves in our most vulnerable moment to the public scrutiny of social media in the hope that sharing our story will facilitate access to desperately needed care. This is wrong.

In his all-too-brief 7 years, Colton has taught me so many things about strength, and love, and the gift of life. To all who hear his story, I pray you learn just one thing from him – that the right to health care extends throughout a person's life. My child deserves to live with dignity and as free from suffering as possible from the time he was a newborn in the NICU all the way to this moment in hospice, as he lies beside me struggling to hang on for just one more day.

Ms. ESHOO. Thank you, Elena. Beautiful testimony. Beautiful testimony. I wish Xiomara were here. Maybe we can provide a tape so that when she gets older she can hear her mother's testimony in the Congress of the United States. Thank you.

I now would like to recognize Mr. Thomas Miller, resident fellow at the American Enterprise Institute. Welcome, and thank you. You have 5 minutes.

STATEMENT OF THOMAS P. MILLER

Mr. MILLER. Thank you, Chairwoman Eshoo. The mortifying silent C in my written testimony in your name must have been due to the speed with which I delivered the testimony on time. But I apologize for that.

Thank you also, Ranking Member Burgess and members of the subcommittee. Now let us all take a deep breath and get to it.

The *Texas* case remains in its relatively early stages. Its ultimate fate is as much as another 16 months away. The probability of a Supreme Court ruling that would overturn the entire ACA remains very, very low, just by last December's decision at the Federal district court level.

Any formal enforcement action to carry out that decision has been stayed while the case continues on appeal. We have been here before. Two longer-term trends in health policy persist: our overreliance on outsourcing personal healthcare decisions to third-party political intermediaries and then our chronic inability to reach compromises and resolve health policy issues through legislative mechanisms. They have fuelled a further explosion in extending health policy battles to our courts.

So welcome back to Groundhog Day, ACA litigation version. The plaintiff's overall case is not frivolous, but it does rely heavily on taking the actual text of the ACA literally and thereby limiting judicial scrutiny to what the Congress that enacted appeared on the limited record of that time to intend by what it did.

The plaintiffs are attempting to reverse engineer and leverage the unusually contorted Supreme Court opinion of Chief Justice Roberts in *NFIB* v. *Sebelius*.

Now, come critics insist that the 115th Congress that zeroed out the mandate tax also expressed a clear intent to retain all other ACA provisions. This ignores the limited scope of what that Congress had power to do through the vehicle of budget reconciliation in the tax-cutting Jobs Act. All that its Members actually voted into law was a change regarding individual mandate.

It did not and could not extend to the ACA's other nonbudgetary regulatory provisions, nor did it change the findings of fact still in statutory law first made by the 111th Congress that insisted the individual mandate was essential to the functioning of several other ACA provisions, notably, guaranteed issue and adjusted community rating.

The plaintiffs are not out of bounds in trying to hold Congress to its past word—it happens once in a while—and in building on the similar reasoning used by other Supreme Court majorities to strike down earlier ACA legal challenges.

Since that's the story for ACA defenders, they should have to stick to it, at least until a subsequent Congress actually votes to

eliminate or revise those past findings of fact already in permanent law.

But, even if appellate courts also find some form of constitutional injury in what remains of the ACA's individual mandate as a tax-free regulatory command, the severability stage of such proceedings will become far more uphill for the plaintiffs.

Most of the time, the primary test is functionality in the sense of ascertaining how much of the remaining law with the Congress enacting it believe could be retained and still operate as it envisioned.

Given the murkiness of divining or rewriting legislative intent in harder cases like this one, it remains all but certain that an ultimate Supreme Court ruling would, at a minimum, follow up previous inclinations revealed in the 2012 and 2015 ACA challenges and try to save as much of the law as possible.

Even appellate judges in the Fifth Circuit will note carefully the passage of time, the substantial embedded reliance costs, and the sheer administrative and political complexity of unwinding even a handful of ACA provisions on short notice.

So don't bet on more than a narrow finding that could sever whatever remains of an unconstitutional individual mandate without much remaining practical impact from the rest of the law.

On the health policy front, we might try to remember that, when congressional action produces as flawed legislative product justified in large part by mistaken premises and misrepresentations, it won't work well.

The ACA's architects and proponents oversold the effectiveness and attractiveness of the individual mandate, claiming it could hold the law's insurance coverage provisions together while keeping official budgetary costs and coverage estimates within the bounds of CBO's scoring.

But what worked to launch the ACA and keep it viable in theory and politics did not work well in practice, and, to be blunt, one of the primary ways that the Obama administration sold its proposals for health policy overhaul was to exaggerate the size, scope, and nature of the potential population facing coverage problems due to preexisting health conditions.

Of course public policy should address remaining problems. It could and should be improved in other less proscriptive and more transparent ways than the ACA attempted.

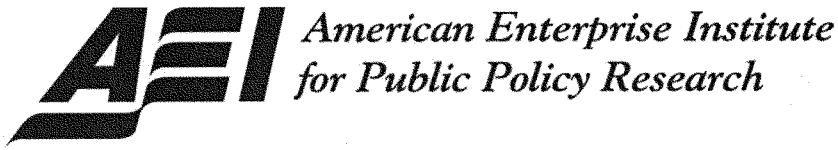
My written testimony suggests a number of option available to lawmakers if some of the ACA's current overbroad regulatory provisions were stricken down in court in the near future.

However, we are not back in 2012 or 2010 or even 2017 anymore, at least outside of our court system. Changes in popular expectations and health industry practices since 2010 are substantial breaks on even well-structured proposals for serious reform. But that is where the real work needs to be restarted.

It is often said with apocryphal attribution that God takes care of children, drunks, or fools, and the United States of America. Well, let's not press our luck. To produce better lawsuits, fewer lawsuits, let us try to write and enact better laws.

Thank you.

[The prepared statement of Mr. Miller follows:]



Statement before the House Committee on Energy and Commerce

Subcommittee on Health

Hearing

Texas v. U.S.:
The Republican Lawsuit and
Its Impacts on Americans with Pre-Existing Conditions

Thomas P. Miller, J.D.

Resident Fellow in Health Policy Studies

American Enterprise Institute

February 6, 2019

Thank you Chairwoman Eschoo, Subcommittee Ranking Member Burgess, and Members of the Subcommittee for the opportunity to testify today on an unusual subject. It's one that borders on the premature, if not speculative, end of the intersection between the health law, policy, and politics spheres of influence, which have been known to collide rather unusually over the last decade when it comes to the Affordable Care Act (ACA). The particular case at issue today, more commonly referred to as *Texas v. Azar*, remains in its relatively early stages, with an ultimate fate as much as another 16 months away. The probability of a Supreme Court ruling that would overturn the entire ACA remains very low, despite last December's decision at the federal district court level reaching exactly that legal conclusion. In any case, any formal enforcement action to carry out that decision has been stayed while the case continues on appeal to the U.S. Circuit Court of Appeals for the Fifth Circuit. In the meantime, all current provisions of the original ACA as enacted in March 2010 (and then altered, to a modest degree, by subsequent legislation and far more frequently by regulatory re-interpretations and administrative actions by both the Obama and Trump administrations) will remain in full force unless and until a higher court either upholds the December ruling or modifies it in part. On the other hand, overturning that entire decision in whole would return us to the same boat, no matter how leaky it has become.

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee and health policy researcher at several other Washington-based research organizations. In addition, I do have some prior involvement in earlier litigation involving the ACA; not just as an analyst and

commentator but also more directly in a number of other areas of ACA-related litigation. I filed an amici brief with colleagues on the severability issue in *NFIB v. Sebelius* in 2012 and worked very closely with the legal strategists initiating and shaping the line of litigation that culminated in the *King v. Burwell* decision in 2015.

My testimony today aims to provide a broad, but necessarily brief, overview across the overlapping domains of health policy, health law, and health politics. Based on past history with the ACA, there are few certainties but more of a wide continuum of possibilities. However, I will suggest some upper and lower ranges of their respective probabilities.

The opening advice, or admonition, is that we've been here before. Although patience is growing thin in traveling a similar path again, it will take a while longer for the smoke to clear and overheated rhetoric to cool. Nevertheless, even our less-responsible parties in government and politics will have little to gain and far more to fear from actually harming the current and future health care of their fellow Americans. They might try, but they won't succeed. Many of us may continue to disagree over what type of public policies can best improve or at least maintain, rather than impair, the current state of U.S. health care, but those differences predominantly involve means, not ends.

Unfortunately, two longer term trends in health policy – our overreliance on outsourcing personal health care decision to third-party political intermediaries and our chronic inability to reach compromises and resolve health policy issues through legislative mechanisms – have fueled a further explosion in extending those battles to our courts. Hence, another hearing today, at least nominally starting at that point.

My testimony will be divided into the three domains I indicated above. First, it will briefly assess some of the main strengths and weakness of the *Texas v. Azar* lawsuit that was filed in early 2018 by a group of 18 Republican state attorneys general and two governors, as well as the subsequent federal district court ruling. I will also touch on the case's somewhat more speculative but ultimately determinative prospects on appeal. Although a number of important legal issues could resurface at the appellate level, such as standing and the magnitude of any injury to the U.S. Constitution, the most decisive one remains likely to involve severability. In short, even if the remaining form of the individual mandate, as a regulatory command without a tax penalty, has become unconstitutional, what happens to the rest of the ACA? And, because it could become a future factor in the legislative and executive branches' respective timelines for future policy making, I'll offer a back-of-the-envelope forecast of when the legislative clock might strike for talk to end and hard decisions to begin.

Second, I will highlight the most significant health policy problems that could be put in play eventually by various final outcomes in this litigation, and the more effective responses. Although the realm of improved health policy decision making does not have to be so closely tied to this particular case's progress, I will assume for purposes of this hearing that it will be. Acting only when absolutely necessary, at nearly the last minute, or somewhat later, is not unfamiliar territory for many current officeholders in Washington. In any case, these mixes of policy decisions would revolve primarily around both "when" it might be necessary to engage them and "what" might need to be addressed. Far too little attention has been paid to the existence of other policy options

than those simply enacting very similar provisions of the ACA all over again, minus any of their lingering legal problems.

Third, we should focus more closely on the main roots of these persistent disputes over health policy that are transferred to the courts. They reflect failures of the legislative and overall political process. Poorly drafted bills, full of complex and ambiguous terms and overly ambitious but untested mechanisms that lack sufficient and sustainable political support but are pushed into law by whatever means are necessary have substantial negative spillover effects. They produce an aftermath of implementation snafus, unintended consequences, and toxic bitterness that, as is the modern American way, tends to migrate sooner rather later toward next-stage political warfare via litigation. This is particularly so when most channels of reconsideration and adjustment in Congress remain largely stalemated, if not frozen.

We could consider a more transparent and accountable approach to enacting and amending such laws, but we haven't chosen to done so for quite some time. If we want fewer ACA-like lawsuits, we might consider insisting on better-written laws that are more understandable, workable, and sustainable.

The *Texas v. Azar* Litigation

A sizable volume of pleadings, briefs, and rulings in this case at the federal district court level, as well as in recent academic and health policy commentary, already provides more than sufficiently detailed analyses of the respective arguments and contentions.[1] For purposes of this hearing, I will offer just a few observations and tentative conclusions.

"Literally" Uphill, but Far from Frivolous

The plaintiffs' case is not frivolous, but it does rely heavily on taking the actual text of the ACA literally, or at least "at its word," and thereby limiting judicial scrutiny to what the 111th Congress that enacted it appeared, on the limited record of that time, to intend by what it did. The ACA was unusual in its lack of substantially documented legislative history, its last-minute take-it-or-leave rescue via a still-unrefined Senate-passed bill in March 2010, and its underlying contradictions and political subterfuges. The plaintiffs in *Texas v. Azar* constructed their arguments to, in effect, reverse engineer and leverage the unusually contorted Supreme Court opinion of Chief Justice Roberts in *NFIB v Sebelius*. The Chief's "majority opinion of one" in the case had "saved" the ACA only by finding that the individual mandate provision could be found constitutional as a tax, rather than a regulatory penalty (despite how then-President Obama and the Congress that enacted preferred to describe it).[2] Therefore, they argue that when a subsequent Congress in 2017 reduced the maximum amount of the annual tax for failing to comply with it to "$0," beginning in 2019 (and thereby eliminating any tax liability), it also thereby made the remaining individual mandate provision in the ACA unconstitutional, in accordance with the rest of the Roberts opinion.

Some critics of this argument have insisted that the 115th Congress that zeroed out the mandate tax also expressed a clear intent to retain all of the other provisions of the ACA. This contention seems misplaced, once one recognizes the limited scope of what that Congress had power to do through the vehicle of budget reconciliation in the Tax Cut and Jobs Act of 2017. Whatever some members of that Congress may have "wanted" to do, in either further reaffirming or weakening the ACA, all that they actually *voted into*

law as a change regarding the individual mandate did not, and could not, extend to the ACA's other non-budgetary, regulatory provisions. Earlier proponents of more sweeping rollbacks of ACA regulatory provisions in the same Congress already had learned from the Senate parliamentarian that they could not do so through majority-vote, budget reconciliation mechanisms.

Such procedural inability to make possible changes in other underlying statutory law provisions is equivalent to inaction that simply leaves them in place, as originally enacted. On the other hand, enacting a specific change in a particular provision can indeed change its legal status from constitutional to unconstitutional.

Do Findings of Fact Demonstrate Legislative Intent?

Determining the legislative intent of Congress regarding the role of the individual mandate as it related to the rest of the law is at the heart of the severability component of the *Texas v. Azar* litigation. The plaintiffs contend that the Findings of Fact included in the ACA statute by the 111th Congress that passed it should be determinative on this point. That Congress essentially said that the individual mandate was essential to the functioning of several other ACA provisions, including protections against exclusions of coverage or higher premium charges for individuals with pre-existing health conditions (hereinafter more commonly referred to as "guaranteed issue" and "adjusted community rating"). Whether or not those "findings" have been borne out in practice or the economic and policy connection was quite as tight as that Congress officially assumed, the plaintiffs are not out of bounds in holding Congress to its past word, and in building on

the similar reasoning used by other Supreme Court majorities to strike ACA legal challenges in *NFIB v Sebelius* and in *King v. Burwell.*

In other words, if that's the "story" for ACA defenders, they should have to stick to it, at least until a subsequent Congress actually votes to eliminate or revise those past Findings of Fact already embedded in permanent law.

Whatever the 111th Congress "may" have really intended is far more complex. At best, one might conclude that, in the final analysis, it really aimed to pass whatever surviving, though problematic version of the ACA it could, by whatever legislative and political means would work, and then try to implement it and fix it up later, as needed, as it went along. However, this gap between what was officially said with a "wink" and what actually was the political calculation is far harder to recognize in the courts as official legislative intent.

Changing Views of the Individual Mandate

The *Texas v. Azar* case indirectly highlights the changed understanding of the limits of the individual mandate since its enactment in 2010. It's somewhat ironic to find a good bit of tactical repositioning on both sides to fit the current legal moment. At least some of the mandate's past champions have begun to downplay its current and future role, while at least some ACA opponents would prefer to overstate its ongoing impact, at least for purposes of legal standing in this particular case. Even though the Congressional Budget Office, once perhaps one of the foremost advocates of the mandate's effects on health insurance coverage and costs within the ACA framework, has begun to back away from its past estimates, in incremental stages, in recent years. Nevertheless, when CBO

was advising the 111th Congress on the likely effects of the individual mandate, it placed great weight on its role as a social norm alone, even without any tax or monetary penalty effect, in incentivizing millions of Americans to obtain or retain ACA-required insurance coverage.

Hence, although the plaintiffs in *Texas v. Azar* still may face challenges to their legal standing at the appellate level, the two individuals added to the original complaint, after it was first filed early last year by state government officials, probably have pleaded just enough of a small, but plausible, injury (being compelled to follow the law) to keep the case in court.

Arguing for Maximum Nonseverability, or Even Limited Severability, Will Get Harder

Even assuming that appellate courts ahead also find some form of constitutional injury in what remains of the ACA's individual mandate as a tax-free regulatory command, the severability stage of such proceedings will become far more uphill for the plaintiffs/appellees.

Supreme Court guidance on severability doctrine has been far from totally consistent in the past. It even could be accused of being selectively results-based in certain instances. Nevertheless, the broad trend for guiding principles in this area is to focus on determining the legislative intention behind the provisions of any law coming into possible constitutional jeopardy. There also is a clear judicial bias toward retaining as much of a law as is possible, to the extent that it would not be directly affected by any constitutional infirmity. However, these tests for determining legislative intent have shades of gray, and they can be dialed somewhat up or down, as desired. Most of the

time, the primary test is functionality, in the sense of ascertaining how much of the remaining law would the Congress enacting it believe could be retained and still operate as it envisioned. An alternative "legislative bargain" test, such as whether that Congress still would have enacted the rest of the law if it knew of the constitutional problems in other related provisions, seems to have fallen into more disfavor recently as too subjective and harder to ascertain.

Critics of current severability doctrine observe that it can lead to excessive judicial rewriting of complex, interconnected statutory provisions or focus unnecessarily on providing a broad remedial tool rather than limiting courts to deciding constitutional issues only to the extent that they directly affect the parties immediately before them.

Given the murkiness of divining legislative intent in harder cases like the ACA challenges to the individual mandate, past and present, it's better to conclude that, although several different severability settings are hypothetical conceivable (see, e.g. several lower court decisions in earlier ACA cases[3]), it remains all-but-certain that an ultimate Supreme Court ruling in this case will, at a minimum, follow its previous inclinations revealed in the 2012 and 2015 ACA challenges and try to save as much of the law as possible (see, e.g., the Court's rewriting in *NFIB v. Sebelius* of the impermissibly coercive Medicaid expansion mandate into a state option).

On first glance, this still could suggest that several regulatory provisions closely tied to the individual mandate (guaranteed issue, community rating, and other pre-ex condition protections; if not the employer mandate and essential health benefits) might remain in jeopardy of being declared nonseverable from an unconstitutional individual mandate. It's a theoretically plausible viewpoint, given that even the Obama

administration's Solicitor General once adopted that legal position during briefing and oral argument in *NFIB v. Sebelius*. But that legal premise fails to account for the passage of time since the pre-implementation stage of the ACA law in 2012, the substantial embedded reliance costs of various health sector participants in adjusting to compliance with the ACA since then, and the sheer administrative and political complexity of unwinding even a handful of ACA provisions on short notice, let alone invalidating future operation of the entire law.

Of course, ACA-related litigation often has defied past consensus forecasts, at least in the lower courts. The plaintiffs/appellees in *Texas v. Azar* may continue to have a "puncher's change" in future stages of court, and the Fifth Circuit is well-known as one of the most conservative appellate court circuits in the country. But they don't have much of a chance at landing a decisive haymaker at the Supreme Court, if past history is any guide to the future.

In short, some may enjoy the litigation theatrics while others either fear them or hope to leverage them to score other political points, but don't bet on more than a narrow finding that could sever whatever remains of an unconstitutional individual mandate (without much remaining practical impact) from the rest of the law.

The Appellate Timeline

We should not rule out some extended overtime ahead in playing out more fully this lingering legal dispute. The most likely timeline ahead would include a decision in the Fifth Circuit by late summer. If that appellate court finds against the plaintiffs/appellees on the merits regarding the constitutionality of the current individual

mandate, further litigation, for all practical purposes, would be over at that point. The possibility of a successful effort to get the Supreme Court to consider that decision on appeal and revive the legal issues would be extremely doubtful. One wildcard could involve en banc reconsideration of a ruling initially unfavorable to the Republican attorneys general by the entire Fifth Circuit, and a reversal then would become far more possible. On balance, I would expect the most likely scenario for the Fifth Circuit to involve changing the degree of severability and protect more, but not all, of the rest of the law. At that stage, the more closely related regulatory provisions tied to the individual mandate could still be in play as nonseverable.

If that turns out to be the case, the Supreme Court would accept the case on appeal. It's hard to envision such a matter being scheduled for oral argument before early 2020 and, in an echo of the timelines for previous major ACA legal challenges at the High Court, a final ruling would be most likely to arrive in late June of that year.

The Health Policy Context for Responses to *Texas v. Azar*

In the face of the above uncertainties and likelihoods, what lessons should health policymakers learn and what preparations can they make for the near future?

Laws Built on Faulty Premises Produce More Lawsuits

When congressional action produces a flawed legislative product, justified in large part by mistaken premises and misrepresentations, it won't work well. It will face substantial negative popular reaction for a number of years. Multiple lawsuits to overturn or modify it will grow rapidly and widely. The ACA's architects and proponents oversold the effectiveness and attractiveness of the individual mandate, touting it as an essential part

of the balancing act of subsidies and regulation that could hold the law's insurance coverage provisions together while keeping official budgetary costs within the bounds of CBO-scored budget neutrality.

The underlying theories and political beliefs of some that the individual mandate embodied in the ACA could achieve its stated goals in increasing coverage, limiting cost increases, and minimizing adverse selection turned out to miss the mark. However, they sufficed (barely) to provide the political cover to get the law enacted in 2010 and then were mostly accepted sufficiently in several Supreme Court case to get the law in business. What worked to launch the ACA and keep it viable in theory did not work as well in practice.

As I testified before a House Ways & Means subcommittee two years ago, "The ACA's individual mandate was primarily designed to help fill in the gaps between what the law's advocates could deliver politically in larger taxpayer subsidies for expanded health insurance coverage and the higher costs of coverage produced by more aggressive regulation of health insurance. It essentially aimed to require less-cost, low-risk individuals not only to obtain or retain federally-mandated minimum essential coverage, but also to pay more for it, in order to cross-subsidize lower premiums for other high-risk and/or low-income individuals. However, the individual mandate continues to face significant political limits on how large the mandate's penalties can be, how aggressively they can be enforced, and how much compliance the mandate will produce. Hence, the mandate's best future for continued survival involves operating much more as a gentle "suggestion" or nudge (with modest penalties and weak enforcement) rather than a more polarizing 'command.'"[4]

Whether an even kinder and gentler iteration of the individual mandate still amounts to an unconstitutional command beyond the powers of Congress remains to be adjudicated more fully in the *Texas v. Azar* case. But we did learn at the least that the previous Congress was eager to "cash it in" at its highest budget-score value in order to help finance, under budget scoring rules, part of the federal tax cuts it wanted to enact in late 2017 through budget reconciliation.

In a sense, one legislative fiction not only helped pass a controversial law, but ultimately begat another artificial budgetary score, which then lead to the opportunity to launch another lawsuit challenging the ACA all over again. Only in American politics?

The Slow Death of a Sales Job

To be blunt, one of the primary ways that the Obama administration "sold" its proposals for health policy overhaul was to exaggerate the size, scope, and nature of the potential population facing coverage problems due to pre-existing health conditions[5] ACA advocates then argued that the only way to address those problems was with a heavy dose of (adjusted) community rated premiums and income-related tax subsidies, complemented by an individual mandate. Unfortunately, this combination also made the coverage offered in ACA exchanges less attractive to younger and healthier individuals, who were asked to pay more for insurance that they valued less. We ended up with the worst of both worlds, a mandate despised by many (low-risk) individuals that largely failed to accomplish its intended goals. To the extent that net insurance coverage gains still were achieved under the ACA, they were due overwhelmingly to the combination of generous insurance subsidies for lower income ACA exchange enrollees, plus an

aggressive expansion of relatively less-expensive (but even more generously taxpayer-subsidized) Medicaid coverage in many states.

Right-Sizing Estimates of Serious, but Smaller, Problems

It's important to remember that the problem of pre-existing condition coverage, before the ACA was enacted and implemented, was limited almost entirely to the individual market. A host of semi-specialized risk pools and other pre-ACA legal provisions already offered various types of such insurance protection to many otherwise-vulnerable Americans.[6] Of course, public policy to address remaining problems *could* and *should* be improved in other less prescriptive and more transparent ways than the ACA's tangled web of less-visible regulatory cross-subsidies and income-related premium tax credits (for example, extending HIPAA's continuous-coverage provisions and risk protections to the individual market).[7] However, the price of maintaining and extending more choice and freedom, with accompanying responsibilities, within the sphere of competitive private insurance markets must include ensuring that our safety net protections for the most vulnerable Americans are sufficient, robust, and realistic. Various policy options such as better targeted subsidies, more sustainably funded high-risk pools, well-structured reinsurance mechanisms, more effective investments in the early determinants of improved lifetime health, and delivery system reforms that actually work all should play far larger roles than the ACA's more narrow focus on using broad regulatory commands alone to police remaining problems of excessive and unfair risk-based insurance coverage and pricing at the individual level.

Better Alternatives Are Available

Hence, if the ACA's current, overbroad regulatory provisions involving guaranteed issue, adjusted community rating, and prohibition of coverage exclusions for pre-existing conditions were stricken down in court in the near future as inextricably tied to an unconstitutional individual mandate, there are better policy alternatives available to lawmakers. Whether they would choose to adopt them, of course, would remain to be seen. The biggest near-term hurdles, not surprisingly, would involve time, money, and political willpower.

Other Potential Responses to Defuse Legal Problems

Some less-wise, but otherwise politically viable policy alternatives in the other direction – to head off future legal liabilities -- might include either doubling down on the ACA's premises or moving away from them. The first move might restore an individual mandate with at least some monetary penalties, if not even larger ones than before. Or individual states could adopt and implement ACA-style insurance regulations on their own. Other humbler legislative actions that could save the ACA from additional legal jeopardy might include adopting new congressional findings of fact that, in essence, would revise or eliminate the aforementioned findings by the 111th Congress when it enacted the original ACA. Perhaps even a simple admission on the record along the lines of "We were wrong. Sorry," might be a good start. Of course, if further disruption and political division is desired, some members of the current Congress could always accelerate action on their future plans for Medicare for All, or at least Many More.

The Most Powerful Factor in Washington Policymaking Is the Political One

Sadly, we are here today primarily to score talking points or deflect them. Meanwhile, the many shortcomings of the ACA as enacted and implemented persist, and the path to better alternatives remains obstructed, if not increasingly abandoned. When the going gets tough through regular legislative channels, more zealous advocates in health policy are particularly prone to seek other forms of redress through the courts and regulatory workarounds. We experienced a great deal of that during the Obama administration's years, and the last two years of the Trump administration have provided somewhat of a mirror image response in reverse through newer litigation and regulation. Revising portions of complex health care legislation, let alone installing a more comprehensive alternative is not only politically difficult; it poses immense structural and transitional challenges. The exhaustion of most substantial repeal and replace efforts through legislation in the last Congress has left a host of lesser ACA-opposition efforts flickering at a lower ember, while onetime legal defenders of ACA rules and regulations are initiating lawsuits of their own to overturn the Trump administration's proposed and implemented changes to them.

Groundhog Day may have been last Saturday, but it often seems to repeat every day when it comes to legal battles over the ACA. It would help to recheck and change the dates on our calendars. On Capitol Hill, we are far better at defending or attacking the ACA in more of a continuous loop than we are at fixing it constructively. Some closing observations follow

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The ACA Has Losers, as Well as Winners

I don't want to neglect pointing out the disappointing results and collateral damage caused by the ACA's execution of its stated objectives. Yes, U.S. taxpayers spent more money, or we borrowed it, and millions more Americans were covered with insurance than before while others had their coverage upgraded and subsidized more generously. At the same time, less-visible victims of the ACA lost the coverage they had preferred to keep or had to pay much more for it if they fell outside of the law's more generously subsidized cohorts. Insurance and health care markets were substantially destabilized for years, although, with enough premium hikes and Silver-loaded subsidy alchemy in the last two years, that's begun to change. Nevertheless, the overall size of the individual market actually have grown smaller than its pre-ACA levels.

Perhaps most of all, our political discourse and civility has suffered deeply. All political actors need to be more sensitive to the risks of unleashing less-predictable and manageable drastic changes on this front without far better transition and implementation plans.

Time Shifts in Law & Politics

The possible policy options noted further above, for dealing with pre-existing condition protections and related insurance issues differently, remain largely moot at the moment, unless and until a highly unlikely future court ruling in *Texas v. Azar* unscrambles the current ACA eggs and necessitates at least somewhat more immediate responses. Under the current status quo, the political center of gravity on most of the ACA has shifted, as evidenced by changes in public opinion polls and last November's

election returns. Mounting a theoretical case for a turn elsewhere in the more market-friendly policy direction suggested above still would need to develop much more of a change in public perceptions, political support, and realistic transitional timelines in order to become more viable. We are not back in 2010, or 2012, or even 2017 anymore. Changes in popular expectations, health industry practices, and sunk-cost financial commitments since 2010 are substantial brakes on even well-structured proposals for serious reform. Moving from where we are stuck at the moment in health policy, like it or not, will continue to be a heavy lift

We Could Buy A Little More Time, but Should Not Waste It

If a need for short-term transitional adjustments, if not complete emergency action, arises after an unexpected development in the *Texas v. Azar* litigation, we should expect the ultimate court decision itself then to provide some transition time before it goes into effect. Although that time may still be squandered in procrastination, indecision, and finger pointing, we do ultimately have to take some deep breaths and remember that voters eventually will insist on a more representative and accountable performance by their elected officials. We certainly need a better-functioning Congress that writes, enacts, and monitors more effective laws, in order to fail less and succeed more in health policy. Sooner or later, we will get one.

Notes

[1] For one particularly noteworthy contribution ahead that captures most of the reasoning behind the initial *Texas v. Azar* ruling, see Josh Blackman, "Undone: The New Constitutional Challenge to Obamacare," 23 Texas Review of Law & Politics __ (Forthcoming 2019).
[2] Although four dissenting justices would have declared the entire ACA nonseverable from its unconstitutional individual mandate and therefore unenforceable as well, the Court never had to reach a final decision on possible severability, given the ruling opinion's finding that the mandate still could be found constitutional after all.
[3] During the two years before the Supreme Court ruling in *NFIB v. Sebelius*, the three different federal district courts delivering rulings on the severability issue after finding the individual mandate unconstitutional were evenly divided. Their decisions ranged from complete nonseverability (Florida, 2011) to partial severability including guaranteed issue and pre-existing condition coverage provisions (Pennsylvania 2011) and to full severability that struck down only the individual mandate provisions (Virginia 2010).
[4] Thomas P. Miller, Testimony before the House Ways and Means Subcommittee on Oversight hearing on "Examining the Effectiveness of the Individual Mandate under the Affordable Care Act." January 24, 2017.
[5] Mark V. Pauly and Thomas P. Miller, "A Better (but Modest) Case for High-Risk Pools," American Enterprise Institute, March 2017.
[6] Tom Miller, "The Concentration and Persistence of Health Care Spending," 40 *Regulation* 4: 28-34.
[7] Thomas P. Miller, Testimony before the House Energy and Commerce Subcommittee on Health hearing on "Protecting America's Sick and Chronically Ill," April 3, 2013.

Ms. ESHOO. Thank you.

And now our last witness, Mr. Thomas Miller, resident fellow—I am sorry—Mr. Simon Lazarus, constitutional——

Mr. MILLER. I think he's younger than I am.

Ms. ESHOO [continuing]. Constitutional lawyer and writer. Welcome. It is lovely to see you, and thank you for being here to be a witness and be instructive to us.

You have 5 minutes.

STATEMENT OF SIMON LAZARUS

Mr. LAZARUS. Thank you, Chair Eshoo, and Ranking Member Burgess and members of the subcommittee. My name is Simon Lazarus. I am a lawyer and writer on constitutional and legal issues relating to, among other things, the ACA.

I have had the privilege of testifying before this subcommittee and other congressional committees numerous times. I am currently retired, and the views that I express here are my own and cannot be attributed to any of the organizations for which I previously worked or other organizations.

I have to say that I am not sure how important my task is, because I think all of the witnesses have pretty much agreed with the bottom line, and that includes the witnesses invited by the minority, and that is that this decision to invalidate the entire ACA is, in significant respects, and I think many of us agree that in all respects, completely baseless legally and has close to zero chances of being upheld on appeal.

And in light of all of that, Tom, I have to—I am puzzled by your assertion that the lawsuit is not frivolous, because that sounds to me like the definition of frivolousness in a lawsuit.

In any event, I think it should be underscored that it is not a coincidence that even the minority witnesses think very little of this lawsuit, because, as soon as the decision came down, it was attacked in extremely strong terms across the political spectrum.

As the Wall Street Journal editorialized, "While no one opposes Obamacare more than we do, Judge O'Connor's decision is likely to be overturned on appeal." Legal experts, including prominent anti-ACA conservatives, have blistered Judge O'Connor's result.

For example, Phillip Klein, the executive editor of the Washington Examiner, called the decision "an assault on the rule of law." Professor Jonathan Adler, who is an architect of the second fundamental legal challenge to the ACA—that's *King* v. *Burwell*—which I think the idea for which was hatched at a meeting that you probably hosted——

Mr. MILLER. I have been here before.

Mr. LAZARUS. OK. And that effort to kill the ACA was rejected by the Supreme Court in 2015. In any event, Professor Adler called the decision, quote, "an exercise of raw judicial power unmoored from the relevant doctrines concerning when judges may strike down a whole law because of a single alleged legal infirmity buried within it."

And on the courts, if one is going to be a prognosticator, just look at the basic facts. Chief Justice John Roberts' pertinent opinions nearly ensure at least a 5–4 Supreme Court majority to reverse Judge O'Connor, and moreover it should be noted that Justice

Brett Kavanaugh, looking at his prior decisions as a DC circuit judge, also looks very likely to join a larger majority to reverse Judge O'Connor.

So my job here is just to try to explain what the legal reasons are for this negative judgment on O'Connor's decision, so I am going to try to briefly do that.

To begin with, the court could well dismiss the case for lack of standing to sue on the part of any of the plaintiffs who brought the case. The State government plaintiffs barely pretend to have a colorable standing argument.

The two individual plaintiffs complain that, though it is enforceable, the mandate nonetheless imposes a legal obligation to buy insurance and they would feel uncomfortable violating that obligation.

The problem with this is that Chief Justice Roberts in his 2012 *NFIB* v. *Sebelius* decision, which upheld the mandate, expressly ruled that and based his decision, really, on the determination that, if individuals did not buy insurance—thus, quote, "choosing to pay the penalty rather than obtain insurance"—they will have fully complied with the law.

Now, post-TCJA—the Tax Cut and Jobs Act—a nonpurchaser will still not be in violation of the law simply because Congress reduced to zero the financial incentive to choose the purchase option.

So no one is compelled to buy insurance in order to avoid a penalty since none exists nor to follow the law, because he will be following or she will be following the law.

So there is no injury period, no standing to sue. That is a very likely result, even in the Fifth Circuit, I would say.

Ms. ESHOO. Mr. Lazarus, can you just summarize——

Mr. LAZARUS. OK. I am sorry.

Well, in addition, I would just say on the merits the ACA's mandate provision remains a valid exercise of the tax power and that is pretty much for the same reasoning that there is no standing, and that is because Congress' determination after the original ACA passed to drop the penalty to zero did not strip Congress of its constitutional power under the tax authority.

And nor can its subsequent determination sensibly mean that it was no longer using that power. And finally, I would just want to add really to what other people have said and some of the members of the subcommittee have eloquently said, that to take the further leap that, if the mandate provision is unconstitutional after the reduction of the penalty to zero—which it really should not be found, but if it is—there is absolutely no basis whatsoever for striking down the rest of the ACA.

[The prepared statement of Mr. Lazarus follows:]

Committee on Energy and Commerce Subcommittee on Health Hearing on "*Texas v. U.S.*: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions"

February 6, 2019

Written Statement of Simon Lazarus

Madame Chair Eshoo, Ranking Member Burgess, members of the Subcommittee, thank you for the opportunity to testify on the legal implications and basis – or, as has been recognized across the political spectrum – lack of legal basis – for the recent decision by a federal district judge in Texas to invalidate the Affordable Care Act in its entirety.

I am Simon Lazarus, a lawyer and writer on constitutional and legal issues relating to, among other things, the ACA. I have had the privilege of testifying before this subcommittee and other Congressional committees numerous times over the now near-decade in which the ACA has been the law of the land. I am currently retired from positions at the Constitutional Accountability Center (2012-2017) and the National Senior Citizens Law Center (now Justice in Aging) (2003-2012). The views I express here are my own, and cannot be attributed to these or any other organizations. This written statement incorporates thoughts and material previously expressed in briefs, articles, and other public materials which I have written or helped write.

The District Court decision in *Texas v. United States*: A Brief Summary

Late Sunday afternoon, December 30, Texas federal district judge Reed O'Connor issued an order following up on his blockbuster December 14 decision invalidating the entire Affordable Care Act (ACA). Evidently, Judge O'Connor had ingested the widespread condemnation of that decision. He granted the request of pro-ACA state attorneys general led by California's Xavier Becerra, that he stay his ruling until the appellate process finishes. Hence, the law will remain in effect – quite likely, permanently, as far as this lawsuit is concerned.

The prospect that Judge O'Connor's decision is likely never to take effect does not mean that it should be disregarded as some sort of non-event, or that there is any excuse for making light of this judge's willingness to strip vital protections – for the millions of individuals with pre-existing conditions as well as other guarantees affecting substantially all Americans – and threaten chaos for the nation's entire heatlh care system. On the contrary, this perversion of America's justice system merits bipartisan condemnation as, to quote one eminent conservative commentator, the editor of the *Washington Examiner,* "an assault on the rule of law."

In 2012, per the controlling opinion of Chief Justice John Roberts, the Supreme Court held that the ACA provision popularly (though misleadingly) known as the "individual mandate,: exceeded Congress' authority to regulate interstate commerce, but nevertheless upheld the provision as an exercise of Congress' power to tax. In December 2017, after multiple failures to repeal Obamacare, Congress included a provision in the Tax Cut and Jobs Act that set at zero the tax penalty for failing to buy ACA-compliant insurance, while leaving other provisions of the mandate and the law intact. Then, Texas state Attorney General Kenneth Paxton came up with a legal theory that zeroing out the penalty rendered the mandate provisions no longer an exercise of the tax power, hence, unconstitutional. Further, he made the quantum leap of asserting that, if the mandate provision is unconstitutional, the entire statute must be invalidated – 2300 pages of provisions integral to every sector of the nation's health system and vital to protections relied upon by literally all its more than 300 million patients. In February 2018, Paxton's coalition of Republican states filed a complaint embodying these claims with District Judge O'Connor, widely recognized as a "favorite of Republican leaders in Texas, [for] reliably tossing out Democratic policies they have challenged."

On December 14, O'Connor embraced Paxton's theory. While highly debatable, this portion of his ruling was, in and of itself, of no practical consequence. With the penalty now zero, declaring the mandate itself void should not meaningfully shrink ACA-insured ranks. What made the decision a potential real-world catastrophe – for the ACA and the countless health providers and patients who – as even the *Wall Street Journal* acknowledged – now rely on it, is that O'Connor also bought the Republican states' claim that striking the mandate meant that the entire ACA had to be tossed along with it.

Why bipartisan experts consider Judge O'Connor's decision unlikely to survive on appeal

O'Connor's edict so egregiously flouts applicable law and societal exigencies, that, as the *Wall Street Journal* editorialized, while "No one opposes Obamacare more than we do," the decision "is likely to be overturned on appeal and may boomerang politically on Republicans." Indeed, Chief Justice John Roberts' pertinent opinions nearly ensure, with his four progressive colleagues, a 5-4 Supreme Court majority to reverse O'Connor. Moreover, prior decisions by Justice Brett Kavanaugh, during his long service on the D.C. Circuit Court of Appeals, augur for a larger majority.

Legal experts, including prominent anti-ACA conservatives, have blistered Judge O'Connor's result. Here are some examples::

- As noted above, Philip Klein, Executive Editor of the *Washington Examiner,* no less an avowed opponent of the ACA, as a matter of policy, than the *Wall Street Journal* editorial board, called the decision "an assault on the rule of law."

- Case Western Reserve professor Jonathan Adler, recipient of the Federalist Society's Paul M. Bator Award for excellence in teaching and scholarship and a central architect of the second fundamental legal challenge to the ACA (*King v. Burwell,* rejected by the Supreme Court in 2015), in a *New York Times* article co-

authored with Yale health law expert Abbe Gluck, called the decision "an exercise of raw judicial power, unmoored from the relevant doctrines concerning when judges may strike down a whole law because of a single alleged legal infirmity buried within it;"

- Harvard Law professor Lawrence Tribe, no conservative, but universally acknowledged for decades as among the nation's most respected constitutional experts, called the decision "legally indefensible from start to finish;'"

Given such show-stopping legal inadequacies, Judge O'Connor's decision seems unlikely to survive review even in the right-leaning Fifth Circuit. Even a hostile reviewing panel will likely be reluctant to lift his stay pending Supreme Court review. And, while no one can predict such matters with certainly, on the basis of prior decisions by a majority of the justices, Supreme Court reversal appears highly likely.

The Texas v. United States plaintiffs lack standing to bring the case.

To begin with, the Court could well throw Texas and its anti-ACA allies out of court, without entertaining their constitutional arguments at all, by dismissing their suit on standing grounds. Transparently, the state plaintiffs themselves lack any legally cognizable injury to justify their asking an Article III court to hear their far-fetched legal allegations. Well aware of this threshold hole in their case, they recruited two individual plaintiffs. Their complaint is that, even with no enforcement sanction, the mandate imposes a legal obligation to buy insurance that they would feel uncomfortable to ignore. But this claim is directly contradicted by the Supreme Court's characterization of the ACA's mandate provision. Chief Justice Roberts, in his 2012 *NFIB v. Sebelius* decision, expressly ruled that, if a person did not buy insurance, thus "choos[ing] to pay [the prescribed penalty] rather than obtain health insurance, they have fully complied with the law." After Congress retained intact the entire corpus of Section 5000A, as well as the rest of the ACA, a non-purchaser will still *not* be in violation of the law, simply because Congress *reduced* (to zero) the financial incentive to buy insurance.

In common-sense terms, as construed by the Supreme Court, the so-called "mandate" section of the ACA – Section 5000A – does not in fact impose a categorical mandate; rather, it gives individuals a choice: either purchase ACA-compliant insurance *or* pay the penalty prescribed by Subsection (b) (1) of that section. As amended by the 2017 Tax Cuts and Jobs Act (TCJA), Section 5000A still provides that choice, except that, with TCJA's reduction of the amount of the penalty to zero, there is, literally no financial cost to choosing not to purchase insurance. Hence, no financial injury.

Further, no basis exists for claiming that Congress' decision to reduce to zero the financial bite of foregoing insurance perversely transforms applicable provisions of the law so as to turn that lawful choice into a rigid command. In 2012 Chief Justice Roberts observed that, in light of the Congressional Budget Office's forecast that approximately four million individuals would fail to purchase ACA-prescribed insurance, "We would expect Congress to be troubled by that prospect if such conduct were unlawful. That Congress apparently regards such extensive failure to comply with the mandate as

tolerable suggests that Congress did not think it was creating four million outlaws." That sensible observation was rendered no less indisputable by Congress' decision last year to reduce to zero the financial penalty for foregoing insurance. In other words, individuals who choose that option have breached no legal obligation, and suffer no psychological injury of the tenuous sort the *Texas v. United States* plaintiffs allege. No financial injury, no injury, period. No standing to sue.

In sum, If the case reaches the Supreme Court, the Court is quite likely to order it dismissed on the ground that no standing exists, for the Republican state attorneys general who organized the litigation, nor for the individual plaintiffs they recruited.

On the merits, the ACA's "mandate" provision remains a valid exercise of the tax power, taking into account Congress' 2017 reduction of the penalty to zero..

Were the Court to reach the merits of the case, the justices could well conclude that, with a penalty set at zero, the otherwise intact mandate provision remains a valid exercise of the tax power. This is true for essentially the same common-sense reason that the individual plaintiffs recruited by Texas' attorney general lack standing. In the Supreme Court's 2012 decision upholding the ACA "mandate" as an exercise of the tax power, the Court construed the relevant section of the law, Section 5000A. as a unitary whole, in which the subsection purporting to require most eligible individuals to buy insurance, had to be read, in light of the following subsection, which prescribes the penalty for non-compliance, as simply an option. That basic fact remains true, except that the penalty alternative is now set at zero, hence, there is even less coercion to pressure individuals to buy insurance they don't think they need.

Texas' and Judge O'Connor's entire case rests on a reading of the ACA's mandate provisions flatly antithetical to the Supreme Court's holistic construction – which, after all, constitutes The Law. At the outset of his December 14, 2018 opinion, and repeatedly throughout its 55 pages, the judge asserts that, with the penalty for going uninsured set at zero, "the Individual Mandate *continues* to *mandate* the purchase of health insurance . . . ." *Texas v. United States,* N.D. Texas, C. A. No. 4:18-cv-00167-0 at page 2 (December 14, 2018), and that, without a tax penalty, that "mandate" cannot be justified under the tax power, must therefore rest solely on the interstate commerce power. (emphasis supplied) Since the Court held in *NFIB v. Sebelius* that the commerce clause did not authorize an absolute requirement to buy insurance, Judge O'Connor contends, that requirement must now be invalid. But that reading of the ACA is manifestly wrong. As Chief Justice Roberts construed the relevant provisions of the law, the ACA in fact did not impose a categorical mandate, it created a choice. That remains the case today. The fact that Congress has set the penalty at zero does not make the shared responsibility payment any more mandatory, if anything, it makes it less so.

In sum, under the Court's 2012 decision, Congress had, and exercised, the authority under the tax power to give individuals a choice whether to buy insurance or pay a penalty. Congress' subsequent 2017 determination, that the goals of the law could be served if the penalty were reduced to zero, did not strip Congress of that constitutional

authority, nor can that determination sensibly be understood to mean that Congress was no longer exercising that authority.

The states and friend of the court briefs opposing Judge O'Connor's decision provide additional arguments favoring the view that the ACA mandate, with a zero penalty, remains a valid exercise of the tax power. They point out that neither applicable precedent nor Chief Justice Roberts' analysis in *NFIB v. Sebelius* impose a rigid rule that, under all circumstances, Congress cannot be understood to exercise its taxing authority, unless a measure actually raises revenue. They also show that, were a valid tax provision to automatically lose its validity as a tax, if it were, in a given year or other time-period, to cease bringing in at least some actual payments to the government, bizarre, literally absurd consequences would follow. Such consequences were certainly not intended by Congress in 2010 or 2017, nor by the framers who gave Congress its sweeping tax-and-spend authority in 1787. For example, it makes no sense to interpret the Constitution or the ACA, as Judge O'Connor has, to mean that the shared responsibility payment provision of the law died when, without repealing or amending it, Congress zeroed out the penalty, but will spring back to life if a future Congress reinstates a positive dollar figure.

Such arguments reinforce the straightforward point I have sought to highlight here: Judge O'Connor's opinion suffers from s a pervasive, root flaw. His blinkered reading of the law and the Constitution directly contradicts the common-sense, holistic, and realistic approach to construing major and complex federal statutes that the Supreme Court, led by Chief Justice Roberts, prescribed in its landmark decisions construing the ACA.

On the issue that matters in the real world – whether invalidating the mandate requires or justifies throwing out the rest of the statute – Supreme Court reversal of O'Connor's decision looks close to a sure thing.

Even if a final reviewing decision, by the Fifth Circuit Court of Appeals or the Supreme Court, were to grant plaintiffs standing and to accept their merits claim that, with the penalty zeroed out, the remaining individual mandate "command" provision of Section 1500A (a) is unconstitutional – an outcome few observers expect – such a result will have virtually no impact on the operation of the ACA, nor on the millions of Americans – in reality, substantially all Americans – who depend on the ACA and its guarantees for people with pre-existing conditions and myriad other protections that now are "baked into" the national health care system. To declare invalid the law's shared responsibility payment provision, when that provision has no financial penalty behind it, will, by itself, have little if any depressive effect on the number of enrollees in health insurance plans.

The sole reason that public attention is focused on this litigation – and the sole reason why Texas Attorney General Kenneth Paxton and his partisan allies filed the lawsuit – is their claim that this – now toothless – provision is so indispensable to the operation of every component of the ACA, that it is, in lawyers' jargon, "inseverable" from the rest of the statute. Hence, its demise requires extinguishing the entire law along with it. Fortunately, as recognized by virtually all commentators across the political spectrum,

this prescription for chaos in the nation's health care system is even more starkly at odds with applicable, long-established legal precedent than his embrace of ACA opponents' dubious standing and merits claims.

Repeatedly, Chief Justice Roberts has vigorously applied the established rule that "[W]hen confronting a constitutional flaw in a statute, we . . . limit the solution, . . . severing any problematic portions while leaving the remainder intact." Specifically, In *NFIB v. Sebelius*, Roberts rejected the very open-ended approach to severability on which Texas and Judge O'Connor expressly rely. "The question here," he wrote, "is whether Congress would have wanted the rest of the Act to stand [without the Medicaid expansion fund cut-off mechanism the Court found unconstitutionally coercive] . . . . We are confident that Congress would have wanted to preserve the rest of the Act."

Further, there is a substantial basis for expecting Justice Brett Kavanaugh to join the Chief Justice and the four progressive justices to sever the rest of the ACA from the mandate, if the latter is held unconstitutional. While on the D.C. Circuit, Justice Kavanaugh applied reasoning closely paralleling – indeed, foreshadowing – Roberts' decisions in both the above cases, and in another (important) case he similarly stressed that "Supreme Court precedent requires us to impose the narrower remedy of simply severing the [defective] provision."

In this case, there is no mystery to what Congress intended when, in 2017, it zeroed out the penalty for foregoing insurance. It did so without amending, referencing, or so much as mentioning any other provision of the so-called "Individual Mandate" section, Section 5000A, let alone any other provision of the ACA. Hence, Congress' judgment, that the ACA could function with the penalty set at zero is embodied in the text of the law itself. For a court contemplating the, often speculative, question of whether Congress would have intended to sever a statutory provision found to be defective, or to strike down some or all of the rest of the statute, that question here is not speculative at all. The Supreme Court has repeatedly ruled that "enacted text is the best indicator of intent." All of Judge O'Connor's, and Texas', argument that the "individual mandate" was deemed by Congress to be essential to the overall law – hence, Congress would have wanted the whole law to be struck along with that provision – is drawn from findings and legislative history of the 2010 version of the law. However credible that dubious inference may be with respect to the Congress of 2009 and 2010, it was rendered irrelevant and flat-out refuted by the contrary judgment that Congress expressly incorporated in the text of the TCJA in 2017. And that conclusion applies with equal force to the Trump Administration's position – that the court should strike – as inseverable – "only" two critical protections for people with pre-existing conditions, the "guaranteed issue" and "community rating" provisions of the law. If found unconstitutional, the shared responsibility payment provision must be severed, and the entire remaining statute left intact, as Congress left it in 2017.

The relevant statutory text is the end of the inquiry, as a matter of law. However, it is worth noting that there was nothing irrational about Congress' 2017 judgment that the multiple goals of the ACA could be well served with a penalty reduced to zero. Prior to adopting that amendment to the original law, Congress had available to it a November 2017 report by the CBO that concluded that, "[I]f the individual mandate penalty was

eliminated but the mandate itself was not repealed . . . . [n]ongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade." As Professor Jonathan Adler observed, "Congress in 2010 may have thought that a mandate may have been an essential component of the ACA, but a subsequent Congress indicated otherwise by eliminating the penalty without altering the other parts of the law." Professor Adler's succinct conclusion bears repetition: "That is why the states' argument about severability (and that accepted by DOJ) is wrong."

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In sum, the lawsuit filed by Attorney General Paxton and his allies, in the court they are well-known to "favor," is a transparently political enterprise. Judge O'Connor's acceptance of the thin legal cover fabricated to support that effort should and likely will be given short shrift before the appeals process has run its course.

Ms. ESHOO. Thank you very much.

All right. I am going to—we have how concluded the statements of our witnesses. We thank you again for them. Each Member will have 5 minutes to ask questions of the witnesses, and I will start by recognizing myself for 5 minutes.

I appreciate the discussion about the legalities, and of course we are discussing *Texas* v. *United States* today. But the issue of preexisting conditions keeps coming up, and I would like Ms. Young and anyone else to chime in.

This issue of what our Republican colleagues say that they are for, and I listen to C–SPAN a lot and especially during the days running up to the election, and they covered Senate races and House races, and I heard Republicans over and over and over again in those debates with their opponents saying, "I am for preexisting conditions."

Now, can anyone address how you extract that out of what we have now, the Affordable Care Act, and have standalone insurance policies? Where is the guarantee about what the price would be for that policy?

Would you like to——

Ms. YOUNG. The Affordable Care Act—absolutely. The Affordable Care Act requires that all insurance plans charge consumers the same price regardless of——

Ms. ESHOO. That I understand. That's what we put in. But the minority is saying that they are for preexisting conditions, except they have voted against the ACA countless times.

So if you were to extract just that one issue and write a bill on it, where is the guarantee on what the price would be for that standalone policy?

Ms. YOUNG. In my view, it is very difficult to put together a system of protections for people with preexisting conditions that doesn't include a panoply of reforms similar to many of the reforms that were included in the Affordable Care Act.

So you need to ensure people can buy a policy. You need to ensure that that policy doesn't exclude coverage for their particular healthcare needs.

You need to ensure that they are able to purchase at a fair price and you need to surround that with reforms that really create a functioning insurance market by providing financial assistance, stable risk adjustment, and other associated provisions like that.

Ms. ESHOO. I want to get to something that is out there, and that is what I refer to in my opening statement. I refer to them as junk plans. It is my understanding that many of these plans exclude coverage for prescription drugs, for mental health and substance use disorders.

Who would like to address this? Is this correct?

Ms. YOUNG. I can address that.

Ms. ESHOO. Uh-huh. Go ahead.

Ms. YOUNG. I believe you are referring to short-term limited duration coverage.

Ms. ESHOO. Right. Mm-hmm.

Ms. YOUNG. Those plans are not required to cover any particular benefit, and many of them can and likely will exclude coverage for

benefits like prescription drugs, maternity care, substance use and mental health services, things like that.

Ms. ESHOO. Now, are these plans medically underwritten?

Ms. YOUNG. Many of them are, yes.

Ms. ESHOO. And how does that differ from the process by which Americans get health insurance on the individual market today?

Ms. YOUNG. Medical underwriting refers to a process where insurance companies require individuals to fill out a detailed health history questionnaire and then use the results of that to determine if the individual can purchase a policy and if so on what terms.

That was a common practice in the individual market before the Affordable Care Act. It is permitted for short-term limited duration plans today.

In contrast, in the ACA-compliant individual market, insurers are not prohibited to medically underwrite. Consumers sign up for a policy based only on information about their age and their income if they are seeking tax credits with no health history screening.

Ms. ESHOO. I see. Mr. Lazarus——

Mr. MILLER. Chairwoman Eshoo, could you ask the rest of the panel, and we are getting a one-sided view of this. The ACA's protections are——

Ms. ESHOO. I didn't call on you. I would like to call on Mr. Lazarus. Are you giving us comfort that the lawsuit is not going to go anywhere? Is that what you believe?

Mr. LAZARUS. I think all of the witnesses have basically said that, at least with respect to the notion that, if the mandate provision is now found to be unconstitutional, which I don't think it will be or should be, the quantum leap that the Republican attorneys general and Judge O'Connor took to then say the whole law has to go, I don't think any member of the panel thinks that there is much chance of that occurring.

So I don't know whether that answers your—that doesn't mean, however, that the fact that there is this dagger pointed at the heart of our healthcare system is out there causing uncertainty, that it was—basically, opponents of the ACA have outsourced to a judge, which Chairman Pallone correctly said was a target of forum shopping who has a widespread reputation of, one article said, tossing out Democratic policies that Republican opponents don't like.

Ms. ESHOO. I think my time has more than expired. Thank you.

I now would like to recognize the ranking member of the subcommittee, Dr. Burgess.

Mr. BURGESS. I thank you for the recognition.

Mr. Miller, let me just give you an opportunity. You were trying to respond with something about the ACA protections.

Mr. MILLER. Sure. It is a complex issue, but we need to remember that in the best of the world, the ACA left a lot of other folks unprotected. If you didn't comply with the individual mandate, you didn't get coverage. You got fined. You got insult on top of injury, and there is no coverage to it.

So there are breakdowns in any imagined perfect system. There are other approaches which can also fill that hole. You are going to have to put some money in. You are going to have to resolve——

I don't think the Republicans did a good job of it in 2017 in explaining and defining what that meant. They began backfilling as

they went along with reinsurance. There are ways to extend HIPAA over to the individual market.

Those are all thoughtful alternative approaches, and if you don't have an individual mandate, you should come up with something else. And we are not going to have an individual mandate. That appears to be the case.

So you are leaving a hole there and there are other ways to provide stronger incentives, and it requires some robust protections where if you went into something like a high-risk pool or an invisible risk pool you could requalify for that full-scale portability after 18 months.

So there are ways to connect the dots. It is heavier lifting, and it is more work than just waving your arms and saying, "We mandated it, it must work," even though it doesn't.

Mr. BURGESS. And I thank you for that clarification, and just—continuous coverage was part of the bill that we worked on 2 years ago.

Mr. MILLER. A number of options. Yes.

Mr. BURGESS. Which, of course, is what exists in Medicare. I mean, if you do not purchase Medicare within 3 months of your 65th birthday, guess what? You get an assessment for the rest of your life in Part B of Medicare.

So, Mr. Miller, I actually agree with you and, I guess, other witnesses. My expectation is that this case will not be successful on appeal, and I base that on the fact that I have been wrong about every assumption I have made about the Affordable Care Act ever since its inception in 2009.

So perhaps I can be wrong about that assumption, but I do assume that it will not survive on appeal.

Let me just ask you, because I have had difficulty finding this information—you may have some sense—how much money has been collected under the individual mandate? The fines that have been paid—do we have an idea what that dollar figure is?

Mr. MILLER. Yes. I did that a couple years ago in the Ways and Means. I knew it was going to come up today. I can supply it for you.

Mr. BURGESS. Great.

Mr. MILLER. This is—with a bit of a lag it ends up being calculated. Not a lot, and it's somewhat randomly distributed. It tends to be the lower-income people who didn't know how to get out of the individual mandate who ended up paying it, surprisingly enough. But it did not amount to a large amount, and it didn't have a lot of coverage effects.

Mr. BURGESS. So, basically, the effect of the Tax and Jobs Act of 2017 was current law because no one behaved as if it was a real thing anyway.

Mr. MILLER. Well, it had some other ripple consequences. But in that, practical consequences were not as significant as is often said.

Mr. BURGESS. Well, let me ask you this. I mentioned in my opening statement that perhaps ways to end this lawsuit would be to either repeal the individual mandate outright or reestablish the tax within the individual mandate. Do you agree that either of those activities would——

Mr. MILLER. That requires actually legislating, which is a hard thing to do these days on Capitol Hill.

Mr. BURGESS. I think—yes, sir. But it would achieve the goal of breaking the lawsuit.

Mr. MILLER. Sure. And there is lots of other things. I mean, States could pay us their own individual mandate. As I said, you could also just rescind your findings of fact in the old Congress and say, "We were wrong, we are sorry."

Mr. BURGESS. I don't think that is going to happen.

Let me just ask you. I mentioned the phenomenon of silver loading in my opening statement. Would you walk us through, for people who are not familiar with that as a technical term——

Mr. MILLER. Sure.

Mr. BURGESS [continuing]. The phenomenon of silver loading?

Mr. MILLER. It is a bit of a ripple of the other litigation over the cost-sharing reduction subsidies, and that has got a tangled web in itself.

But, cleverly, a number of States, insurance regulators, and insurers figured out a way to game the system, which is how do you get bigger tax credits for insurance by increasing your premiums.

There was also worry about what those market were doing, which fueled some of that increase, and a lot of spikes in the individual market over the previous 2 years as a result of that, and the silver loading embellished that.

Now, that was great for folks who were already covered where, because of the comprehensiveness of their subsidy income related, they weren't out any extra dollars as those premiums went up.

But the folks in the rest of the individual market—and Avik can talk to this as well—that is where we had our coverage losses, and that is where you got the damage being done. Those are the victims—the byproducts of doing good on one hand and it spills over into other people.

Mr. BURGESS. That's the teacher and policeman that I referenced in my district who have two children. They are outside the subsidy window.

Mr. Roy, could you just briefly comment on the effect of a Medicare for All policy on what union members receive as their health insurance?

Mr. ROY. Well, I mean, of course, there are many different definitions of Medicare for All, but if we define it as the elimination of private insurance then, obviously, union members who have either Taft-Hartley-based plans or employer-sponsored insurance, that would be replaced by a public option or something like that. I assume that is what you mean.

Mr. BURGESS. Yes, sir. Thank you. Thank you for being here.

I yield back.

Ms. ESHOO. Thank you, Ranking Member.

And who are we going to? To recognize the gentlewoman from the great State of California and its capital, Sacramento, Ms. Matsui.

Ms. MATSUI. Thank you, Madam Chair.

Thank you all for joining us today. The topic of this hearing is incredibly important to me and my constituents and all Americans whose lives have been changed by the Affordable Care Act.

A special thank you to Ms. Hung for sharing your daughter's story and for your incredible advocacy work on behalf of children and families everywhere.

When we started writing the ACA 9 years ago, I consulted with a full range of healthcare leaders in my district in Sacramento. They called together the hospitals, the health plans, the community health centers, the patients, and all those who contribute to our healthcare systems and all those who use it also.

Everything was carefully constructed. We tried to think about everything but, obviously, you can't think of everything. But we consulted as widely as possible because we also knew that each policy would affect the next and the system as a whole.

You simply cannot consider radical changes to the law in a vacuum, yet that is exactly what this ruling of the lawsuit does. By using the repeal of the individual mandate in the GOP tax bill as justification of this suit, the court has declared the entire Affordable Care Act invalid.

Millions of Californians and Americans stand to lose critical health protections, including protections for people especially with preexisting conditions. Vital protections for Medicare beneficiaries including expanded preventive services and closing the prescription drug doughnut hole will be thrown into chaos.

I was pleased to join my colleagues to vote for the House of Representatives to intervene in this lawsuit and defend the ACA in our continued fight to protect people with preexisting conditions and for the healthcare of all Americans, and I think you know that that is something that all Americans care about when you think about preexisting conditions. Everybody has some sort of preexisting conditions.

For me, the potential consequences of the lawsuit are too great to not fully consider, especially for the impact on people confronting mental illness and substance abuse.

The passage of the ACA was a monumental step forward in our fight to confront the mental health and substance abuse crisis in this country and led to the largest coverage gains for mental health in a generation through the expansion of Medicaid.

Ms. Linke Young, can you briefly discuss why the consumer protections of the ACA are so important to individuals struggling with mental illness or substance abuse?

Ms. YOUNG. Absolutely. Preexisting law—law that existed prior to 2009—established a baseline protection for people with mental illness that said that, if their insurance plan covered mental illness—mental health needs—then it had to do so on the same terms that it covered their physical treatment.

But it didn't require any insurance product to include coverage of mental health benefits. And so it was typical for coverage in the individual market to exclude mental health benefits completely.

With the Affordable Care Act, plans were required to include coverage for mental health and substance use disorder services and to do so at parity on the same terms as they include coverage for physical health benefits, and that brought mental health benefits to about 10 million Americans who wouldn't have otherwise had it.

In addition, the Medicaid expansion in the 37 States and DC and that have taken that option has enabled many, many people with

serious mental health needs, including substance use disorder, to access treatment that they would not otherwise have been able to access.

Ms. MATSUI. So this would be very serious, and I am thinking about the 37 States that did expand Medicaid, if this decision was upheld.

I just really feel, frankly, that it is difficult enough when you have mental illness or someone in your family does, the stigma that is attached to it, whereas with the Medicaid expansion I believe that most people will seek the treatment that they really need.

And what do you foresee with the loss of this expansion if it were to happen?

Ms. YOUNG. If Federal funding for Medicaid expansion was no longer available, then the States that have expansion in place would need to choose whether to find State funding to fill that gap or to scale back their expansion or cut benefits or reduce provider rates or some combination of those policies.

The Congressional Budget Office and most experts expect that many States would retract the expansion and move those residents that were covered through expansion off the Medicaid rolls, and most of them are likely to become uninsured and would not continue to have access to mental health and substance use disorder coverage.

Ms. MATSUI. So, in essence, we will be going backwards then once again. OK.

Thank you very much, and I yield back the balance of my time.

Ms. ESHOO. Thank you, Ms. Matsui.

I would now like to recognize the gentleman from Kentucky, Mr. Guthrie.

Mr. GUTHRIE. Thank you very much, and again, congratulations on your——

Ms. ESHOO. Thank you.

Mr. GUTHRIE [continuing]. On being the chair. I enjoyed being vice chair a couple of times and learned a lot about the healthcare system and moving forward.

And I know today the title is how does the *Texas* case affect preexisting conditions, and I think we are hearing from everybody that it would probably be near unanimous if we did a legislative fix to preexisting conditions regardless of where the case goes, and so I was listening to Dr. Burgess talk earlier about having a hearing for Medicare for All, and I think the chair of the full committee said that, well, "Why would you want to have a hearing for a piece of legislation you say you're not for?"

I think it is important for us to talk about and the issues that would come because there are, I think, at least four or five presidential candidates that already said they were for it.

So it is not just some obscure bill that somebody files every year. It has now gotten into the public space that we need to discuss.

And Ms. Hung, I appreciate your testimony. I have nothing compared to your issues with your child, but I had a son that had some issues when he was a boy. He is 23 now, and so about a month of just, "What is going to happen?"—so I understand the preexisting conditions—and then another year and a half, maybe 2

years, in and out of children's hospitals. But we got the best words a parent can hear when a physician walks in: "We know what the problem is now, and we can fix it."

Matter of fact, just last fall he thought he was having some problems—so he lives in Chicago, west of Chicago. I went to see a—to a doctor with him and the doctor said, "Hey, it is something else, it is something routine we can treat." He goes, "By the way, you had a really great surgeon when he was 8." So we were just reinforced with it. So everything kind of works.

And so what has kind of impressed me, and I guess I am going to just talk a little bit instead of ask questions, but what has always impressed me about the care—Vanderbilt Children's Hospital is where we were—that he has received and just the innovation our healthcare system is producing.

It is absolutely amazing innovation coming out in our healthcare system. The artificial pancreas is real now. People can have it now. You can cure hepatitis C with a pill. It is just amazing what is happening with some people, not a lot. It is not universal, but stage four melanoma is being cured with precision medicine.

I mean, those things are happening in our healthcare system. They are expensive, and my biggest concern if we go to a Government-run, that we just lose that healthcare. We innovate, and the world—and President Trump talked about it a little last night—is living off our investment in innovation. But if we don't invest and innovate, who is going to do it and who is going to have the care that we have?

As a matter of fact, we are investing and innovating so quickly, this committee spent an awful lot of time over the last couple of years to put 21st Century Cures in place so the Government regulatory structure can keep up with the vast investment.

I know we spent a lot of time in the last couple years doing oversight. I hope we will continue to do oversight of implementation of 21st Century Cures.

So my only point is, and I will yield back in just a couple seconds, is that it is important when we look at such massive changes to our healthcare system, the way people get health insurance.

You know, most people still get it through their employer. Is that going to go away? People get it through—we talked about the Indian Health Services. Is that going to go away? Is it a road to get rid of the VA?

Just, there is so much change that is proposed in what people boil down to one—a bumper sticker, Medicare for All—that it has implications for everybody. It has implications for the whole country, and universal coverage is a positive thing.

But if you get to the—I tell you, if you get to the Medicare reimbursements throughout the entire healthcare system, I am convinced we won't have the innovation that completely—my son is completely healed—that had some innovative surgeries—for his privacy I won't say—but 15 years ago that now are probably completely different on what you see.

My cousin is a NICU doctor, and the stuff that—the babies that he now sees that are surviving, and we have a colleague here that had a daughter born without kidneys who, I guess—Abby must be about 5 or 6 now.

And so it is just—that is a concern, and I think that when we are going to have a piece of legislation that has kind of been boiled down to a bumper sticker but it is going to have impact on everybody living in this country and everybody throughout the world—because I wish the world would help subsidize some of the innovations that we are producing—that it is worthy for us to have serious discussions and not just dismiss it as we are not being serious.

So and I can tell you I am, I know Dr. Burgess is and I think the rest of the committee would be, and I appreciate you guys all being here and sharing your stories.

But we can fix preexisting conditions. I think we are all on board with that, and Madam Chair, I yield back.

Ms. ESHOO. I thank you, Mr. Burgess. Always a gentleman.

Let us see. Who is next? The chairman of the full committee, Mr. Pallone.

Mr. PALLONE. Thank you.

I wanted to ask Ms. Young a couple questions—really, one question. On the day of the Texas district court's ruling, President Trump immediately praised Judge O'Connor's decision to strike down protections for preexisting conditions.

The next day he referred to the ruling as, quote, "great news for America," and just last week in an interview with The New York Times, President Trump boasted that the *Texas* lawsuit will terminate the ACA and referred to the ruling as a victory.

In his testimony, Mr. Roy claims that President Trump supports protecting people with preexisting conditions. I think that could not be further from the truth. The truth is, President Trump has sought to undermine and unravel protections for more than 130 million Americans living with preexisting conditions and, understandably, that is not a record that Republicans want to promote.

But I also want to remind folks that, since this is not a fact that my colleagues on the other side seem to want to acknowledge, and that is that the Republican lawsuit brought by Republican attorneys general, who asked the district court to strike down the entire ACA.

So the fact that my colleagues and our minority witnesses today are trying to disassociate themselves from Judge O'Connor's ruling, which did exactly what the Republican AGs asked for, I think is quite extraordinary.

Mr. Roy asserts in his written testimony that Congress should pass a simple bill reiterating guaranteed issue and community rating in the event that the district court's decision is upheld by the Supreme Court.

So, and then we have this GOP bill or motion during the rules package where they said that, you know, they would do legislation that would only include guaranteed issue and community rating, and that would ensure sufficient protections for preexisting conditions, whatever the courts decide.

So, basically, Ms. Young, I have one question. Can you explain why what Mr. Roy is asserting—that reinstating only these two provisions on guaranteeing issue and community rating—is insufficient to protect individuals with a preexisting condition and the same, of course, is with the House GOP bill that would do that.

Why is this not going to work to actually guarantee protection for individuals with preexisting conditions?

Ms. YOUNG. The district court's opinion, as you note, struck down the entirety of the ACA. So not just its protections for people with preexisting conditions, but the financial assistance available to buy marketplace coverage, funding for Medicaid expansion, a host of provisions in Medicare, protections through the employer insurance and associated reforms.

So a standalone action that reinstated two preexisting conditions protections without wrapping that in the financial assistance and the risk adjustment and the Medicaid expansion and the other components of the ACA that are, in my view, important to make the system function, would not restore the system that we have today where people with preexisting conditions have access to a functioning market where they can buy coverage that meets their health needs.

In fact, there have been some efforts by the Congressional Budget Office to score various proposals that keep some types of preexisting condition protections in place but eliminate the financial assistance, and the Congressional Budget Office, under some scenarios, actually finds that those lead to even greater coverage losses than simply repealing the Affordable Care Act.

So implementing those two provisions on their own without financial assistance and other protections would be insufficient.

Mr. PALLONE. I mean, I think this is so important because, you know, again, Mr. Roy—and he is just reiterating what some of my Republican colleagues say. They just neglect all these other things that are so important for people with preexisting conditions.

You didn't mention junk plans. I mean, my intuition tells me, and I am not—you know, I talk to people about it in my district—you know, that if you start selling these junk plans that don't provide certain coverage, one of the things is it is important for people with preexisting conditions to have a robust plan that provides coverage for a lot of things that didn't exist before the ACA.

I mean, that is, again, important—the fact that you have a robust essential benefits is also important for people with preexisting conditions, too, right?

Ms. YOUNG. Those are both critical protections. In particular, the ACA seeks to ensure that insurance for the healthy and insurance for the sick are part of a single combined risk pool.

Efforts to promote short-term plans or other policies that don't comply with the ACA protections siphon healthy people out of the central market and drive up costs for those with preexisting conditions and anyone else seeking——

Mr. PALLONE. Yes. So you are pointing out the very fact that you have a larger insurance pool, which has resulted from the ACA, in itself is important for people with preexisting conditions and if you take out the healthier or the wealthier because you don't have a mandate anymore, that hurts them too, correct?

Ms. YOUNG. Efforts to move healthier people out of the individual market will increase premiums for those that remain in complaint coverage, yes.

Mr. PALLONE. All right. Thank you so much.

Ms. ESHOO. Thank you, Mr. Pallone.

And now I want to recognize the ranking member of the full committee, Mr. Walden.

Mr. WALDEN. Thank you, Madam Chair, and I want to thank all of our witnesses. We have another hearing—an important one—going on downstairs. That is why some of us are bouncing back and forth between climate change and healthcare.

And I want to again say thank you for being here and reiterate that as Republicans we believe strongly in providing preexisting condition protection for all consumers, and if you go back to 1996, when HIPAA was passed under Republicans, we provided for continuous coverage protection for people with pre-ex.

I mean, this is something we believe in before ACA and something I believe in personally and deeply and something that we are ready to legislate on, and I think at least giving that guarantee and certainty to people would make a huge level of comfort for them.

And I just—you know, I didn't mean to shake things up this morning, but asking for a hearing on Medicare for All was something I thought was appropriate, given that other committees are already announcing their hearings, and that going back to when ACA was shoved through here and then Speaker Pelosi saying we had to pass it so you could find out what is in it—we don't want to repeat that. We need to know what is in it. We need thoughtful consideration. I think this committee is the place to have that. So I still think that is important.

I want to thank both Tom and Avik for being here—Mr. Roy—for being here on short notice. You said, Mr. Roy, that Congress should pass a simple standalone measure guaranteeing that insurers offer coverage in the individual health insurance market to anyone regardless of prior health status.

Mr. ROY. Yes, I did.

Mr. WALDEN. And do you want to respond? You didn't get a chance to kind of respond here. So do you want to respond to what was asked of the other witnesses around you?

Mr. ROY. Well, thank you, Mr. Walden. I appreciate the opportunity to actually explain my written testimony——

Mr. WALDEN. Go ahead.

Mr. ROY [continuing]. In this setting. The key here is that three-fourths of the variation of the premiums in health insurance in a fully underwritten market are associated with age, not health status or gender or anything else—preexisting conditions.

Mr. WALDEN. OK.

Mr. ROY. So the point is, if everybody of the same age—all 27-year-olds, all 50-year-olds, all 45-year-olds—if all 45-year-olds are charged the same premium, the variation in premiums between the healthy paying a little more and the sick paying a little less is not that big of a difference. It doesn't cause a lot of adverse selection.

What drives adverse selection in the ACA is the fact that younger people are forced to pay, effectively, double or triple what they were paying before——

Mr. WALDEN. Right.

Mr. ROY [continuing]. To allegedly subsidize the premiums for older people. So revising age bands would be a huge step in moving in the right direction. Reinsurance, which is effectively a high-risk

pool within a single-risk pool, would help basically also reduce the premiums that healthy people pay so that people with preexisting conditions could get better coverage.

So you can have a standalone bill that would ensure that people with preexisting conditions have access to affordable coverage.

Mr. WALDEN. I would hope so. I think it is really important. I mean, we were for preexisting protections. I was for getting rid of the insurance caps before ACA. I thought they were discriminatory against those who through no fault of their own had consequential health issues that could have blown through their lifetime caps.

And so I think there are things we could still find common ground on, and I wonder if you want to address the Medicare for All proposal as well.

Now, we haven't seen it spelled out. I know the Budget Committee is, I guess, having it scored and hearings on it. But I am concerned about the impacts it may have on delay in terms of getting healthcare. I am concerned about what it might do to the Medicare trust fund.

Do you have—do you want to opine on that while you are here?

Mr. ROY. Well, I have written a lot at Forbes and elsewhere about how Medicare for All from a fiscal standpoint is unworkable because of the gigantic transfers it would assign to the Federal Government.

It would increase Federal spending by somewhere between 28 and 33 trillion dollars over a 10-year period, which would be an increase in overall Federal spending of 71 percent.

Now, that is not if—that excludes the impact of cutting what you pay hospitals and doctors and drug companies by 50 percent, which is what you would have to do to effectively make the numbers work.

I do want to urge you, Mr. Walden, and your colleagues that while Medicare for All is unworkable, and I think most people know that, the status quo is unacceptable, too.

Mr. WALDEN. Right.

Mr. ROY. And I think it is extremely important for this committee in particular to tackle the high cost of hospital care, the high cost of drug prices.

Mr. WALDEN. Yes. That was—if I had stayed on as chair that was going to be our big priority this cycle. Surprise billing—I mean, you go in, you have a procedure, you have played by all the rules, and it turns out the anesthesiologist that put you under wasn't in your program and you get billed. That is wrong. That is just—I think we can find common ground on that one.

We took on the issue of getting generic drugs into market, and under the change in the law we passed last year, Dr. Gottlieb now has set a record for getting new generics in the market and driving both choice and innovation but also price down, and this administration—I have been in the meetings with the president and CEOs of the pharmaceutical companies. He is serious about getting costs down on drugs and getting to the middle part of this, too.

We need to look from one end to the other and, Madam Chair, I think we can find common ground here to do that and get transparency, accountability so consumers can have choice and so we can drive down costs.

I have used up my time, and I thank our witnesses again.

Madam Chair, I yield back.

Ms. ESHOO. I thank the ranking member.

We plan to examine all of that, and I think—I hope that we can find common ground on it because these are issues that impact all of our constituents, and they need to be addressed.

And on the surprise billing, I know that the Senate is trying to deal with it, and we should here as well. I think that your clock is not working at the witness table.

Mr. ROY. That is correct.

Ms. ESHOO. But it is working up here, OK. So maybe you can refer to that one.

Now I would like to call on the gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Madam Chair. Witnesses, thank you very much for being here, and colleagues, thank you for all of your attention here.

I just think it is so wrong for the Trump administration and Republicans in Congress to continue to try to rip affordable health coverage away from American families, especially our neighbors with preexisting conditions.

This lawsuit is just a continuation of their efforts to do that. When they couldn't pass the bill here in the Congress—in the last Congress, despite Republican majorities—and I am sorry to say that my home State of Florida under Rick Scott's administration joined that Federal lawsuit.

Thirteen Democratic members of the Florida delegation have written to our new Governor and attorney general, asking—urging them to remove the State of Florida from the Federal lawsuit that would kill the Affordable Care Act and rip health coverage away from American families, including individuals with preexisting health conditions.

This follows the letter we sent to Rick Scott as well, and I would like to ask unanimous consent that these letters be admitted into the record of this hearing.

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

Ms. CASTOR. American families are simply tired of the assault on affordable healthcare and, Chairwoman Eshoo, you raised the point about the skimpy junk insurance plans, because one way that the Trump administration and Republicans are trying to undermine affordable care are these junk health plans that do not provide fundamental coverage.

When you pay your hard-earned copayment and premiums, you should actually get a meaningful health insurance policy, not some skimpy plan that is just going to subject you to huge costs.

These subpar and deceptive junk plans exclude coverage for preexisting conditions. They discriminate based on age and health status and your gender.

Consumers are tricked into buying these junk plans, mistakenly believing that they are the comprehensive ACA plan, but then they are faced with huge out-of-pocket costs. For example, in a recent Bloomberg article, Dawn Jones from Atlanta was enrolled in a short-term junk plan when she was diagnosed with breast cancer.

Her insurer refused to pay for her cancer treatment, leaving her with a $400,000 bill.

Another patient in Pennsylvania faced $250,000 in unpaid medical bills because her junk short-term policy did not provide for prescription drug coverage and other basic services.

The Trump administration now is actively promoting these junk plans, and I want American families and consumers across the country to be on alert. Don't buy in to these false promises.

Ms. Young, you have talked a little bit about this, but will you go deeper into this? Help us educate families across the country. I understand that these plans often impose lifetime and annual limits. Is that correct?

Ms. YOUNG. It is, yes.

Ms. CASTOR. And that is something the Affordable Care Act outlawed?

Ms. YOUNG. Correct.

Ms. CASTOR. Can you describe what these plans typically look like and what kind of coverage they purport to provide?

Ms. YOUNG. Short-term limited duration insurance is not regulated at the Federal level. None of the Federal consumer protections apply. Some State law protections may apply or——

Ms. CASTOR. Consumer protections—name them.

Ms. YOUNG. The requirement that plans cover essential health benefits, the prohibition on annual and lifetime limits, the requirement that the insurance company impose a cap on the total copays and deductibles an individual can face over the year, requirements to cover preventive services, to not exclude coverage for preexisting conditions and other——

Ms. CASTOR. Wait a minute. Wait a minute. I have heard some of my Republican colleagues say they are all in favor of that. But can you be in favor of preexisting condition protection on the one hand and then say, "Oh, yes, we believe these junk insurance plans are the answer," like the Trump administration and Republicans in Congress are promoting?

Ms. YOUNG. Short-term limited duration plans do not have to comply with the requirements about preexisting conditions. That is correct.

Ms. CASTOR. Can you describe why an individual who is healthy when they sign up for one of these junk plans could still be subject to hundreds of thousands of dollars in medical bills?

Ms. YOUNG. There is no requirement that short-term plans cover any particular healthcare cost. So an individual who doesn't read the fine print behind their policy might discover, for example, that the plan only covers hospital stays of a few days and individuals are on the hook for all additional hospital expenses.

They may find that the plan has a very low annual limit, so that once they have spent 10 or 20 thousand dollars, they are responsible for bearing the full cost or any variation like that where they simply discover when they need to access the healthcare system that the plan doesn't include the coverage that they had hoped to purchase.

Ms. CASTOR. Thank you very much, and we will be working to ensure that consumers are protected and, when they pay their pre-

miums and copays, they actually get a meaningful health insurance policy.

Thank you, and I yield back.

Ms. ESHOO. I thank the gentlewoman.

I now would like to call on Mr. Griffith from Virginia. You are recognized for 5 minutes.

Mr. GRIFFITH. Thank you very much, Madam Chair. I appreciate it.

Here is the dilemma that we have. In my district, which is financially stressed in many parts of it—I represent 29 jurisdictions in rural southwest—always put the pause in there—Virginia.

So when ACA came in so many of my people immediately came to me, long before the Trump administration came in, and in their minds the ACA was junk insurance, because when they were promised that their premiums would go down, they now had premiums that were financially crippling.

When they were promised that they would have better access, they now found that they had high deductibles and they now found that their copays had gone through the roof.

So there is no question—I never argued—that the preexisting condition was a problem that should have been dealt with long before the ACA, and I understand the concerns and the frustration that people had who had preexisting conditions, and we need to take care of that and we will take care of that.

I don't see anybody who would argue at this point that we shouldn't deal with people with preexisting conditions and make sure they have access to affordable healthcare, which is why I supported our attempts to get an amendment put in on day one of this Congress that would say, get the committees of jurisdiction.

In fact, it referenced the Energy and Commerce Committee—this committee—and the Ways and Means Committee to report out a bill that took care of all of the concerns we have heard today and said it guarantees no American citizen can be denied health insurance coverage as the result of a previous illness or health status and guarantees no American citizen can be charged higher premiums or cost sharing as the result of a previous illness or health status, thus ensuring affordable health coverage for those with preexisting conditions.

That is where we are. That is what we stand for. So, you know, I find it interesting that this debate has become—you know, and I am hearing about junk insurance and how Republicans are evil, that they want junk insurance.

I hear it on a regular basis that my people think that what they have got now is junk. It is all they can afford, and it is costing them a fortune.

So, Mr. Roy, what do you have to say about that?

Mr. ROY. I have found the conversation we have been having about so-called junk insurance interesting because nobody seems to be asking the question as to why people are voluntarily buying so-called junk insurance.

They are buying it because the premiums are half or a third or a quarter of what the premiums are for the Affordable Care Act for them.

Mr. GRIFFITH. And if you can't afford something else, you are going to buy something that you can afford. Isn't that correct?

Mr. ROY. A hundred percent. So a plan that has all the bells and whistles but it is unaffordable to you is effectively, worthless, whereas a plan that may not have all the bells and whistles but at least provides you some coverage is.

And the great tragedy of the Affordable Care Act is that we did not have to have that dichotomy. We could have had plans that had robust coverage for people with preexisting conditions and protections for people regardless of health status and yet were still affordable.

I have outlined it both in my written testimony, in my oral testimony, and many, many other documents that I have presented to this committee in the past, how we could achieve that.

Mr. GRIFFITH. Now, you would agree with me for those people who may have bought the junk insurance without knowing what they were getting into that we probably ought to pass something that says that the things that aren't going to be covered—if you're only getting $20,000 worth of care and then you have to take the full bill after that, as Ms. Castor talked about—we should have that in bold language on the front of the policy.

You would agree that we should put some consumer protection in that and make sure there is transparency so people are well-advised of what they are getting or not getting. Isn't that true?

Mr. ROY. I have no problem with robust disclosure about what is in a short-term limited duration plan versus an ACA-compliant plan. To a degree, we already have that in the sense if you are buying off the ACA plan, I think most consumers know that those plans have fewer protections, but more disclosure, and more clarity in disclosure would be a good thing.

Mr. GRIFFITH. Absolutely. I agree with that.

You know, what is interesting is everybody seems to have gone after Judge O'Connor. I don't know him. I haven't studied his opinions.

But I do find this interesting. I thought it was the right thing to do. He put a stay on his ruling so it didn't create a national catastrophe or suddenly people are having to scramble to figure out what to do.

Mr. Miller, isn't that a little unusual in this day—I mean, people have accused him of being biased or having a political bent and using his power. But I seem to recall all kinds of opinions by judges that I thought were coming from a slightly different philosophical bent but who went out there on a limb, stretched—pushed the envelope of the law.

But instead of saying, "Now, let us wait until the appeal is over and make sure this is right before we affect the average citizen," they just let it go into effect. But Judge O'Connor said, "No, in case this is overturned, I want to make sure nobody is adversely impacted" and put a stay on his own ruling.

Isn't that unusual, and wasn't that the right thing to do?

Mr. MILLER. No, it is not—it is hopscotch. We have had some Federal judges who have had nationwide injunctions reaching way beyond what you would think would be the normal process.

Mr. GRIFFITH. Yes. I have noticed that.

Mr. MILLER. I think all the parties understood what practically was going on here. I would just point out on the legalities of this, just to clean up the record, one of the things about——

Ms. ESHOO. Just summarize quickly, because your time is up.

Mr. MILLER. My time is up. OK.

Mr. GRIFFITH. You could summarize, she said.

Ms. ESHOO. Quickly.

Mr. MILLER. I will just say, real fast, we left out the argument about tax guardrails, which was in Chief Justice Roberts' opinion, and Si is exaggerating what is there and isn't there.

The problem is that, when you take it apart, there is nothing left behind.

Ms. ESHOO. OK. I think your time is expired.

Mr. MILLER. It was his testimony, was that this tax didn't exist anymore.

Ms. ESHOO. All right. We are now going to go to and recognize Dr. Ruiz from California.

Mr. RUIZ. Thank you. It is so wonderful to be on this committee finally. So thank you to all——

[Laughter.]

Ms. ESHOO. He hasn't stopped celebrating.

Mr. RUIZ. Thank you to all the witnesses for joining us today. We have over 130 million Americans that have preexisting conditions. The ACA defended full protections for people with preexisting conditions, and those are three components.

One is that insurance companies cannot deny insurance to people with preexisting conditions; two, they cannot deny coverage of specific treatments related to the preexisting condition illness; and three, they cannot discriminate by increasing the prices towards people who have a preexisting condition.

Let me give you some examples of some of the benefits and hardships that people would face if this lawsuit is completed.

My district is home to Desert AIDS Project, an FQHC that was founded in 1984 to address the AIDS crisis. It is the Coachella Valley's primary nonprofit resource for individuals living with HIV/AIDS. They have grown to become one of the leading nonprofits and effective HIV/AIDS treatment in the Nation.

And the folks at Desert AIDS Project know how to end the HIV/AIDS epidemic. Basically, you need prevention and you need treatment. They told me that the ACA has been critical in providing treatment to the HIV—in order to get the HIV viral load at an uninfectious low level.

So the problems before the ACA was that insurance companies didn't used to have to pay for HIV tests, for example, or individuals with HIV couldn't get Medicaid coverage until they were really sick on full-blown AIDS, many already on their death beds.

Now, because of the ACA, insurance companies must cover essential health benefits like HIV tests and antiviral medications, which by the way the folks on the other side have attempted to repeal.

Because of the ACA and the Medicaid expansion many HIV-infected middle class families now have health insurance for the very first time. Unfortunately, I can't say that for HIV patients throughout our country including in States like Texas that didn't expand the Medicaid coverage.

And, by the way, this is another example of ACA that those on the other side attempted to repeal. Before the passage of the ACA, 90 percent of Desert AIDS Project clients did not have health insurance, and now, with the ACA, 99.9 percent of clients have health insurance coverage in Desert AIDS Project.

Let me repeat that statistic. Insurance coverage for these patients went from only 10 percent to 99.9 percent because of the ACA. And yet, the president, while claiming to be committed to eliminating the HIV/AIDS epidemic in 10 years, is actively taking measures to take away these protections of this very population by rolling back the Medicaid expansion and weakening and undermining preexisting conditions protections.

This would be devastating to Desert AIDS Project clients and patients, and yet this is just one example of the devastation that repeal of the ACA would cause on individuals with preexisting conditions.

Ms. Young, could you discuss the potential impact of the lawsuit on individuals with preexisting conditions if the district court's decision is upheld?

Ms. YOUNG. If the district court decision were to be upheld as written, it would disrupt the coverage for people with preexisting condition in all segments of the insurance market.

So we talked a lot about the individual market. The core protections in the individual market today would be eliminated along with the financial assistance that enables them to afford coverage and make those markets stable.

In employer coverage, people with preexisting conditions would also face the loss of certain protections. They would once again be exposed to lifetime or annual limits and they could face unlimited copays.

Mr. RUIZ. Let me get to another point because, you know, we are hearing a lot of political trickery here in the conversations. A number of the folks on the other side have introduced bills that will pick and choose which one of these three components that make up full protections for preexisting conditions that they want to have in certain bills.

For example, one bill says, we want guaranteed issue and community rating which will help keep the costs low for everybody but don't include the prohibition on preexisting coverage exclusions.

Another bill includes guaranteed issue and the ban on preexisting coverage exclusion but does not include the community rating, saying, well, let us charge people with preexisting more than other folks.

So they claim these bills are adequate to protect consumers with preexisting conditions. Can you explain why these bills are inadequate to protect individuals with preexisting conditions?

Ms. YOUNG. Very briefly, requiring insurance companies to sell a policy but allow preexisting condition exclusions requires them to sell something but it doesn't have to have anything in it. It is a little bit like selling a car without an engine.

And allowing unlimited preexisting condition rate-ups tells the consumer that they can buy a car but they could be charged Tesla prices even if they are buying a Toyota Camry. That is not what

the Affordable Care Act does. It puts in place a comprehensive series of protections.

Mr. RUIZ. Thank you.

Ms. ESHOO. Your time has expired. I thank the gentleman.

I now would like to recognize Dr. Bucshon from Indiana.

Mr. BUCSHON. Thank you, and congratulations on your chairmanship. Look forward to working with you.

I am a physician. I was a heart surgeon before I was in Congress, and we all support protections for preexisting conditions. Look, I had a couple of patients over the years who I did heart surgery on who had—one had had Hodgkin's disease in his 20s, and his entire life after that he could not afford health coverage, and that is just plain wrong. We all know that.

I had an employee of mine whose wife met her lifetime cap because of a serious heart condition and had to ultimately go onto Medicaid. That is not right.

So I think Republicans for many years have supported protecting people with preexisting conditions. I think we are in a policy discussion about the most appropriate way to do that.

And so I really think what we should be focusing on is to make sure that people actually have coverage that they can afford—quality affordable health coverage, and under the ACA, as was previously described, the deductibles can be very high. You couldn't keep your doctor and your hospital, as everyone said that supported the ACA, and so we are not meeting that goal.

And now we have heard from the Democrats about Medicare for All and their bill in the last Congress, H.R. 676, would have made it illegal for private physician practices to participate in a Government healthcare program. And by the way, Medicare for All doesn't even solve the main problem we have in healthcare, which is the huge cost.

I keep telling people if you continue to debate how to pay for a product that is too expensive, you are not going to catch up. It doesn't matter who is paying for it. It doesn't matter if the Government is paying for it or a partial hybrid system like we have now.

So I am hoping we can have some hearings on how we get the cost down, and the insurance problem kind of almost can solve itself if we can do that.

We should be talking about the fact that people with preexisting conditions really don't have protections, and it doesn't work if you don't have actual access to a physician.

So Mr. Miller and Mr. Roy—I will start with Mr. Roy—can you talk about what could happen in the U.S. if private physician practices were not allowed to participate in a single-payer program, hypothetically, and would that create access issues for patients?

Mr. ROY. Well, we already have access issues for patients in the Medicaid program. A lot of physicians don't accept Medicaid——

Mr. BUCSHON. That is correct.

Mr. ROY [continuing]. Even though they theoretically participate in the Medicaid program. That is also an increasing problem in Medicare because there are disparities in the reimbursement rates between private insurers, Medicare, and especially Medicaid.

And this is one of the other flaws in the ACA, is it relied on a program with very poor provider access to expand coverage. I think

the exchanges at least have the virtue of using private insurers to expand coverage rather than the Medicaid program with its much lower reimbursement rates.

Mr. BUCSHON. So I would argue that, you know, then if you go to a Medicare for All, you have access issues on steroids, potentially, and especially if you don't allow private practice physicians—what I am saying, nonhospital or Government-employed physicians, which is what we would all be—to participate in the program, which is actually not what other countries do.

In England, for example, you can have your private practice and also participate in the National Health Service.

Mr.——

Mr. MILLER. You are more likely to have Medicaid for All than Medicare for All until you solve the—and say "Stop, we can't deal with that." The problem is we would love to give away all kinds of stuff. We just don't want to pay for it.

Now, we can shovel it off into ways in which you get less than what was promised and say, "We have done our job." We did that to an extent with the ACA. You find the lowest-cost way to make people think they are getting something that is less than what they actually received.

That is why the individual market as a whole has shrunk in recent years. It is because those people who are not well-subsidized in the exchanges are finding out they can't afford coverage anymore.

Mr. BUCSHON. So, I mean, and I will stick with you, Mr. Miller. Do you think if the iteration of Medicare for All bans private practice physicians not to be able to participate that we would put ourselves at risk of creating a two-tiered system where the haves can have private coverage and there can be private hospitals as there is in other countries?

Mr. MILLER. Well, already we have got plenty of tiers in our system to begin with. It would exacerbate those problems and I don't think we would live with it politically, which is why it would probably short circuit.

But it is at least a danger when people believe in the theory of what seems easy but the reality is very different.

Mr. BUCSHON. Yes. I mean, I would have an ethical problem as a physician treating patients differently based on whether or not they are wealthy or whether or not they are subjected to a Medicare for All system, right.

So, ethically, I can tell you physicians would have a substantial problem with that. Other countries kind of do that because that is just the way it is there and I think in many respects their citizens don't have a problem with it because that is just what they have always lived with.

But I would agree with you that in the United States there would be some issues.

Mr. Roy, do you have any comments on that?

Mr. ROY. I do. I would just like to add that at the Foundation for Research on Equal Opportunity we put together a detailed proposal for private insurance for all, where everyone buys their own health insurance with robust protections for preexisting conditions and health status and robust financial assistance for people who

otherwise can't afford coverage in a way that is affordable, that would actually reduce Federal spending by $10 trillion over three decades but would ensure 12 million more people have access to health insurance than do today under current law.

So there are ways to address the problem of affordability and access of health insurance while also reducing the underlying cost of coverage and care and making the fiscal system more sustainable.

Mr. BUCSHON. Yes. I mean, I think we should be also putting focus on the cost of the product itself, right, and the reasons why it costs so much are multi-factorial. It is a free market system.

The other thing is, I told my local hospital administrators that if we get Medicare for All, get ready to have a Federal office in your private hospital that tells you how to run your business.

I yield back.

Ms. ESHOO. I thank the doctor.

And last, but not least, Mr. Rush from Illinois is recognized for 5 minutes for questioning.

Mr. RUSH. Thank you, Madam Chair.

Madam Chair, I also want to congratulate you for your becoming chair of the subcommittee and——

Ms. ESHOO. I thank you very much.

Mr. RUSH [continuing]. I have been a Member of Congress for quite—for, as you have, for over 26 years, and this is my first time being a member of this subcommittee, and I am looking forward to working with you and other members of the subcommittee.

I want to—as I recall, when this Affordable Care Act was passed, there were millions of Americans who were without health insurance totally. They were uninsured. They had no help at all, no assistance from anyone to deal with their illnesses and their diseases.

And since the Act was passed, approximately 20 million Americans have gained health coverage, including over a million in my State, and I don't want to overlook that fact. I don't want to get that fact lost in the minutia of what we—of any one particular aspect of our discussion.

In 2016, almost 14,000 of my constituents received healthcare subsidies to make their healthcare more affordable. One aspect of the ACA that I like is insurance companies must now spend at least 80 percent of their premium on actual healthcare as opposed to other kinds of pay for CEOs and also for an increase of their profits.

And the insurance rate has increased between—the uninsured rate, rather, has increased between the years 2013 and 2017—since 2017 in my State.

Ms. Young, how many Americans would expect to lose coverage if this court decision in *Texas* were upheld?

Ms. YOUNG. The Congressional Budget Office has estimated that repeal of the Affordable Care Act against their 2016 baseline would result in 24 million additional uninsured Americans, and upholding the district court's decision we could expect sort of broadly similar results with adjustments for the new baseline.

Mr. RUSH. Mm-hmm.

I want to ask Ms. Hung, you've been sitting here patiently, remarkably, listening to a lot of discussion between experts. But how do you feel about your daughter? How do you feel? What is your

reaction to all of this as it relates to the looming problem that you have if this case is upheld?

Ms. HUNG. Thank you. No one is going to sit here and say that they are not going to protect preexisting conditions, right. No one is going to say that. But that is what we have seen. That is what families like mine have seen—repeal efforts, proposals that don't cover preexisting conditions or claim to give a freedom of choice to choose what kind of insurance we want.

Well, the choice that I want is insurance that covers, that guarantees that these protections are in place. I don't want to sit in the NICU at my daughter's bedside wondering if she is going to make it and also then have to decide what kind of insurance I am going to buy and imagine what needs that she will have in order to cover that.

So I sit here and say, well, what worked for me is that I got to spend 169 days at my daughter's bedside without worrying about whether we would go bankrupt or lose our home, and that is the guarantee that we need.

Mr. RUSH. Madam Chair, I yield back.

Ms. HUNG. Thank you.

Ms. ESHOO. I thank the gentleman.

I now would like to call on another new member of the subcommittee, and we welcome her. Ms. Blunt Rochester from the small but great State of Delaware.

[Laughter.]

Ms. BLUNT ROCHESTER. Thank you, Madam Chairwoman.

First of all, thank you so much for your leadership. It is an honor for me to be on this subcommittee. And excuse me, I had competing committees for my first day of subcommittees and so I have been running back and forth.

But this is a very important topic, and I want to acknowledge Ms. Hung. The last time I saw you we were at a press event with then-Leader Pelosi highlighting the Little Lobbyists and the work that you do and have been doing, and just your support of protecting preexisting conditions for children across the country.

And it is really admirable that you advocate not only for your child but for all children across the country and have been fighting for decades. And I was hoping that you could talk a little bit about the formation of the Little Lobbyists and who they are, what it is all about, how it formed.

Ms. HUNG. Thank you, Congresswoman, and thank you for your support. I did not set out to start the Little Lobbyists. It kind of just happened. We were following the news, where families like mine, families with children with complex medical needs and disabilities, were very concerned, were very worried. And we decided to speak up and tell our stories.

And I tell my story because I know that many have been fortunate to not experience the challenges and hardships that we have seen. I also know that many have not experienced the joy and gratitude that I had in being Xiomara's mother.

So I feel a responsibility to uplift these stories that we weren't seeing being represented. Now, I have spent more than my fair share of time in the hospital. I have witnessed my baby on the brink of life and death one too many times.

I know what is possible with access to healthcare—quality healthcare—and I think I can say that I have a profound understanding, more than many Americans, how fragile life is, and it is with that understanding that I have chosen to spend my time raising that awareness.

I acknowledge my privilege. I acknowledge my proximity to Washington, DC, to come here. There are so many stories like mine across the country of families who are just fighting for their children, who want to spend that time on their kids and not worrying about filing for bankruptcy or losing their home or wondering if they can afford lifesaving medication.

Ms. BLUNT ROCHESTER. Yes, that was going to be my next question. How does this uncertainty affect your family? How is it affecting individuals that you work with and are talking to and other Little Lobbyists?

Ms. HUNG. It is everything. It is everything. So the uncertainty is not knowing. I mean, we don't know what the future holds. None of us do. But to add this on top of what we are going through, on top of the NICU moms that I know that are worrying, who are trying to keep their jobs and trying to be there for their children, to add this level of uncertainty on top of it is just devastating.

Ms. BLUNT ROCHESTER. I wanted to have your voice heard. I know from hearing that we have a lot of great experts and a great panel here, and I would like to bring it back to what this is all about. Maybe—I don't know if I am the last one speaking or—but I wanted to bring it back to why we are doing this and why we are here.

I have served the State of Delaware in different capacities, as our deputy secretary of health and social services, I have been in State personnel, so I have seen healthcare from that perspective and also from an advocacy perspective as CEO of the Urban League.

But hearing your story makes this real for us and is really one of the reasons why I wanted to be on this committee. So I thank you for your testimony. I thank the committee for your expert testimony, and I yield back the balance of my time.

Ms. ESHOO. Thank you very much.

I don't see anyone else from the Republican side.

Mr. BURGESS. There's some people coming back, but proceed.

Ms. ESHOO. OK. All right. We will move on.

I now would like to recognize the gentleman from California, Mr. Cárdenas.

Mr. CÁRDENAS. Thank you, and thank you, Chairwoman Eshoo and Ranking Member Burgess, and all the staff for all the work that went into holding this hearing of this committee, and I appreciate all the effort that has gone into all of the attention that we are putting forth to healthcare both at the staff level and at the Member level, and certainly for the advocates in the community as well.

Thank you so much for your diverse perspectives on what is important to the health and well-being of all Americans.

I think, while the legal arguments and implications of this case are important, I want to take a few minutes to focus on the very personal threats posed by these attacks to the Affordable Care Act.

This ruling, if upheld, would take away healthcare for tens of millions of Americans, including our most vulnerable, especially children and seniors. They are especially at risk, and people with preexisting conditions, we would see them just be dropped from the ability to get healthcare.

For some of us, this is literally a life-and-death situation and, as lawmakers, I hope that we don't lose sight of the fact of how critical this is, and as the lawmakers for this country, I hope that we can move expeditiously with making sure that we can figure out a way to not allow the courts to determine the future and the fate of millions of Americans when it comes to their healthcare and healthcare access.

Also, I want to thank everybody who is here today, and also the court's ruling would ideologically and politically, you know, follow through with the motivation that I believe close to 70 times or so in this Congress there was an effort to end it, not mend it, when it comes to the Affordable Care Act, and I think it is inappropriate for us to look at in such a black-and-white manner.

There are cause and effects should the Affordable Care Act go away. I happen to be personally one of those individuals that, through a portion of my childhood, did not have true access to healthcare, and it's the kind of thing that no parent should go through and the kind of situation that no American should ever have to contemplate, waiting until that dire moment where you have to go to the emergency room instead of just looking forward to the opportunity to, you know, sticking out your tongue and asking the doctor questions and they ask you questions and they find out what is or is not wrong, and that is the kind of America that used to be.

And since the Affordable Care Act, imperfect as it is, that is not the America of today. The America of today means that, if a young child has asthma, that family can in fact find a way to get an equal policy of healthcare just like their neighbor who doesn't have a family member with a preexisting condition.

So with that, I would like to, with the short balance of my time, ask Ms. Hung, could you please expand on the uncertainty that you have already described that your family would face should this court decision end the Affordable Care Act as we know it?

And then also could you please share with us, are you speaking only for you and your family or is this something that perhaps hundreds of thousands if not more American families would suffer that fate that you are describing?

Ms. HUNG. Thank you. I am here on behalf of many families like mine. The Little Lobbyists families are families with——

Mr. CÁRDENAS. Dozens or thousands?

Ms. HUNG. Thousands, across the country, families with children with complex medical needs and disabilities. And these protections that we are talking about today, they are not just for these children. They are for everyone. They are for everybody. Any one of us could suddenly become sick or disabled with no notice whatsoever. Any one of us could go suddenly from healthy to unhealthy with no notice and have a preexisting condition. An accident could happen, a cancer diagnosis, a sick child.

There is no shame in being sick. There is no shame in being disabled. Let us not penalize that. There is no shame in Xiomara needing a ventilator to breathe or needing a wheelchair to go to the playground.

But there is shame in allowing insurance companies to charge her more money just because of it, more for her care, and there is shame in allowing families like mine to file for bankruptcy because we can't afford to care for our children.

It is that uncertainty that is being taken away or at risk right now. Our families are constantly thinking about that while we are at our children's bedside.

Mr. CÁRDENAS. I just want to state with the balance of my time that this court case could be the most destructive thing that could have ever happened in American history when it comes to the life and well-being of American citizens.

I yield back the balance of my time.

Ms. ESHOO. I thank the gentleman.

I now would like to recognize my friend from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Madam Chair, and congratulations on chairing the best subcommittee in Congress, that's for sure—the most important.

Ms. ESHOO. Oh, thank you.

Mr. BILIRAKIS. Mr. Miller, the *Texas* court decision hinges on the individual mandate being reduced to zero in the law. Can you explain the court's reasoning in their decision?

Mr. MILLER. Well, I mean, we have to go back to a lot of convoluted reasoning in prior decisions in order to get there. So this is a legacy of trying to save the Affordable Care Act by any means possible, and it gets you into a little bit of a bizarre world.

But if you take the previous opinions at their face—it was somewhat of a majority of one by Chief Justice Roberts—he basically saved the ACA, which otherwise would have gone down before any of this was implemented, by having a construction which said, "I found out it is a tax after all," and he had three elements as to what that tax was.

The problem is, once you put the percentage at zero and the dollar amount at zero, it is not a tax anymore. It is not bringing in revenue. You don't pay for it in the year you file your taxes. It is not calculated the way taxes are.

So that previous construction, if you just look in a literal way at the law, doesn't hold anymore. What we do about it is another issue beyond that. But on the merits, we have got a constitutional problem, and in that sense that court decision was accurate. People then say, "Where do you go next?," and that is the mess we are in.

Mr. BILIRAKIS. Yes. Could legislation be passed that would address the court's concern, such as reimposing the individual mandate?

Mr. MILLER. All kinds of legislation. You are open for business every day, but sometimes business doesn't get conducted successfully. There are a wide range of things that I can imagine and you can imagine that would deal with this in either direction.

You have to pass something. What we are doing is we are passing the buck. We are trying to uphold some odd contraption, which

is the only one we have got, as opposed to taking some new votes and saying, "What are you in favor of and what are you against?" and be accountable for it and build a better system.

Mr. BILIRAKIS. Thank you.

Mr. Roy, you have written extensively on how to build a better healthcare system. The goal of the individual mandate, when the Democrats—now the majority party—passed the ACA, was to create a penalty to really force people to buy insurance.

Are there alternative ways to provide high-quality insurance at low prices without a punitive individual mandate?

Mr. ROY. Absolutely. So, as we have discussed already and I know you haven't necessarily been here for some of that discussion, simply the fact that there is a limited open enrollment period in the ACA prevents the gaming of jumping in and out of the system, and that is a standard practice with employer-based insurance. It is a standard practice in the private sector parts of Medicare. That is a key element.

Another key element is to reform the age bands—the 3-to-1 age bands in the ACA—because that actually is the primary driver of healthy and particularly younger people dropping out of the market.

Another key piece is to actually lower, of course, the underlying cost of healthcare so that premiums will go down and making sure that the structure of the financial assistance that you provide to lower-income people actually matches up with the premium costs that are affordable to them.

And a big part of it is, again, making the insurance product a little bit more flexible so plans have the room to innovate and make insurance coverage less expensive than it is today.

Mr. BILIRAKIS. All right. Thank you very much.

I yield back, Madam Chair, the rest of my time.

Ms. ESHOO. Thank you, Mr. Bilirakis.

I now would like to recognize the gentleman from Oregon, Mr. Schrader.

Mr. SCHRADER. Thank you, Madam Chair. I appreciate that.

I think sometimes we forget that the ACA was a response to a bipartisan concern about the construction of the healthcare marketplace prior to the ACA.

It was a pretty universal opinion, not a partisan issue, that healthcare costs were completely out of control. Whether you were upper middle class or low income or extremely wealthy, it was unsustainable.

And the ACA may not be perfect but, as pointed out at the hearings, it gave millions of Americans healthcare that didn't have it before. It started to begin the discussion that we are talking about here: How do you create universal access in an affordable way to every American?

Certainly, I am one of the folks that believe healthcare is a right, not a privilege, in the greatest country in the world. We are discussing about different ways to get at it.

I think one of the most important things that doesn't get talked about a lot is the importance of the essential health benefits. It gets demonized because, well, geez, "I am not a woman so I shouldn't have to pay for maternity. You know, I am invincible. I

am never really going to get sick, so I don't need to pay for, you know, emergency healthcare."

Those things are ancillary. I guess, Ms. Young, talk to us a little bit about why the essential health benefits are part of the Affordable Care Act, and there have been some attempts by the administration and different Members not, I think, realizing how important they are with these often, you know, cheaper plans. Just get the cost down—they are ignoring maybe the health aspects of that. Could you talk a little bit about that?

Ms. YOUNG. Absolutely.

Prior to the Affordable Care Act, insurers could choose what benefits they were going to place in their benefit policies.

The Affordable Care Act essential health benefit requirements require that all insurers in the individual and small group markets cover a core set of 10 benefits—things like hospitalizations and doctors visits as well as maternity care, mental health and substance use disorder, prescription drugs, outpatient services.

So, really, ensuring that the insurance that people are buying offers a robust set of benefits that provides them meaningful protection if they get sick.

If you return to a universe where an issuer can choose what benefits they are going to put inside of a policy, you could have an insurance benefit that, for example, excludes coverage for cancer services and another policy that excludes coverage for mental health needs, and one that excludes coverage for a particular kind of drug.

Mr. SCHRADER. And that might be in the fine print and people may not realize that as they sign up for policies.

Ms. YOUNG. That is correct, yes. So it would require consumers to really pile through the insurance—different policies to understand what they were buying.

It also provides a back-door path to underwriting because insurers, for example, that exclude coverage for cancer from their benefit won't attract any consumers who have a history of cancer, who have reason to believe that they may need cancer coverage.

And so it really takes our insurance market from one that successfully pools together the healthy and the sick to one that becomes more fragmented.

Mr. SCHRADER. Right. Well, and another piece of the Affordable Care Act that gets overlooked—and, again, it has been alluded to by different Members and some of you on the panel—is the innovation, the flexibility—I mean, the Center for Medical Innovation, the accountable care organizations.

Instead of—you know, it seems to me we are focused just on cost: How do I itemize this cost? We ask you guys these questions—the rate bands and all that stuff. We should be concerned about healthcare.

I mean, the goal here is to provide better health. It's not to support the insurance industry or my veterinary office or whoever. The goal is to provide better healthcare, and the way you do that is by, I think, you know, having the experts in different communities figure out what is the best healthcare delivery system.

Do you need more dentists in one community? Need more mental health experts in another community?

I am very concerned that, if the Affordable Care Act is undone, that a lot of this innovation that has been spawned, the accountable care organizations that are going, would begin to dissolve. There would be no framework for them to operate in.

Just recently in Oregon, where I come from, we had a record number of organizations step up to participate in what we call our coordinated care organizations that deal with the Medicaid population and have over 24 different organizations vying for that book of business.

Could you talk just real briefly—I am sorry, timewise—real briefly about, you know, what would happen if those all went away?

Ms. YOUNG. As you note, the Affordable Care Act introduced a number of reforms and how Medicare pays to incentivize more value-based and coordinated care.

If the district court's decision were to be upheld, then the legislative basis for some of those programs would disappear and there would really be chaos in Medicare payment if that decision were upheld.

Mr. SCHRADER. OK. Thank you, and I yield back, Madam Chair.

Ms. ESHOO. I thank the gentleman.

I can't help but think that this was a very important exchange in your expressed viewpoints and counterpoint to Mr. Miller's description of the ACA as an odd contraption.

I now would like to——

Mr. MILLER. I would respond on that if I had the opportunity.

Ms. ESHOO. I am sure you would.

Let us see, who is next? Now I would like to recognize Mr. Carter from Georgia.

Mr. CARTER. Well, thank you, and thank all of you for being here. Very, very interesting subject matter that we have as our first hearing of the year. I find it very interesting.

Mr. Miller, let me ask you, just to reiterate and make sure I understand. I am not a lawyer. I am a pharmacist, so I don't——

Mr. MILLER. Good for you.

Mr. CARTER. Yes. I don't know much about law or lawyers and——

Mr. MILLER. It is a dangerous weapon.

Mr. CARTER. Well, let me ask you something. Right now, this court case, how many patients is it impacting?

Mr. MILLER. Well, people hypothetically might react thinking it is real, but otherwise, nobody.

Mr. CARTER. But it is my understanding it is still in litigation.

Mr. MILLER. Correct. Correct. And it is going to take a while, and it is going to end up differently than where it starts. But we are doing this, you know, make believe because it scores a lot of points.

Mr. CARTER. Well, I—make believe—I mean, we are in Congress. We are not supposed to be make believe.

Mr. MILLER. Well——

Mr. CARTER. I mean, I am trying to understand why this is the first hearing, when it is not impacting a single patient at this time, it is still in litigation, we don't know how it is going to turn out, we don't know how long it is going to take. Judging by other court cases that we have seen, it may take a long, long time.

Mr. MILLER. Well, to be fair, I used to run hearings in Congress on staff.

Mr. CARTER. Well——

Mr. MILLER. The majority can run any kind of hearing it wants to.

Mr. CARTER [continuing]. We are not here to be fair. So anyway, I am trying to figure out why this is the first hearing. I mean, you know, earlier the chairman of the full committee berates our Republican leader because he asked for a hearing on something that he is opposed to and that I am opposed to, and I am just trying to figure it out.

You know, one of the things that we do agree on is that preexisting conditions need to be covered. Isn't it possible for us to still be working on preexisting conditions now and legislating preexisting conditions while this is under litigation?

Mr. MILLER. What you need are majorities who are willing to either spend money——

Mr. CARTER. Well——

Mr. MILLER [continuing]. Change rules and move things around. But that has been hard for Congress to do.

Mr. CARTER. Well, I think that the record will show that, you know, one of the first bills that we proposed in the Republican Party, in the Republican conference, was for preexisting conditions—Chairman Walden. In fact, I know he did because I cosponsored it.

Mr. MILLER. Mm-hmm. Yes. It was one of the more thorough ones, actually.

Mr. CARTER. It is something that—we have concentrated on that. So thank you for that. I just want to make sure.

Mr. Roy, I want to ask you, did you testify before the Oversight Committee recently?

Mr. ROY. Last week, yes.

Mr. CARTER. What were they talking about in the Oversight Committee? What were you testifying about?

Mr. ROY. Prescription drug prices. The high cost of prescription drugs.

Mr. CARTER. Prescription drugs. Go figure. Here we are in the committee and the subcommittee with the most jurisdiction over healthcare issues, and Oversight has already addressed prescription drug pricing?

Mr. ROY. Well, you have 2 years in this committee, and I look forward to hopefully being invited to talk——

Mr. CARTER. Well, I do too. I am just baffled by the fact that, you know, drug pricing is one of the issues—is the issue that most citizens when polled identify as being something that Congress needs to be active on, and I am just trying to figure out. In Oversight they have already addressed it.

Mr. ROY. You know, one thing I will say about this topic, Mr. Carter, is that it is one of the real opportunities for bipartisan policy in this Congress. We have a Republican administration and a Democratic House where there has been a lot of interest in reducing the cost of prescription drugs, and I am optimistic that we really have an opportunity here to get legislation through Congress.

Mr. CARTER. And I thank you for bringing that up because Representative Schrader and I have already cosponsored a bill to stop what I think is the gaming of the system of the generic manufacturers and the brand-name manufacturers of what they are doing in delaying generic products to get onto the market.

So, Madam Chair, I am just wondering when are we going to have——

Ms. ESHOO. Gentleman yield? Would the gentleman yield?

Mr. CARTER. And if I could ask a question.

Ms. ESHOO. Mm-hmm.

Mr. CARTER. When are we going to have a hearing on prescription drug costs?

Ms. ESHOO. I can't give you the date. But it is one of the top priorities of the majority. It is one of the issues that we ran on with the promise to lower prescription drug prices. I believe that there is a bipartisan appetite for this, and we will have hearings and we will address it and we welcome your participation.

Mr. CARTER. Well, reclaiming my time. I appreciate that very much, Madam Chair, because it is a pressing issue and it is an issue that needs to be addressed now and today, unlike what we are discussing here today that is not impacting one single person at this point.

So, you know, with all due respect, Madam Chair, I hope that we can get to prescription drug pricing ASAP because it is something that we need to be and that we are working on.

And, Mr. Roy, you could not be more correct. This is a bipartisan issue. I practiced pharmacy for over 30 years. Never did I once see someone say, "Oh, this is the price for the Democrat, this is the price for the Republican, this is the price for this person and that person." It was always the same. It was always high. That is why we need to be addressing this.

So I thank you for being here. I thank all of you for being here and, Madam Chair, I yield back.

Ms. ESHOO. I thank the gentleman.

I now would like to recognize a new member of the subcommittee, Ms. Barragán from California. Welcome.

Ms. BARRAGÁN. I thank you. Thank you, Ms. Chairwoman.

My friend from Georgia asked why we are having this as the first hearing, and I just have to say something because, you know, I am in my second term, and in my first term when the Republicans were in the majority they spent all of their time trying to take away healthcare coverage for millions of Americans.

They talk about preexisting conditions and talk about saving people with preexisting conditions. But this very lawsuit is going to put those people at stake.

So why are we having this hearing? Well, because you guys have been working to take away these coverages and we are trying to highlight the importance of this lawsuit.

Now, you had 2 years and, yes, you could have started with prescription drug prices and reducing those, and that wasn't done. So you are darn right the Democrats are going to take it up.

You are darn right that we are going to have hearings on this, and I am proud to say that our chairwoman and our chairman have been working hard to make sure we are going to work to

bring down prescription drug prices. But the hypocrisy that I hear on the other side of the aisle can't just go completely unanswered in silence.

So, with that said, I am going to move on to what my comments have been. I want to thank you all for your testimony here today. It has been really helpful to hear us understand the potentially devastating impact of this lawsuit and of the district court's decision.

The court's decision would not only eliminate protections for preexisting conditions but would also adversely impact the Medicaid program and end the Medicaid expansion.

Now, the Affordable Care Act's expansion of Medicaid filled a major gap in insurance coverage and resulted in 13 million more Americans having access to care.

I represent a district that is a majority minority—about 88 percent black and brown people of color and, you know, black and brown Americans still have some of the highest uninsured rates in the country. Both groups have seen their uninsured numbers fall dramatically with the ACA. You know, between 2013 and 2016, more than 4 million Latinos and 1.9 million blacks have secured affordable health coverage. Ultimately, black and brown Americans have benefitted the most from the ACA's Medicaid expansion program.

Ms. Young, I would like to ask, can you briefly summarize the impact of the lawsuit on Medicaid beneficiaries and, in particular, the expansion population?

Ms. YOUNG. Medicaid expansion is, as you note, a very important part of the Affordable Care Act's coverage expansion, and it is benefitting millions of people in the 37 States that have expanded or are in the process of expanding this year.

Medicaid expansion has been associated with better financial security, and failure to expand is associated with higher rates of rural hospital closures and other difficult impacts in communities.

If this decision were to be upheld, then the Federal funding for Medicaid expansion would no longer be provided and States would only be able to receive their normal match rate for covering the population that is currently covered through expansion. That is an impact of billions of dollars across the country and a very large impact in individual States.

States will have the choice between somehow finding State money to make up that gap or ending the expansion and removing those people from the Medicaid rolls or potentially cutting provider rates or making other changes in the benefit package or some combination.

So you are looking at a potentially loss of—see very significant losses of coverage in that group as well as an additional squeeze on providers.

Ms. BARRAGÁN. Thank you.

Ms. Hung, how has Medicaid helped your family afford treatment, and why is Medicaid and Medicaid expansion so important for children with complex medical needs and their families?

Ms. HUNG. Medicaid is a lifesaving program. I say this without exaggeration. Medicaid is the difference between life and death. It

covers what health insurance doesn't cover for a lot of children with complex medical needs.

Notably, it covers long-term services and supports, including home and community-based services that enable children's independence. For a lot of families who do have health insurance like mine, health insurance doesn't really cover certain DME—durable medical equipment—certain specialists, the ability to go out of State.

And so that is the difference for a lot of our families.

Ms. BARRAGÁN. Great. Well, thank you all. I yield back.

Ms. ESHOO. Thank you very much.

Now, the patient gentleman from Montana, Mr. Gianforte.

Mr. GIANFORTE. Thank you, Madam Chair, and thank you to the panelists for your testimony today.

Every day, I hear from Montanans who ask me why their healthcare costs keep going up and continue to increase while their coverage seems to shrink at the same time.

While we look for long-term solutions to make healthcare costs more affordable and accessible, I remain firmly committed to protecting those with preexisting conditions.

In fact, I don't know anyone on this committee, Republican or Democrat, who doesn't want to protect patients with preexisting conditions. Insuring Americans with preexisting conditions can keep their health insurance and access care is not controversial.

It shouldn't be. We all agree on it. Which brings us to today. In the ruling in *Texas* v. *Azar*, it has not ended Obamacare. It hasn't stripped coverage of preexisting conditions, and it hasn't impacted 2019 premiums.

While we sit here today talking about it, the Speaker has moved to intervene in the case and the judge ruling has been appealed. The case is working itself through the courts.

We could have settled this with a legislative solution less than a month ago. One of the earliest votes we took in this Congress was to lock in protection for patients with preexisting conditions.

Unfortunately, Democrats rejected that measure. And yet, here we are in full political theater talking about something we all agree on—protecting Americans with preexisting conditions.

We should be focused instead on the rising cost of prescription drugs, telehealth, rural access to healthcare, and other measures to make healthcare more affordable and accessible.

I hope this committee will hold hearings and take action on these issues important to hardworking Montanans. I can understand, however, why my friends on the other side of the aisle do not want to take that path.

Some of their party's rising stars and others jockeying for Democratic nomination in 2020 have said we should do away with private insurance. They advocate for a so-called Medicare for All. In reality, Medicare for none.

Their plan would gut Medicare and the VA as we know it, and force 225,000 Montanan seniors who rely on Medicare to the back of the line. Montana seniors have earned these benefits, and lawmakers shouldn't undermine Medicare and threaten healthcare coverage for Montana seniors.

Since we all agree we should protect patients with preexisting conditions, let us discuss our different ideas for making healthcare more affordable and accessible.

We should put forward our ideas: on the one hand, Medicare for All, a Government-run single-payer healthcare system that ends employer-sponsored health plans; on the other, a health insurance system that protects patients with preexisting conditions, increases transparency, choice, and preserves rural access to care and lowers cost.

I look forward to a constructive conversation about our diverging approaches to fixing our healthcare system. In the meantime, I would like to direct a question to Mr. Miller, if I could.

Under Medicare for All, Mr. Miller, do you envision access to care would be affected for seniors and those with preexisting conditions in rural areas in particular?

Mr. MILLER. Well, that is a particular aspect. I think, in general, the world that seniors are currently used to would be downgraded. You are taking—spreading the money a little wider and thinner in order to help some. This is the story of the ACA.

We can create winners, but we will also create losers. Now, the politics as to who you favor sort out differently in different folks. It is hard to get a balancing act where everybody comes out on top unless you make some harder decisions, which is to set priorities and understand where you need to subsidize and what you need to do to improve care and the health of people before they get sick.

Mr. GIANFORTE. So it is your belief that, if this Congress were to adopt a Medicare for All approach, seniors would be disadvantaged? It will be more difficult to access care?

Mr. MILLER. They would be the first to be disadvantaged, as well as those with employer-based coverage because—if you swallowed it whole. I mean, there are lots of other problems Avik mentioned. It is not just the spending. It is actually the inefficiency of the tax extraction costs.

When you run that much money through the Government, you don't get what you think comes out of it.

Mr. GIANFORTE. One other topic, quickly, if I could. Telehealth is very important in rural areas. It is really vital to patients in Montana. How do you foresee telehealth services being affected under a single-payer system?

Mr. MILLER. Well, Medicare has probably not been in the forefront of promoting telehealth. I think there is a lot more buzz about telehealth as a way to break down geographical barriers to care, to have more competitive markets.

And so, if past history is any guide of Medicare fee-for-service, it is not as welcoming to telehealth as private insurance would be.

Mr. GIANFORTE. OK. And I yield back.

Ms. ESHOO. I thank the gentleman.

I now would like to recognize the gentleman from Vermont, Mr. Welch.

Mr. WELCH. Thank you. I will be brief. Just a few comments.

I think it is important that we had this hearing. This did not come out of thin air. I mean, I was on the committee when we wrote the Affordable Care Act. Very contentious. It was a party-line vote.

I was on the committee when we repealed it—this committee repealed the Affordable Care Act, and we never saw a bill. We never had a hearing.

And now we have a continuation of this effort by the Republican attorneys general to attack it, and we have the unusual decision by the administration where, instead of defending a Federal law, they are opposing a Federal law.

So it is why I have been continuing to get so many letters from Vermonters who are fearful that this access to healthcare that they have is really in jeopardy.

Loretta Heimbecker from Montgomery has a 21-year-old son who is making $11.50 an hour. He has got a medical condition from birth, and absent the access to healthcare he wouldn't be able to work and the mother would probably be broke.

I have got a cancer patient, Kathleen Voigt Walsh from Jericho, who would not have access to the treatment she needs absent this. I mean, Ms. Hung, you really, in your own personal presentation, have explained why people who really need it would be scared if we lost it.

And I also served in Congress when the essential agenda on the Republican side was to try to repeal it. I mean, it was a pretty weird place to be—Congress—when on a Friday afternoon, if there is nothing else to do, we would put a bill on the floor to repeal healthcare for the sixtieth time. I mean, we are just banging our head against the wall.

So thank you for having this hearing because I see it as a reassurance to a lot of people I represent that we mean business—that we are going to defend what we have.

Now, second, on some of the criticisms about this not being a hearing on prescription drugs, Mr. Roy, you were in—did a great job helping us start the process in Oversight and Government Reform.

But I know our chair of this subcommittee—this is the committee where there is actual jurisdiction—is totally committed to pursuing this, and I thank our chair.

And I have been hearing very good things from President Trump about the need to do this. So my hope is that we are going to get a lot of Republican support to do practical things so we are not getting ripped off, as the president has said, by us paying the whole cost of research—a lot of it, by the way, from taxpayers, not necessarily from the companies—and have to pay the highest prices.

So I am commenting and not asking questions. But I know that there has been extensive and excellent testimony. But I just want to say to the chair and I want to say to my colleagues, Republican and Democrat, if the net effect of this hearing is that we are affirming a bipartisan commitment not to mess with the Affordable Care Act, then I am going to be able to reassure my constituents that their healthcare is safe.

And if the criticism is essentially we have got to do more, we are ready to do more, right?

Madam Chair, so I thank you for this hearing, and I thank the witnesses for their excellent testimony and look forward to more down the line.

Ms. ESHOO. I thank the gentleman for his comments and his enrichment of the work at this subcommittee. I think it is important to note that, on the very first day of this Congress, that House Democrats voted to intervene in this case—the very first day of the Congress—as it moves through appeal.

So we are the ones that are representing the Government, and I think that, for my colleagues on the other side of the aisle, you may not like my suggestion, but if you are for all of these things that you are talking about, write to the attorneys general and the Governors that brought the suit and say, "We want it called off. We want to move on and strengthen the healthcare system in our country." You will find a partner in every single person on this side of the aisle.

With that, I would like to recognize Mr. O'Halleran—what State?

Mr. BURGESS. Arizona.

Ms. ESHOO. Arizona—from the great State of Arizona—who is, I believe, waiving on to the subcommittee, and we have a wonderful rule in the full committee that, if you are not a member of a subcommittee you can still come and participate. But you are the last one to be called on. So thank you for your patience, and thank you for caring and showing up.

Mr. O'HALLERAN. I thank you, Madam Chair. I am also usually last in my house also to be called on.

Thank you, Madam Chair. Although I am not a permanent member of the subcommittee, I appreciate your invitation for me to join you today to discuss this issue that is so critical to families across Arizona, and thank you to the witnesses.

As some of you know, the district I represent is extremely large and diverse—the size of Pennsylvania. Twelve federally recognized Tribes are in my district.

Since I came to Congress 2 years ago, I have been focused on working across the aisle to solve healthcare issues. We face these issues together because it is one thing that I hear about every single corner of my rural district and one of the overriding issues in Congress.

A district where hospitals and the jobs they provide are barely hanging on and where decades of toxic legacy of uranium mining has left thousands with exposure-related cancers across Indian country.

A district where Medicaid expansion made the difference for some veterans getting coverage, some hospitals keeping their doors open, where essential health benefits meant some struggling with opiate addiction could finally get substance abuse treatment.

I am here because the lawsuit we are discussing today isn't about any of those policies and how they save taxpayer dollars and protect rural jobs. I am a former Republican State legislator. I know that this lawsuit is purely motivated not by what is best for the people we are representing but by politics.

Ms. Young, I have three questions for you. The first is, the first letter I ever sent as a Member of Congress was a bipartisan letter to congressional leadership about dangers of ACA repeal on the Indian Health Care Improvement Act, which was included in the ACA.

Madam Chair, I ask unanimous consent to enter my letter into the record.

Ms. ESHOO. So ordered.

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

Mr. O'HALLERAN. Ms. Young, can you describe what the fate of this law would be if this lawsuit succeeds and what it means for Tribal communities?

Ms. YOUNG. The district court's opinion as written struck down the entire Affordable Care Act so it would—even unrelated provisions like the Indian Health Care Improvement Act—so, if the decision were upheld, then the Indian Health Care Improvement Act would no longer have the force of law and the improvements included in that law, like better integration with the Veterans Health Service and better integration for behavioral health and other core benefits for the Indian Health Service, would be eliminated.

Mr. O'HALLERAN. Thank you, Ms. Young.

Are cancers caused by uranium exposure considered a preexisting condition?

Ms. YOUNG. I suspect that under most medical underwriting screens they would be, yes.

Mr. O'HALLERAN. Thank you. And, Ms. Young, over 120 rural hospitals have closed since 2005. Right now, 673 additional facilities are vulnerable and could close. That is more than a third of rural hospitals in the United States.

If this lawsuit succeeds, do you anticipate rural hospitals and the jobs they provide would be endangered as a result of fewer people having health coverage?

Ms. YOUNG. As you know, rural hospitals face a number of challenges and a number of difficult pressures. There has been research demonstrating that a State's failure to expand Medicaid is associated with higher rates of rural hospital closures. And so, if the Federal funding for Medicaid expansion were removed, then it is likely that that would place additional stress on rural hospitals.

Mr. O'HALLERAN. Thank you.

Madam Chair, this is why last year I led the fight to urge my State's attorney general to drop this partisan lawsuit. So much is at stake in Arizona for veterans, the Tribes, for jobs in rural communities like mine.

I am interested in finding bipartisan solutions to the problems we have got, and I will work with anyone here to do that. But this lawsuit doesn't take us in that direction. It takes us back, and my district can't afford that.

Thank you, and I yield back.

Ms. ESHOO. I thank the gentleman for making the time to be here and to not only make his statement but ask the excellent questions that you have.

At this time I want to remind members that, pursuant to the committee rules, they have 10 business days to submit additional information or questions for the record to be answered——

Mr. BURGESS. Madam Chair?

Ms. ESHOO. Yes.

Mr. BURGESS. Could I seek recognition for a unanimous consent request?

Ms. ESHOO. Sure. Just a minute. Let me just finish this, all right?

I want to remind Members that, pursuant to committee rules, Members have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared, and I ask each of the witnesses to respond promptly to any such questions, and I see your heads nodding, so I am comforted by that, that these questions that you may receive.

And I would recognize the ranking member, and I also have a list of—to request unanimous consent for the record.

Mr. BURGESS. Oh, I can go after you.

Ms. ESHOO. OK. The first, a statement for the record from the American Cancer Society Cancer Action Network and 33 other patient and consumer advocacy organizations; a statement for the record from the American Academy of Family Physicians; a statement for the record from the American College of Physicians; the Wall Street Journal editorial entitled "Texas Obamacare Blunder." I think that was referenced by Mr. Lazarus earlier today.

Jonathan Adler and Abbe Gluck, New York Times op-ed entitled "What the Lawless Obamacare Ruling Means"; a brief of the amicus curiae from the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry.

Isn't it extraordinary what we have in this country? Just the listing of these organizations.

The U.S.A. Community Catalyst, the National Health Law Program, Center for Public Policy Priorities, and Center on Budget and Policy Priorities; the brief of the amici curiae from the American Cancer Society, the Cancer Action Network, the American Diabetes Association, the American Heart Association, the American Lung Association, and National Multiple Sclerosis Society supporting defendants; and a statement for the record from America's Health Insurance Plans.

So I am asking a unanimous consent request to enter the following items in the record. I hear no objections, and I will call on—recognize the ranking member.

[The information appears at the conclusion of the hearing.][1]

Mr. BURGESS. Thank you. First off, thank you for reminding me why I have not yet paid my AMA dues this year.

[Laughter.]

Mr. BURGESS. I have a unanimous consent request. I would ask unanimous consent to place into the record the letter that was sent by Mr. Walden and myself regarding the Medicare for All hearing.

Ms. ESHOO. No objection.

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

Ms. ESHOO. The only request that I would make is that maybe on your email mailing list that, when you notify the chairman of the full committee, that maybe my office can be notified as well.

Mr. BURGESS. Welcome to the world that I inhabited 2 years ago.

Ms. ESHOO. That's why I think you will understand.

[1] The amici briefs have been retained in committee files and also are available at https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=108843..

Mr. BURGESS. I never found out until after the fact.

Ms. ESHOO. Right. Right.

Mr. BURGESS. But I would take that up with your full committee chair. I am sure they will recognize the importance of including you in the email distribution list.

Ms. ESHOO. I thank the gentleman.

Let me just thank the witnesses. You have been here for almost 3 hours. We thank you for not only traveling to be here but for the work that you do that brings you here as witnesses.

Mr. Lazarus says he is retired, but he brings with him decades of experience. We appreciate it. To each witness, whether you are a majority or minority witness, we thank you, and do get a prompt reply to the questions because Members really benefit for that.

So our collective thanks to you, and to Ms. Hung, what a beautiful mother. You brought it all. I am glad that you are sitting in the center of the table, because you centered it all with your comments.

So with that, I will adjourn this subcommittee's hearing today. Thank you.

[Whereupon, at 1:03 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

Congress of the United States
Washington, DC 20515

January 9, 2019

The Honorable Ron DeSantis
Governor
State of Florida
400 S. Monroe St.
Tallahassee, FL 32399

RE: Affordable Health Care for Floridians

Dear Governor DeSantis:

Congratulations on your swearing in as governor of the great State of Florida. We look forward to working with you to improve the lives of all Floridians. Affordable health care is fundamental to the wellbeing of the families we represent and we encourage you to shift the state's focus to constructive improvements in care and coverage and build on the success of the Affordable Care Act, Medicaid and Medicare.

The success of the Affordable Care Act in Florida is clear as demonstrated by the historic number of Floridians who found affordable health coverage through the Affordable Care Act (ACA) marketplace for 2019 – approximately 1.8 million Floridians. Florida again led the nation in the number of citizens who enrolled. Affordable health coverage will bring economic security and peace of mind to many of our neighbors. Even in the midst of concerted efforts by the Trump Administration and Republicans at every level of government to sabotage the ACA, the citizens of Florida have spoken on the importance of affordable health coverage through the robust enrollment numbers.

Affordable coverage for Florida families is at risk, however, due to a misguided federal lawsuit making its way through the courts. We encourage you and Attorney General Ashley Moody to *remove the State of Florida from the federal lawsuit that would kill the ACA and rip health coverage away from American families, including individuals with preexisting health conditions*. Former Governor Rick Scott and Attorney General Pam Bondi never should have joined the lawsuit to destroy the ACA. Following the federal court ruling last month, it is more imperative than ever for the State to withdraw and instead side with the almost eight million Floridians with preexisting conditions – including the 2.1 million Floridians with preexisting conditions who have individual coverage. We urge you to stand up for Florida families and vital ACA consumer protections that save lives and save money. As we asked Governor Scott in June 2018, we urge you to withdraw from this dangerous lawsuit and work with us to adopt consumer protections that will protect Florida families – especially those with preexisting conditions.

PRINTED ON RECYCLED PAPER

The ACA, Medicaid, Medicare and private health policies work in tandem to keep Floridians healthy and well. Misguided changes to our insurance framework spell trouble for Florida. For example, recent comments regarding "Medicaid block grants" as a potential way to control costs for health services for Florida families caught our attention because block grants would cause massive losses of revenue to the State and trigger huge cuts in care. A Medicaid block grant would put the health of our most vulnerable neighbors and our state's budget in jeopardy. Instead, we encourage you to work with us to *expand Medicaid* and to encourage Floridians to enroll in comprehensive coverage. The key to reducing health care costs in Florida is to ensure that Floridians have affordable and meaningful "coverage" and to end the costly and inefficient system that exists now.

Block granting Medicaid or considering per capita caps would be uniquely devastating to Florida. In Fiscal Year 2017, the federal government funded 61.2 percent of the $23 billion Medicaid budget in Florida. A block grant would place an arbitrary cap on that federal Medicaid percentage ("FMAP") and slash billions of federal dollars sent to Florida. At the same time, the needs and population of the state will grow. Federal Medicaid matching dollars must grow or else the state will be on the hook for enormous costs or will have to institute devastating cuts in care.

Florida is more susceptible to economic swings and natural disasters than the rest of the country. Fortunately, the FMAP increases when Florida experiences an economic downturn, health crisis or hurricane, but would not increase under a block grant. Our state cannot afford to suffer under arbitrary "caps" in assistance especially during a crisis. In recent years, hurricane damage to Puerto Rico brought tens of thousands of new Floridians to our state, a Zika outbreak in 2016 put pregnant women at risk, and the opioid crisis continues to grow in our communities. A block grant would put our Medicaid budget at risk and trigger cuts in basic care, cuts to already underpaid providers, and cuts to other important state responsibilities like education and infrastructure.

At present, Medicaid in Florida covers mainly children, seniors in nursing homes and pregnant women - our most vulnerable neighbors. Capping federal resources devoted to their care is inconsistent with our values and unwise due to the major financial burden that would be shifted to the state and local communities. Provider payment rates also would suffer in a state that already underpays many doctors and medical professionals.

Instead of a devastating block grant approach, we urge you to *expand Medicaid to bring billions of our tax dollars home to Florida* and create a more efficient health care system. Medicaid expansion would ensure that our neighbors get the care they need and would boost our economy. Thirty-six states and the District of Columbia already have expanded Medicaid to provide affordable health care to working families and students. This includes several states led by conservative governors who have found a way to make Medicaid expansion work for their states. Florida's failure to expand Medicaid to date has cost our state ***$66 billion*** according to an analysis by the Robert Wood Johnson Foundation and the Urban Institute[1]. Recently announced appointments have us concerned with the direction your administration may take, so we strongly

[1] Stan Dorn et al., Robert Wood Johnson Foundation and Urban Institute, "What is the Result of States Not Expanding Medicaid?" https://www.urban.org/sites/default/files/publication/22816/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-.PDF

urge you not to leave Florida's hard-earned tax dollars in Washington even one more day and expand Medicaid immediately. Otherwise, Florida remains at a significant financial disadvantage compared to the states that acted to expand Medicaid.

Medicaid expansion also is the right thing to do for the health of Floridians. Earlier this year, The Urban Institute estimated that Florida's 15.7 percent uninsured rate would drop 4.5 percent if we fully implemented expansion.[2] In addition to sharp reductions in the uninsured population, "expansion greatly improved access to care, generally improved quality of care, and to a lesser degree, positively affected people's health."[3] Providing hardworking Floridians access to comprehensive health coverage would provide a path toward improving preventive care, management of chronic conditions, diverting routine health care out of hospital emergency departments, and reducing uncompensated care.

Medicaid expansion also is the right thing to do for Florida's budget and economy. Medicaid expansion will boost jobs and enable Florida to move to a more efficient health care delivery model. Earlier estimates suggested that the state would have seen $8.9 billion in increased economic activity and 71,300 new jobs in 2016.[4] These economic benefits would start in the health care sector and then spread throughout other parts of our economy. Additional costs associated with expansion are estimated to be either fully or largely offset by savings from other programs.[5] Furthermore, no studies have shown that expansion would negatively impact job creation, employee behavior, labor force participation, or the number of work hours per week.[6] A healthy workforce makes for a healthy economy.

Finally, Medicaid expansion is popular. A survey published by the University of Maryland's Program for Public Consultation found that 67 percent of Floridians support moving forward with expansion to bring $66 billion in federal funding between 2013-2022 to our state.[7] This fall, residents of three red states, Idaho, Nebraska, and Utah all voted to expand Medicaid coverage. That followed a successful 2017 Medicaid expansion referendum in Maine.

Instead of building additional barriers to health coverage for Floridians, we urge you to work with us to defend the vital consumer protections included in the Affordable Care Act and to expand Medicaid to serve Florida families and create a more efficient system of care in Florida.

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[2] Matthew Buettgens, Robert Wood Johnson Foundation, "The Implications of Medicaid Expansion in the Remaining States: 2018 Update" https://www.urban.org/sites/default/files/publication/98467/the_implications_of_medicaid_expansion_2001838_2.pdf.

[3] Olena Mazurenko et al., "The Effects of Medicaid Expansion Under the ACA: A Systemic Review," Health Affairs, June 2018, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1491.

[4] Families USA, "Florida's Economy Will Benefit from Expanding Medicaid, Feb. 2013, https://familiesusa.org/sites/default/files/product_documents/FL-and-Medicaid-Expansion_0.pdf.

[5] Matthew Buettgens, Robert Wood Johnson Foundation, "The Implications of Medicaid Expansion in the Remaining States: 2018 Update"

[6] Jesse Cross-Call, "Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics Claims," https://www.cbpp.org/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims#_ftn1

[7] Voice of the People & Program for Public Consultation, School of Public Policy, University of Maryland, "Survey on Medicaid Expansion," http://vop.org/wp-content/uploads/2017/04/Medicaid_Expansion.pdf.

Medicaid expansion would aid the state's bottom line as well. A Medicaid block grant would prove devastating to the State of Florida and should be taken off the table immediately. Instead, we urge you to focus on coverage for Floridians and eliminating costly emergency room visits and delayed care.

In your inaugural remarks, you stated that, "[i]n no area is legislative initiative more needed than in the field of health care. The escalating cost of medical care, prescription drugs and health insurance has wreaked havoc on family budgets, priced many out of the market entirely, and has put significant stress on our state budget. ... The people of Florida deserve relief." We agree and urge you to take concrete steps to improve affordable, quality health care to our neighbors across Florida. We look forward to working with you on behalf of all Floridians and to the betterment of the state we love. Thank you.

Sincerely,

Kathy Castor
United States Senator

Ted Deutch
United States Representative

Frederica S. Wilson
United States Representative

Lois Frankel
United States Representative

Al Lawson, Jr.
United States Representative

Debbie Wasserman Shultz
United States Representative

Val Butler Demings
United States Representative

Debbie Mucarsel-Powell
United States Representative

Stephanie Murphy
United States Representative

Darren Soto
United States Representative

Charlie Crist
United States Representative

Donna Shalala
United States Representative

Alcee L. Hastings
United States Representative

Cc:
Lieutenant Governor Núñez
Attorney General Moody
Commissioner of Agriculture Fried
Chief Financial Officer Patronis
Senate President Galvano
House Speaker Oliva
Senate Minority Leader Gibson
House Minority Leader McGhee

United States Senate
WASHINGTON, DC 20510-0905

June 13, 2018

The Honorable Rick Scott
Governor
State of Florida
400 S. Monroe Street
Tallahassee, FL 32399

RE: Protect health coverage for Floridians with pre-existing conditions

Dear Governor Scott,

We are extremely concerned about the Trump Administration's refusal to defend the nation's health care law, and the state of Florida's decision to join as a party to *Texas v. U.S. Department of Health and Human Services (HHS)*. By joining this lawsuit, the state of Florida is actively working to hurt Americans with pre-existing conditions. And, as representatives of the people of Florida, we urge you to withdraw from this dangerous suit immediately—and instead adopt additional consumer protections that will protect those with pre-existing conditions.

Having failed multiple times to rip health coverage away through Congress, the Trump Administration is now attempting to use the court system to take the guarantee of health coverage away from 7.8 million Floridians with pre-existing conditions. This is wrong.

In February, attorneys general in 20 states—including the attorney general of Florida—filed a lawsuit in *Texas v. HHS* to strike down the nation's health care law and all of its critical protections with no plan in place to replace it. And just last week, the U.S. Department of Justice (DOJ) filed a brief in that case urging the court to do exactly what these states are asking for—to overturn critical pieces of the nation's health care law.

If the administration and these attorneys general prevail, health insurers across the country will once again be able to charge unlimited premiums for older adults and discriminate against people with pre-existing conditions by refusing to offer them coverage or charging them exorbitant premiums simply because of their past medical history.

If successful, this dangerous lawsuit that you and Attorney General Bondi have joined will harm roughly 130 million Americans, including 7.8 million Floridians who have a pre-existing condition, such as diabetes, cancer, asthma and Alzheimer's—and it will take us back to a time when health insurers oftentimes outright rejected, or offered severely limited coverage to, Americans with such conditions. It will also put great financial strain on our hospitals and communities due to uncompensated care costs.

Floridians deserve better.

We understand that your decision to join this lawsuit is consistent with your earlier actions in favor of repealing the nation's health care law and refusing to expand Medicaid coverage to 800,000 Floridians. But, just as we did in our letter on May 17, we once again implore you to work with us to set a different course and do what is right for the people of Florida.

We urge you to support protections that prohibit insurance companies from charging people higher rates based on their health status, and to expand Medicaid coverage to 800,000 Floridians who desperately need it. Just last month, the state of Virginia changed its course and chose to finally expand Medicaid coverage for its residents because "key Republicans from rural areas couldn't bear to deny coverage for their constituents any longer." The people of Florida deserve the same.

So, instead of building additional barriers to keep health care coverage away from those in need, we strongly urge you to withdraw from this reckless lawsuit immediately and work with us to increase consumer protections for the people of Florida and continue to prevent health care plans from discriminating against those with pre-existing conditions.

Sincerely,

Bill Nelson
United States Senator

Kathy Castor
United States Representative

Alcee L. Hastings
United States Representative

Frederica S. Wilson
United States Representative

Stephanie Murphy
United States Representative

Darren Soto
United States Representative

Lois Frankel
United States Representative

Ted Deutch
United States Representative

Debbie Wasserman Schultz
United States Representative

Al Lawson, Jr.
United States Representative

Charlie Crist
United States Representative

Val Butler Demings
United States Representative

Congress of the United States
Washington, DC 20515

January 26, 2017

The Honorable Paul D. Ryan
Speaker of the House
H-232, The Capitol
Washington, D.C. 20515

The Honorable Mitch McConnell
Majority Leader, United States Senate
230 U.S. Capitol
Washington, D.C. 20510

Dear Speaker Ryan and Leader McConnell,

As you move forward with plans to repeal and replace the Affordable Care Act, we write to express our grave concern for the impact to tribal citizens and communities who stand to be disproportionately affected. The ACA, while not perfect, has been a health and economic lifeline for thousands of individuals, families, and providers across Indian Country who have benefitted from increased access to coverage, choice, and consumer protections under the law.

The ACA includes critical improvements and investments in health care for American Indians and Alaska Natives, who have long faced wide health disparities and barriers to care. Chief among these achievements is the permanent reauthorization of the Indian Health Care Improvement Act, which until the passage of the ACA had languished for over a decade awaiting reauthorization in Congress. Thanks to its permanent reauthorization, First American communities have benefitted from increased choice and lower out of pocket costs. In addition to expanded coverage and protections under the ACA, the IHCIA has specifically worked to provide:

- Expanded programs for mental and behavioral health treatment and prevention, which are helping to curb the high rates of depression, substance abuse, and suicide on tribal lands.
- New authorities for facilitation of care for Indian veterans, whose community providers are now able to receive reimbursement from the VA for their care.
- Demonstration programs for health care provider shortages – especially critical in our rural communities where families stand to benefit from emerging models of care delivery like telemedicine.
- Expanded authorities for long-term care services, including home health care, assisted living and community-based care - providing needed support to caregivers.
- Expanded authorities for funding of patient travel costs – a critical component of care coordination for patients who must travel hundreds of miles to receive specialized care and treatment.
- New authorities for urban Indian health programs

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Our constituents cannot afford to lose these vital, life-saving programs that are working to improve public health and lower costs across the board. Repealing the ACA without a feasible, bipartisan plan that upholds our commitments to Indian Country will only further widen the glaring health disparities that tribal communities face.

We stand ready and willing to work with you to address, improve, and expand access to affordable health care for all Americans, including our American Indian and Alaska Native brothers and sisters.

Sincerely,

Tom O'Halleran
Member of Congress

Betty McCollum
Member of Congress

Tom Cole
Member of Congress

Derek Kilmer
Member of Congress

Louise McIntosh Slaughter
Member of Congress

Michelle Lujan Grisham
Member of Congress

Daniel T. Kildee
Member of Congress

Raul Ruiz
Member of Congress

Jared Huffman
Member of Congress

Lucille Roybal-Allard
Member of Congress

Suzan K. DelBene
Member of Congress

Alcee L. Hastings
Member of Congress

Don Young
Member of Congress

Pete Aguilar
Member of Congress

Gwen Moore
Member of Congress

Mark Pocan
Member of Congress

Tulsi Gabbard
Member of Congress

Chellie Pingree
Member of Congress

John Conyers, Jr.
Member of Congress

Ben Ray Luján
Member of Congress

Norma J. Torres
Member of Congress

Darren Soto
Member of Congress

Joe Courtney
Member of Congress

Tony Cárdenas
Member of Congress

Grace F. Napolitano
Member of Congress

Colleen Hanabusa
Member of Congress

Denny Heck
Member of Congress

April 23, 2018

The Honorable Alex Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mr. David Kautter
Acting Commissioner, Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge:

Thank you for the opportunity to submit comments on your Departments' proposed rule on Short-Term Limited-Duration (STLD or short-term) insurance. The 21 undersigned organizations urge the

Departments to withdraw this proposed rule unless it is heavily revised to meet our standards of accessibility, affordability, and adequacy that appropriately protects patients and consumers.

Our organizations represent millions of patients and consumers across the country facing serious, acute, and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, manage health, and cure illness. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the aforementioned Departments to make the best use of the collective insight and experience that we, and the individuals we represent, offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles we would use to guide and measure any work to reform and improve the nation's healthcare system.[1] These principles state that: (1) healthcare must be adequate, meaning that healthcare coverage should cover treatments patients need including all the services in the essential health benefits (EHB) package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care, the enrollment process should be easy to undertake, and benefits should be clearly defined.

In this proposed rule, your Departments propose to: expand the maximum coverage period of a short-term plan from three months to less than 12 months; revise the consumer notice required within any short-term plan contract and application materials; and implement these changes within 60 days of the publication of a final rule.

Short-Term Insurance is Not a Long-Term Solution

In light of our organizations' principles, we are deeply concerned about the impact the proposed rule on short-term plans will have on the individuals and families we represent—including those who choose not to purchase STLD plans. While STLD plans can offer cheaper premiums for some consumers, they are not required to adhere to important standards, including coverage for the ten essential health benefit categories, guaranteed issue, age and gender rating, prohibitions on discrimination against people with pre-existing conditions, annual out of pocket maximums, prohibitions on annual and lifetime coverage limits, and many other critical patient and consumer protections.

These plans often require consumers to spend enormous sums during the deductible portion of their benefit design, which can quickly eclipse the premium savings consumers may have while covered by one of these plans.[2] In addition to the exclusions listed above, short-term plans also frequently exempt themselves from many routine medical services that average consumers may not realize are not covered.[3,4] This combination of extraordinary financial risk and the lack of basic patient and consumer

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[1] Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

[2] UnitedHealthcare commercial webpage titled "Short-term Health Plans For Individuals and Families." https://www.uhone.com/insurance/short-term. Accessed on April 10, 2018.

[3] Agile Health Insurance, Everest Prime STM, pg. 11, http://dah38g2inbo50.cloudfront.net/everest-34d8af6c22f69da36d58184e5954eed5.pdf. Accessed on April 18, 2018.

[4] K. Pollitz, *Understanding Short-Term Limited Duration Health Insurance*, Feb. 2018, available at http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance.

protections led those who sell these plans to acknowledge that such plans are "designed solely to provide temporary insurance during unexpected coverage gaps"[5] and contribute to their status under federal regulation as separate and distinct from "individual health insurance coverage."[6]

The connection between access to health insurance and health outcomes is clear for the individuals we represent.[7,8] For example, Americans with cardiovascular disease or associated risk factors who lack health insurance, or are underinsured, have higher mortality rates[9] and poorer blood pressure control than their insured counterparts.[10] We are concerned that short-term plans, while less expensive than Affordable Care Act (ACA)-compliant plans, would be woefully inadequate for the majority of our patient populations regardless of age, gender, or health status.

Furthermore, many of the individuals represented by our organizations would be unable to purchase short-term plans due to a pre-existing condition. It is also likely that they would be unwilling to purchase such plans when confronted with the lack of vital patient protections and basic services these plans offer. Unfortunately, patients and consumers who choose to remain in the individual insurance markets would still be negatively impacted if the proposed rule is finalized in its current form. Consumers who choose to purchase ACA-compliant health plans would see their premiums increase and their insurance options decrease as people leave the market to purchase short-term plans.

Extending the period and renewability of short-term plans would significantly and negatively impact the families and individuals we represent. As such, our organizations are extremely concerned that implementing these policies will once again leave patients and consumers in the lurch with insufficient coverage, unpaid medical bills, long-term impacts on their financial wellbeing, and lifelong health implications – just as many of these plans did prior to the enactment of the ACA. If implemented, this proposed rule would have downstream impacts on the individual insurance markets jeopardizing access to affordable and adequate health insurance options for consumers who do not intend to purchase short-term plans. To sum up, short-term plans are an insufficient and inadequate solution to addressing premium and out-of-pocket costs and will have many long-lasting impacts on the entire health insurance market, as well as the health and wellbeing of the individuals we represent.

Accessibility

As mentioned above, a key principle adopted by our organizations is that healthcare must be accessible. All people, regardless of employment, health status or geographic location, should be able to gain coverage without waiting periods or undue barriers to coverage. At the same time, important patient protections in current law should be maintained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender rating, and excessive

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[5] 83 Fed. Reg. at 7443.

[6] Ibid.

[7] Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

[8] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

[9] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart- public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

[10] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.

premiums for older adults. Our organizations agree that every individual needs access to quality and affordable healthcare in order to maintain or improve their health and wellbeing.

Discriminatory Plan Design

Because short-term plans are exempt from the ACA's pre-existing condition protections, these plans can deny coverage of specific services based on health status and medical history of an individual, or deny coverage altogether. Insurers who offer short-term plans can also discriminate based on health status by charging higher premiums. By definition, these plans are widely inaccessible to our patient and consumer populations.

Protections included in the ACA prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately $1 billion a year and are still commonplace among insurers selling short-term plans.[11] Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, a category that can even include pregnancy. The application process often includes language explicitly excluding applicants who are pregnant, or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Network Adequacy

Short-term plans would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, oncology, maternity and newborn care, mental health, and emergency services, short-term plans are not required to comply with these standards. This is particularly concerning for our organizations as we represent individuals who are most in need of access to emergency services, outpatient care, and specialty physicians. These physicians and health services are also often the most expensive. Without regulation and oversight of network adequacy within these short-term plans as this proposal would allow, the physicians and services that patients require could be excluded from short-term provider networks altogether. They may also include facilities or specialists in the network that are far too distant from beneficiaries to be accessible.

Affordability

Our organizations' principles also recognize that illness and disease impact individuals across the economic spectrum. We believe that everyone – regardless of their economic situation – should be able to obtain the treatment they require to manage, maintain, or improve their health. This means that care should be affordable to an individual, including reasonable premiums and cost-sharing, and that individuals with pre-existing conditions should be protected from being charged more for their coverage. The proposed rule fails to achieve these goals.

Market Segmentation

Under the proposed rule, the Departments themselves acknowledge that, "consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions could face financial

[11] National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

hardship as a result, until they are able to enroll in PPACA-compliant plans that would provide coverage for such conditions".[12] However, allowing short-term plans to proliferate in the market will not only result in more people buying plans that may not cover the services they need, but will also have a negative impact on the stability and viability of the individual market itself. A recent study conducted by the Urban Institute projects that this proposed rule would result in over 2.5 million younger and healthier consumers across the country moving out of minimum essential coverage plans and into short-term plans, increasing premiums for those consumers who remain in the ACA-compliant nongroup insurance market by an average of 18.3 percent.[13] These increases in premiums would also likely be accompanied by an exodus of insurers from the marketplaces as their risk pools become older and sicker.

The Departments expect this very same outcome, stating:

> Allowing [relatively young and healthy] individuals to purchase policies that do not comply with [ACA], but with term lengths that may be similar to those of [ACA]-compliant plans with 12-month terms, could potentially weaken States' individual market single risk pools. As a result, individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market.[14]

They continue, asserting that, "[i]f individual market single risk pools change as a result, it would result in an increase in premiums for the individuals remaining in those risk pools."[15]

Within this proposed rule, the Departments admit that individuals with chronic conditions, which includes nearly half of the adult population in the United States[16] and the very patients and families that we represent, will be harmed by this rule. Individuals with chronic conditions would be ineligible for short-term insurance, either due to discriminatory plan practices or overt and total benefit exclusions, leaving ACA marketplace plans as their only option. For those in the marketplace, the Departments expect the implementation of this rule, if finalized, to raise their premiums by 10 percent on average.[17]

It is clear that the Departments understand the negative impact of the proposed rule. This blatant and intentional segmentation of the individual market will not only harm individuals with chronic, acute or serious health conditions enrolled in short-term plans, but will effectively undermine their ability to obtain affordable comprehensive coverage by exacerbating price increases within the individual market.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only applies to EHB-covered services. But under this proposal, the Departments would facilitate the proliferation of health insurance options that do not have to comply with EHB coverage requirements. The Departments acknowledge that, "[s]hort-term, limited-duration insurance policies would be unlikely to include all the elements of [ACA]-compliant

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[12] 83 Fed. Reg. 7437.

[13] Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. Urban Institute. March 2018. Available at: https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

[14] 83 Fed. Reg. at 7443.

[15] Ibid.

[16] Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. *Prev Chronic Dis*. 2014;11:E62.

[17] 83 Fed. Reg. at 7443.

plans, such as... coverage of essential health benefits without annual or lifetime dollar limits...".[18] Therefore, this proposal would once again subject patients to significant financial insecurity due to medical needs.

In 2007, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.[19] Patients who undergo heart transplants, use specialty medications, have complicated pregnancies, receive a cancer diagnosis, or are diagnosed with rare and complex conditions could easily meet or exceed lifetime and annual caps within a short period of time. For example, prior to the ACA, many children with hemophilia reached the lifetime limit on coverage under both parents' insurance plans before turning 18, leaving them without coverage options.[20,21] For these reasons, we strongly urge the Departments to consider the financial implications for our patients and secure their financial wellbeing by requiring short-term plans to comply with ACA consumer protections.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2018, the annual out-of-pocket limit for an individual is $7,350, and for a family plan is $14,700.[22] Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If the Departments move forward with this proposed dramatic expansion of non-EHB compliant short-term plans, it will also be subjecting consumers and patients with complex and chronic conditions in these plans to unaffordable cost-sharing for medically necessary services.

Adequacy

In our third principle, we assert that healthcare coverage must be adequate, covering the services and treatments patients need, including patients with unique and complex health care needs. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved in all health care plans, whether they are considered short-term policies or not.

As we have already stated, we are deeply concerned that the short-term plans created by this proposed rule could offer entirely inadequate, even discriminatory, coverage to the communities we represent. Our organizations emphatically urge the Departments not to finalize the rule or, if unwilling to do so, modify the proposed rule to fully protect consumers and patients against harm by requiring that all short-term plans that are allowed to operate for longer than the currently permitted three-month limit adhere to the patient protection standards that apply to plans sold on the individual marketplace.

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[18] Ibid

[19] Himmelstein DU, Throne D, Warren E, Woolhander S, Medical bankruptcy in the United States, 2007: results of a national study. Am J Med 2009 Aug; 122(8): 741-6. Doi.

[20] Economic Costs of Hemophilia and the Impact of Prophylactic Treatment on Patient Management," AJMC (4.18.2016), http://www.ajmc.com/journals/supplement/2016/incorporating-emerging-innovation-hemophilia-ab-tailoring-prophylaxis-management-strategies-managed-care-environment/incorporating-emerging-innovation-hemophilia-ab-tailoring-prophylaxis-management-strategies-managed-care-environment-economic-costs?p=1

[21] National Hemophilia Foundation: Strategic Summit Report" (October 2012), at 11: https://www.hemophilia.org/sites/default/files/article/documents/HemophiliaSummitFinalReportOct2012.pdf

[22] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

Essential Health Benefits (EHBs)
One of the most troubling characteristics of short-term health insurance plans is that they are not required to comply with EHB coverage requirements that apply to health plans offered on the individual market.

The individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the creation of the ten EHB categories, patients and consumers frequently found themselves enrolled in plans that failed to provide coverage for the care they routinely relied upon to maintain their health or treat illnesses. Patients with serious illnesses would discover they were not covered for new and innovative treatments, some individuals could not get coverage for emergency room services, and patients with chronic illnesses were often denied coverage for life-improving, sometimes even life-saving, medication. Many of these individuals did not realize at the time of their enrollment that they had selected a plan that did not meet their health care needs, let alone provide adequate coverage for a new diagnosis. Individuals with and without pre-existing conditions have come to rely upon the foundation that EHBs provide for adequate health insurance, and they expect those services to be covered by their insurance.

Short-term plans are allowed to categorically exclude certain benefits, such as maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. We are very concerned that healthy individuals may enroll in a short-term health plan that they believe meets their limited needs, but then not have access to necessary and medically appropriate care, including preventive care, as well as unpredictable but necessary health services such as prescription drugs or emergency room services.

Preventive Services
Short-term plans also would not be required to cover preventive services with no cost-sharing. Current law requires most private health plans to cover preventive services without cost-sharing, including co-pays, co-insurance and deductibles. The defined preventive services are any treatment receiving an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and any immunization having a recommendation from the Advisory Committee on Immunization Practices. They include services like cancer screenings, preventive treatments for cardiovascular disease, screenings for pregnant women, and tobacco cessation. These preventive services save both money and lives and are an important component of healthcare coverage for our patients.

Specific Solicited Feedback
Under the proposed rule, the Departments also solicited specific feedback regarding commenters' perspectives on (1) the appropriate duration of short-term plans; (2)existing regulations, policies, or guidance that limit or create barriers to entry into the short-term plan market; (3) conditions under which issuers should be allowed to incorporate renewability of these plans beyond 12 months; (4) the accuracy of the Departments' estimates of the increase in both premiums and federal spending that would result from this proposal; and (5) the impact of the proposed effective date.

Duration
The Departments ask what the appropriate duration of a STLD plan should be. The proposed rule suggests that the duration should increase from three months (90 days) to under 12 months (presumably 364 days). Our organizations believe this shift is unwarranted and will threaten the accessibility, affordability, and adequacy of health care for patients, as has been previously detailed. The

short-term plans are transitional coverage for people to access some coverage between jobs or other extenuating circumstances but are not considered healthcare coverage as defined by the Affordable Care Act, the Congressional Budget Office (CBO), and our organizations. Since short-term plans are not true health insurance, our organizations believe the duration of the plans should not exceed the current three-month threshold.

Renewability

Unlike insurance plans sold on the individual market, short-term plans also do not have to offer continued coverage once the policy term expires. This means that individuals who purchase these policies and then develop a health condition almost certainly will not have the option to renew their coverage, resulting in an effective rescission of coverage due to health status. This would disproportionately affect the individuals who develop acute, chronic, and serious health conditions while enrolled in short-term plans and cause significant, potentially dangerous disruption to their care.

As such, our organizations do not believe these plans should be renewable or allowed to continue for more than three months. The renewability of plans should be reserved for health insurance that meet the definition of minimum essential coverage (MEC). Under the proposed rule, the STLD plans do not meet that definition. Further, allowing for short-term plans to be renewed will create confusion in the marketplace. Our organizations strongly object to the renewability of the short-term plans.

Effective Date

As proposed, the final rule will become effective 60 days after the publication of the final rule, and any plans sold on or after the 60th day would need to meet the definition contained in that final rule to be considered short-term, limited-duration insurance. Our groups are deeply concerned that this timeline could threaten the stability of the individual market as it will allow for plans to be sold in 2018, after the rate filing process for 2019 is well underway or even complete in some states.
Issuers, state insurance commissioners, and other stakeholders need ample time to address the significant effects that the final rule will have on the individual marketplace. Issuers are already developing rates for the 2019 plan year. The Department of Health and Human Services' guidelines indicate that issuers' deadline for submitting plans in the exchange is less than two months after comments are due.[23] Setting the effective and applicability dates just 60 days after the release of the final rule will not provide enough time to prepare for this major disruption to the health care of millions of Americans purchasing insurance in the individual marketplace.

Moreover, some state legislatures might desire to pass laws that would address the STLD plans sold in their state. As of May 31, however, at least 30 states' regular legislative sessions will have ended. The effective date denies those states the ability to consider the impact of STLD plans on their individual market and to make changes that might compensate or mitigate that effect.

Departmental Estimates

The Departments estimate that the impact of this policy would be minimal, resulting in 100,000-200,000 individuals exiting the individual insurance markets in favor of enrolling in a short-term plan. We are concerned that this estimate is excessively conservative. An analysis conducted by the Urban Institute

[23] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Proposed-Key-Dates-for-Calendar-Year-2018.pdf

estimates that more than 4 million individuals would exit the exchanges to purchase a STLD plan.[24] The significant discrepancy between these two estimates suggests that the Department's estimations may be low and should be recalculated.

Other Concerns

Guided by the real experiences and needs of people with high health care needs that we represent, many of our groups have additional concerns with the proposed rule put forward by your Departments.

Notification to Consumers

Under the proposed rule, the Departments propose modifying the notice to consumers that the plan they are purchasing is not minimum essential coverage (MEC). We appreciate the language that clarifies the plan does not meet federal standards. However, as proposed, the notice is not sufficient to inform consumers that the coverage offered by these plans is frequently inadequate or substandard. Our organizations believe the notice on short-term limited-duration plans, including all plan documents and those that advertise the plans, must clearly articulate that these plans do not meet ACA protections, including those regarding preexisting conditions and essential health benefits.

Medical Loss Ratio

Additionally, as these plans are not ACA-compliant, they are not subject to the ACA's medical loss ratio (MLR) requirements under federal law. The MLR requirement, or so-called '80-20 rule', compels individual and small group health plans to spend at least 80 percent of premium income on health care and quality improvement activities, or rebate amounts in excess of this payout requirement back to the policyholder. Since 2011, insurance companies have paid out $3.2 billion in rebates under the medical-loss-ratio requirement.[25] As such, the MLR requirement represents a major advance in the transparency and value of health insurance coverage, and places a curb on insurers' marketing and overhead expenditures.

Absent this requirement for STLD products, insurers choosing to issue them will be more likely to spend more resources on marketing short-term products and offering higher commissions to their brokers compared to comprehensive ACA-compliant plans. This creates a perverse incentive for brokers to aggressively market these plans, and consumers may purchase them without understanding what they are buying. For patients with pre-existing conditions, unintentionally signing up for a short-term plan can limit access to life-sustaining treatment or leave them with no insurance at all if they are denied coverage – and with no recourse. Without a clear explanation of the basic elements of health insurance that may not be covered by these plans, consumers may not understand the comprehensiveness (or lack thereof) of their coverage. This creates a dangerous situation for patients who may unknowingly purchase plans that do not include the providers, medications, treatments, or services that they need to manage their conditions and stay healthy. As a result, patients may end up being surprised with massive medical bills for treatment that they believed to be covered, likely when they attempt to use their plan and need care most.

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[24] Blumberg, L, Buettgens, M, & Wang, R. The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending, The Urban Institute, February 2018. Available at https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

[25] Health Insurance.org, 'Billions in ACA rebates show 80/20 Rule's impact'. online April 16, 2017.

Concerns with the Public Comment Process

Finally, our groups are concerned with the Departments' comments regarding the finalization of the rule prior to the comment period closure. In a letter to the Governor and Director of the Department of Insurance of Idaho about the enforcement of the Affordable Care Act, Administrator Verma stated that CMS believed that Idaho could modify a proposal to sell state-based plans to comply with the new short-term, limited-duration plan rule so that the state could legally offer them.[26] We are concerned that CMS and other federal agencies and departments would offer guidance to states regarding the implementation of a regulation that is not yet finalized prior to taking into account the opinions and recommendations of all stakeholders who wish to comment.

Conclusion

Our organizations represent millions of patients, individuals, caregivers, and families who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide our recommendations on the proposed rule. However, given the history of discrimination and inadequate coverage within short-term limited-duration plans, we are deeply concerned that the proposed rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at enormous risk.

We urge the Departments to withdraw the proposed rule until the needs of our populations are met and instead, to focus on stabilizing the individual insurance markets and lowering premiums for QHPs.

As leaders in the healthcare and research communities and staunch patient and consumer advocates, we look forward to working with the Departments of the Treasury, Labor, and Health and Human Services' leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this rule. If you have any questions or would like to discuss these comments further, please contact Katie Berge, American Heart Association Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Autism Speaks
Chron's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes

[26] https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Otter.pdf

Mended Little Hearts
NAMI
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocacy Foundation
National Psoriasis Foundation

February 6, 2019

The Honorable Anna Eshoo
Chairperson
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515

The Honorable Michael Burgess, MD
Ranking Member
House Committee on Energy and Commerce
Subcommittee on Health
Washington, DC 20515

Dear Chairperson Eshoo and Ranking Member Burgess:

On behalf of the American Academy of Family Physicians (AAFP), which represents 131,400 family physicians and medical students across the country, I write to share the organization's comments for the hearing *Texas v. U.S.: The Republican Lawsuit and Its Impact on Americans with Pre-Existing Conditions.*

The *Patient Protection and Affordable Care Act* represented a sea change for millions of patients. We are pleased the committee has organized a hearing to examine the law and its impact on health care access for those with pre-existing conditions. It is our hope that during the 116th Congress the committee will also review other elements of the law, including Medicaid expansion, its impact on primary care access, potential individual market improvements, and proposals to maintain cost-sharing reduction payments.

In response to the lawsuit, the AAFP joined a friend-of-the-court brief with the American Medical Association, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the American College of Physicians. Collectively, our organizations commented that the decision would create further disruption, generate uncertainty, increase premiums, and cause declines in coverage.

A 2017 New England Journal of Medicine article indicates that the law's coverage expansion is associated with higher rates of individuals having a usual source of care, greater access to primary care physicians, and higher rates of preventive health screenings.[i] Anecdotal evidence among family physicians also reveals that health care access is saving lives and improving patient health for those who are accessing much-needed care for chronic diseases or detecting health challenges in their initial stages. Again, achieving optimal health does not occur by accident. Realizing the vision of healthy communities, like other national priorities, requires that we identify goals, invest resources, and eliminate barriers, especially for vulnerable citizens.

This issue is important for the AAFP because of our promotion of health care for all in the form of a primary care benefit design featuring the medical home, and a payment system to support it for everyone in the United States.[ii] AAFP believes that all Americans should have access to primary care services (e.g. in the case of infants and children, immunizations and other

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evidence-based preventive services, prenatal care, and well-child care), without cost sharing. The AAFP believes that health care for all should also include services outside the medical home (e.g. hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting access to care for everyone in the United States is consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care. Having both health insurance and a usual source of care (e.g., through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.[iii]

We appreciate the opportunity to comment on this important legislation. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

Sincerely,

Michael L. Munger, MD, FAAFP
Board Chair

---

[i] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., N Engl J Med 2017; 377:586-593

[ii] AAFP, Health Care For All (2014), *available at* http://www.aafp.org/about/policies/all/health-care-for-all.html

[iii] *See, e.g.*, The Robert Graham Center, The Importance of Having Health Insurance and a Usual Source of Care, Am. Fam. Physician (Sept. 15, 2004), *available at* http://www.aafp.org/afp/2004/0915/p1035.html.

Statement for the Record

American College of Physicians

Hearing before the Energy and Commerce Health Subcommittee

On

"Texas v. U.S.: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions"

February 6, 2019

The American College of Physicians (ACP) is pleased to submit this statement for the record and appreciates the efforts of Chairwoman Eshoo and Ranking Member Burgess in convening this hearing on the ruling handed down in Texas v. the United States and its impact on those with pre-existing conditions. We appreciate the subcommittee inviting input from relevant stakeholders, and we are pleased to offer our clinician perspective on this critical issue, especially in how it impacts the patients for whom we provide care.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

For many patients, primary care physicians are the first point of contact with the healthcare system. That means they are often the first to see depression, early signs of cancer or chronic disease, and help manage care for those with pre-existing conditions. They ensure patients get the right care, in the right setting, by the most appropriate health professional, in a coordinated way. The two specialties that provide the majority of adult primary care in the United States are family medicine and internal medicine.

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Texas v. the United States

On December 14, 2018, a federal judge in Texas ruled that the entire Affordable Care Act (ACA) is unconstitutional. The judge's ruling stated that since the ACA's "individual mandate" – a requirement that most Americans maintain "minimum essential" coverage or face a tax penalty -- is unconstitutional, the rest of the law cannot stand without it. The ACA will remain in place pending appeal.

ACP asserts that the ruling from this Texas judge is putting the health of millions of patients at risk. If this ruling stands, patients could once again be turned down or charged more for pre-existing conditions, and insurers would no longer be required to cover essential benefits like prescription drugs, maternity care, doctor visits, and mental health and substance use disorder treatment. The latter benefit is especially crucial as our nation confronts an opioid overdose epidemic that takes 130 lives every day. Additionally, premium subsidies to make coverage affordable would end; high-quality preventive services would be subject to cost-sharing; and annual and lifetime limits on coverage would return. Federal funding for Medicaid expansion would also be terminated, and seniors would no longer have access to no-cost preventive services. We urge the courts on appeal to consider the legal and patient protection arguments made by ACP, together with the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatry, in an amicus curiae brief filed in this case. Our groups together represent more than 560,000 physicians and medical students and we stand united in our believe that protections established by the Affordable Care Act that prohibit insurance companies from denying or discontinuing coverage for individuals with pre-existing conditions or other factors such as gender or race are vital to patient care and wellbeing.

Improving Patients' Lives under the Affordable Care Act

Before the Affordable Care Act (ACA), almost 50 million people went without any health insurance coverage. Many could not afford coverage because they had a pre-existing condition,

and plans sold in the individual market often had skimpy benefits that left people vulnerable to high out-of-pocket costs. The ACA addressed these problems in several ways. It established marketplaces (also called exchanges) where individuals could, during an annual open enrollment period, purchase one of four levels of coverage as well as receive *progressive* income-based premium subsidies (meaning the lower one's income, the higher the subsidy) if their incomes fall between 100 and 400 percent of the federal poverty level (FPL), and cost-sharing subsidies for persons with income up to 250 percent of the FPL. The ACA also established basic consumer protections including: no lifetime or annual dollar limits on coverage; prohibits insurers from denying, cancelling or charging higher premiums to people with pre-existing conditions; requires all health plans to cover 10 categories of essential health benefits; and prohibits insurers from charging higher premiums to women based solely on their gender.

Ensuring Protections for those with Pre-existing Conditions

A 2017 report by the HHS' Office of the Assistant Secretary for Planning and Evaluation found that up to 133 million non-elderly Americans have a pre-existing condition, including common conditions like high blood pressure, high cholesterol, and diabetes. According to a study by the Kaiser Family Foundation, 52 million people (27 percent of the nonelderly population) have a pre-existing condition that would have been deniable in the pre-ACA individual market. For that patient population, the ACA represented a sea change in their ability to access affordable medical care, and even a saving grace in helping to avoid catastrophic medical debt. That all could change if the Texas decision is allowed to stand.

Those with pre-existing conditions also face a further threat in the wake of the administration's 2018 proposal to allow Short-Term, Limited-Duration Insurance Plans to be sold as full-year substitute coverage for Affordable Care Act plans. ACP expressed its opposition to this proposal in April of last year. Short-term insurance plans are intended to provide temporary insurance during gaps in coverage, such as when a person is between jobs and does not have access to employer-based health insurance. Since they are not required to comply with the ACA's

insurance market regulations, they may not include coverage typical of comprehensive, major medical insurance. As noted in the administration's proposal, these policies "would be unlikely to include all the elements of PPACA-compliant plans, such as pre-existing condition exclusion prohibition, coverage of essential health benefits without annual or lifetime dollar limits, preventive care, maternity and prescription drug coverage, rating restrictions, and guaranteed renewability."

A new study also revealed that patients are being led to believe they are purchasing insurance policies that provide comprehensive coverage when in fact they do not, and that states are limited in their ability to police this type of marketing. This means that patients who purchase those plans may find themselves with significant and unexpected financial liability if they need health care services.

Action Needed on the Federal and State Level

This administration, as well as members of Congress and state governors, Attorneys General, and lawmakers from both political parties, have repeatedly promised citizens that essential patient protections, especially for persons with pre-existing conditions, will be protected. Now is the time to act on this promise by continuing all of the ACA's current law protections as this ruling makes its way through the courts, and to urge the higher courts to overrule the Texas judge's decision that jeopardized health care access for millions. We also urge Congress to take appropriate action to ensure that all patient protections afforded by the ACA are preserved, including but not limited to persons with pre-existing conditions.

Conclusion

ACP greatly appreciates the subcommittee convening this hearing and for its desire to hear from stakeholders on the impact of this court ruling on those with pre-existing conditions. ACP hopes and anticipates that this decision by a single federal judge in Texas will be reversed on appeal, but we take nothing for granted and will be doing all that we can to ensure that

patients do not lose current law protections. Please contact Jonni McCrann at jmccrann@acponline.org with any questions or if additional information is needed.

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OPINION | REVIEW & OUTLOOK

Texas ObamaCare Blunder

A judge's ruling will be overturned and could backfire on Republicans.

By The Editorial Board

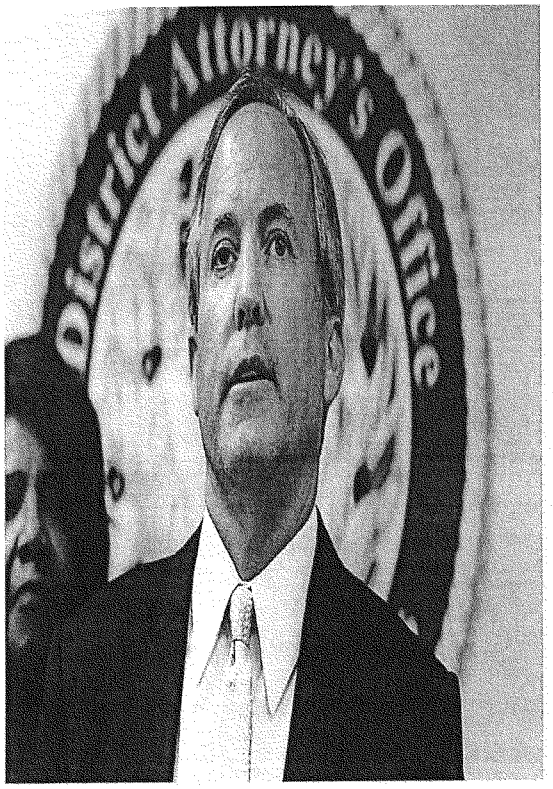
Dec. 16, 2018 4:40 p.m. ET

No one opposes ObamaCare more than we do, and Democrats are now confirming that it was designed as a way-station to government-run health care. But a federal judge's ruling Friday that the law is unconstitutional is likely to be overturned on appeal and may boomerang politically on Republicans.

Judge Reed O'Connor ruled for some 20 state plaintiffs that the Affordable Care Act's individual mandate is no longer legal because Republicans repealed its financial penalty as part of the 2017 tax reform. Recall that Chief Justice John Roberts joined four Justices to say ObamaCare's mandate was illegal as a command to individuals to buy insurance under the Commerce Clause. "The Framers gave Congress the power to *regulate* commerce, not to *compel* it," he wrote.

Yet the Chief famously salvaged ObamaCare by unilaterally rewriting the mandate to be a "tax" that was within Congress's power. Never mind that Democrats had expressly said the penalty was not a tax. Majority Leader Roberts declared it to be so.

Enter Texas Attorney General Ken Paxton, who argues in *Texas v. U.S.* that since Congress has repealed the mandate, the tax is no longer a tax, and ObamaCare is thus illegal. Judge O'Connor agreed with that logic, and he went further in ruling that since



Texas Attorney General Ken Paxton PHOTO: TONY GUTIERREZ/ASSOCIATED PRESS

Congress said the mandate is crucial to the structure of ObamaCare, then all of ObamaCare must fall along with the mandate.

We'll admit to a certain satisfaction in seeing the Chief Justice hoist on his own logic. But his ruling in *NFIB v. Sebelius* was in 2012 and there is more at issue legally now than the "tax" issue in that opinion. One legal complication is that Congress in 2017 repealed the financial part of the individual mandate, not the structure of the mandate itself. Republicans used budget rules to pass tax reform so they couldn't repeal the mandate's express language.

The Affordable Care Act has also been up and running since 2014, which means so-called reliance interests come into play when considering a precedent. Millions of people now rely on ObamaCare's subsidies and rules, which argues against judges repealing the law by fiat.

Judge O'Connor breezes past this like a liberal Ninth Circuit appeals judge handling a Donald Trump appeal. He's right that Democrats claimed the individual mandate was essential to the Affordable Care Act. But when Congress killed the financial penalty in 2017 it left the rest of ObamaCare intact. When judging congressional intent, a judge must account for the amending Congress as well as the original Congress.

In any case, the Supreme Court's "severability" doctrine calls for restraint in declaring an entire law illegal merely because one part of it is. Our guess is that even the right-leaning Fifth Circuit Court of Appeals judges will overturn Judge O'Connor on this point.

As for the politics, Democrats claim to be alarmed by the ruling but the truth is they're elated. They want to use it to further pound Republicans for denying health insurance for pre-existing conditions if the law is overturned. Democrats campaigned across the country against Mr. Paxton's lawsuit to gain House and Senate seats in November, and they will now press votes in Congress so they can compound the gains in 2020.

President Trump hailed the ruling in a tweet, but he has never understood the Affordable Care Act. His Administration has done good work revising regulations to reduce health-care costs and increase access, but the risk is that the lawsuit will cause Republicans in Congress to panic politically and strike a deal with Democrats that reinforces ObamaCare. This is what happens when conservatives fall into the liberal trap of thinking they can use the courts to achieve policy goals that need to be won in Congress.

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The New York Times

What the Lawless Obamacare Ruling Means

It's not based on a solid legal argument. It's an exercise in raw judicial power.

By Jonathan H. Adler and Abbe R. Gluck
Mr. Adler is a professor of law at the Case Western Reserve University School of Law. Ms. Gluck is a professor of law and the faculty director of the Solomon Center for Health Law and Policy at Yale Law School.

Dec. 15, 2018

In a shocking legal ruling, a federal judge in Texas wiped Obamacare off the books Friday night. The decision, issued after business hours on the eve of the deadline to enroll for health insurance for 2019, focuses on the so-called individual mandate. Yet it purports to declare the entire law unconstitutional — everything from the Medicaid expansion, the ban on pre-existing conditions, Medicare and pharmaceutical reforms to much, much more.

A ruling this consequential had better be based on rock-solid legal argument. Instead, the opinion by Judge Reed O'Connor is an exercise of raw judicial power, unmoored fro the relevant doctrines concerning when judges may strike down a whole law because of a single alleged legal infirmity buried within.

We were on opposing sides of the 2012 and 2015 Supreme Court challenges to the Affordable Care Act, and we have different views of the merits of the act itself. But as experts in the field of statutory law, we agree that this decision makes a mockery of the rule of law and basic principles of democracy — especially Congress's constitutional power to amend its own statutes and do so in accord with its own internal rules.

The individual mandate is the law's controversial requirement that all Americans maintain qualifying health insurance coverage or pay a penalty. In 2012, the Supreme Court upheld this penalty as an exercise of Congress's taxing power. In 2017, unable to get the votes to repeal the entire law, Congress just zeroed out the penalty.

In this case, Texas and 19 other states argue that with zero penalty, the mandate lacks a constitutional basis because it will no longer be enforced like a tax. If that were all there was, the case would have little consequence because starting in 2019, the mandate is unenforceable.

But audaciously, the states argued — and Judge O'Connor agreed — that the rest of Obamacare must fall, too. They claim that the mandate is so central to the A.C.A. that nothing else in it can operate without it.

That's not how the relevant law works. An established legal principle called "severability" is triggered when a court must consider what happens to a statute when one part of it is struck down. The principle presumes that, out of respect for the separation of powers, courts will leave the rest of the statute standing unless Congress makes clear it did not intend for the law to exist without the challenged provision. This is not a liberal principle or a conservative principle. It is an uncontroversial rule that every Supreme Court justice in modern history has applied.

Sometimes severability cases are difficult because it is hard to guess how much importance Congress attributed to one provision, especially in a lengthy law like the Affordable Care Act. But this is an easy case: It was Congress, not a court, that eliminated the mandate penalty and left the rest of the statute in place. How can a court conclude that Congress never intended the rest of the statute to exist without an operational mandate, when it was the 2017 Congress itself that decided it was fine to eliminate the penalty and leave the rest of the law intact?

The 55-page opinion devotes just two pages to the intention of the 2017 Congress. Instead, it relies on the perspective of the 2010 Congress that enacted the law, and two Supreme Court cases that were charged with asking questions about that 2010 Congress's intent. While the dozens of pages rehearsing those old viewpoints may look superficially sound, that part of the opinion is smoke and mirrors, because the 2010 Congress's intention *is not relevant to this case* — the 2010 law is no longer what is at issue.

Congress is allowed to amend its own law, and the Constitution does not permit any court to undermine that power. Still, Judge O'Connor wrote that we cannot divine the intent of the 2017 Congress because Congress didn't have the votes to repeal the entire law but wished it could. That's ridiculous. Congressional intent is all about the votes. One would not say Congress wished it could repeal the Civil Rights Act if only a minority of

Congress supported such a move. It is conservative judicial doctrine 101, as repeatedly emphasized by Justice Antonin Scalia, that the best way to understand congressional intent is to look at the text Congress was able to get through the legislative process.

Instead, Judge O'Connor goes down a rabbit hole, hypothesizing whether the 2010 Congress would have enacted the entire law without the mandate and whether the law can function without it. What findings Congress made in 2010 are irrelevant to the interpretation of this later legislative act. Regardless, Congress's own act of 2017 makes clear Congress thinks the law works without an operational mandate. To believe otherwise is to assume Congress enacts unworkable laws and that is not what courts are allowed to presume. Judge O'Connor's claim to the contrary is the equivalent of saying that your 2017 tax cut isn't valid because the 2010 Congress also enacted a tax bill, and wouldn't have included your tax cut there.

What happens next? The health law is likely to continue in place while the case moves to the higher courts. California, the leader of a group of states that stepped in to defend the law because the Justice Department refused to do so, will almost certainly go to the Fifth Circuit — the federal appellate court that presides over Texas — to have the effects of the decision paused and the case reviewed. The House of Representatives will also likely join the lawsuit once the Democrats take control.

If the Fifth Circuit reverses Judge O'Connor, we think it unlikely the Supreme Court will take the case. If the Fifth Circuit upholds the ruling, we are skeptical a majority of the court would sustain this weak analysis.

Chief Justice John Roberts is sensitive to allowing the court to be an instrument of politics, particularly when doing so violates separation of powers. Justice Brett Kavanaugh is an expert on statutory interpretation who has previously said that courts should "sever an offending provision from the statute to the narrowest extent possible unless Congress has indicated otherwise in the text of the statute." To do otherwise would be for the court to substitute its own judgment for Congress's.

Justice Clarence Thomas has opined that the kind of hypothesizing analysis on which Judge O'Connor relied is inappropriate: Congress's intentions "do not count," he wrote earlier this year, unless they are "enshrined" in a text that made it through the "constitutional processes of bicameralism and presentment" — as everyone agrees the 2017 tax bill did.

Friday was another sad day for the rule of law — the deployment of judicial opinions employing questionable legal arguments to support a political agenda. This is not how judges are supposed to act. Reasonable people may disagree on whether the health law

represented the best way to reform America's health care system, and reasonable people may disagree on whether it should be replaced with a different approach. Yet reasonable people should understand such choices are left to Congress, not to the courts.

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Jonathan H. Adler is a professor of law at the Case Western Reserve University School of Law. Abbe R. Gluck is a professor of law and the faculty director of the Solomon Center for Health Law and Policy at Yale Law School. They filed an amicus brief together in this case.

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February 5, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone and Chairwoman Eshoo:

We request that the Committee on Energy and Commerce hold a hearing on the Democratic Medicare for All proposal. Medicare for All was a critical issue in the last election among Democrats running for the House of Representatives, and there are important questions about the proposal that the Committee should investigate.

The American people should hear how House Democrats expect to address the massive costs associated with Medicare for All. Given the Committee's broad health care jurisdiction, we have a responsibility to review any legislative proposal that is supported by so many members of the House majority, especially one that threatens to impact directly the lives of millions of Americans by upending how they receive their coverage, including those with employer and union sponsored plans.

According to a recent media report, Speaker Nancy Pelosi supports holding hearings on Medicare for All.[1] It has also been reported the Budget Committee intends to hold hearings on the proposal,[2] and the Budget Committee Chairman John Yarmuth has requested the Congressional Budget Office produce a report on the "design and policy considerations lawmakers would face in developing single-payer health system proposals."[3]

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[1] Peter Sullivan, *Pelosi supports holding hearings on "Medicare for all,"* THE HILL (Jan. 3, 2019), *available at* https://thehill.com/policy/healthcare/423690-pelosi-supports-holding-congressional-hearings-on-medicare-for-all.
[2] Id.
[3] Letter from The Honorable John A. Yarmuth, Chairman, H. Budget Committee to Keith Hall, Director, Congressional Budget Office (Jan. 8, 2019), *available at* https://budget.house.gov/sites/democrats.budget.house.gov/files/documents/1.8.19.Request%20for%20report%20on%20single-payer_0.pdf.

It has also been reported that Ways and Means Committee Chairman Richard Neal is open to a hearing on Medicare for All.[4] By contrast, the only report of Medicare for All hearings at the Energy and Commerce Committee was a statement by Health Subcommittee Chairwoman Anna Eshoo, which was soon withdrawn when she indicated "that her subcommittee needed to prioritize shoring up Obamacare and crafting sweeping drug price reforms."[5] It is unfortunate that the Committee is not leading on this matter, particularly when, in the 115th Congress, the *Expanded and Improved Medicare for All Act,* was referred primarily to this Committee.[6]

To be clear, the Republican members of the Committee oppose moving to the government run, single option health care system envisioned in the Democrat's Medicare for All proposal for several reasons. The federal debt is currently more than $21 trillion, and it is estimated that Medicare for All could increase the total amount that the government spends on health care by at least $32.6 trillion over the first 10 years.[7] A hearing would provide the opportunity for the Committee to understand how such a program could be paid for.

We are also concerned that the Democrat's Medicare for All proposal will outlaw private insurance in America. That means that not only would 158 million Americans who get health insurance through their employer or union lose their current coverage,[8] but the millions of other Americans who buy private insurance and the millions of seniors who get coverage through the popular Medicare Advantage program would also lose their current plan. In our view, families and individuals are in the best position to decide what type of plan they need, and that right should not be taken away.

We are also concerned that the Democratic Medicare for All proposal will end Medicare as we know it by draining the Medicare Trust Funds that millions of seniors have paid into their entire lives. According to the Congressional Research Service,[9] Medicare for All would use existing federal health funds, including the Medicare trust funds – in addition to massive tax increases – to fund the proposal. Raiding the Medicare trust funds would jeopardize the care of millions of seniors. The current Medicare program is running a deficit, with the Hospital

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[4] Peter Sullivan, *Incoming Dem chairman open to hearing on "Medicare for all,"* THE HILL (Dec. 11, 2018), *available at https://thehill.com/policy/healthcare/420894-incoming-dem-chairman-open-to-hearing-on-medicare-for-all.*

[5] Dan Diamond, *Health committees finalized in new Congress,* POLITICO (Jan. 17, 2019), *available at* https://www.politico.com/newsletters/politico-pulse/2019/01/17/health-committees-finalized-in-new-congress-482627.

[6] Congressional Research Service, *Summary of H.R. 676, Expanded and Improved Medicare For All Act, 115th Congress (Jan. 24, 2017), available at* https://www.congress.gov/bill/115th-congress/house-bill/676.

[7] H. Budget Committee, *Budget Busters: Medicare-for-All* (Sept. 7, 2018), available at https://mailchi.mp/2f08767534co/balance_budget_amendment-459029?e=7f4d75a21c; and Urban Institute, *The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending* (May 9, 2016), *available at* https://republicans-budget.house.gov/budget-buster/medicare-for-all/

[8] Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018-2028* (May 2018), *available at* https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf.

[9] Congressional Research Service, *Information Requested about H.R. 676, as Introduced in the 115th Congress* (Aug. 31, 2018), *available at* https://republicans-energycommerce.house.gov/wp-content/uploads/2018/09/H.R.-676-Memo-Final-083118.pdf.

Insurance Trust Fund scheduled to go bankrupt in 2026 – at which time it will no longer be able to pay full benefits. Instead of shoring up the program, Democrats want to raid Medicare's trust fund to pay for a government takeover of health care, making an already tenuous financial situation even worse for the seniors and other beneficiaries who currently enjoy and depend on their Medicare benefits.

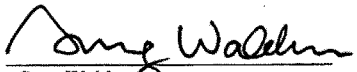
When a new government plan cannot assist or afford all those eligible to receive benefits, massive tax increases and benefit cuts will be the only way to support it. The Democratic Medicare for All proposal breaks the promises made to seniors, the disabled, service members, and others by eliminating the Medicaid program, TRICARE, the Indian Health Service (IHS), and puts a target on the benefits veterans receive from the VA.

The cost to fund the Democratic Medicare for All proposal would lead to a total federal takeover of health care system and destroy thousands of privately-owned health care providers. It would mandate all physicians be employed by public, or not-for-profit institutions, and that would mean more than 1,000 private for-profit hospitals would be prohibited from assisting those in need, leaving 150,000 hospital beds potentially unused.

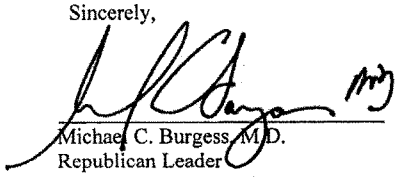
The Energy and Commerce Committee has the broadest health care jurisdiction in Congress, and any serious discussion about the Democratic Medicare for All proposal should start with here. Since Medicare for All is at the top of the Democratic Party's legislative agenda, the Committee should start holding hearings on the proposal.

Thank you for your attention to this matter, and we look forward to seeing Medicare for All hearings on the Committee on Energy and Commerce's schedule in the very near future.

Sincerely,



Greg Walden
Republican Leader



Michael C. Burgess, M.D.
Republican Leader
Subcommittee on Health

The Honorable Jan Schakowsky (D-IL)

1. I am pleased that this hearing focused on the potentially fatal impact of the *Texas v. U.S.* lawsuit on millions of Americans living with pre-existing conditions. In my district, 313,800 people—or 53 percent of my constituents under the age of 64—have a pre-existing condition and could lose health insurance coverage if this dangerous Republican lawsuit is upheld.[1]

   In your written testimony, you also noted that a successful lawsuit would eliminate the Medicare improvements that passed through the Affordable Care Act (ACA), including closure of the prescription drug coverage gap ("donut hole"), expanded coverage for preventative services, and lower out of pocket costs.

   Over 57 million older Americans and people with disabilities rely on Medicare for their health insurance coverage; that translates to 18 percent of our nation's population.[2] Since the passage of the ACA, millions of Medicare beneficiaries have saved over $26 billion on prescription drug costs.[3] In 2016, 10.3 million Americans on Medicare utilized a free annual wellness visit and 40.1 million Americans on Medicare used free preventative services.[4] These benefits are only available because of the ACA.

   a. Please detail how this lawsuit, if upheld, would impact access to care and health care costs for Medicare beneficiaries.

      Answer: In *Texas v. United States*, the lower court has held that the entire ACA should be struck down. If this decision is upheld, the ACA's changes to Medicare would no longer be in force. As a result, policies like the ACA's steps to close the prescription drug "donut hole," elimination of cost-sharing for Medicare preventive services, and coverage for an annual wellness exam would be repealed. As a result, Medicare beneficiaries could face higher costs for drugs and preventive and primary care.

   b. How would the elimination of innovative, incentive-based reimbursement for providers impact the quality of health care for Medicare beneficiaries?

      Answer: The ACA included a number of policies designed to encourage high-value care for Medicare beneficiaries, including authorizing certain changes to the way Medicare pays providers. If the lower court decision in *Texas v. United States* is upheld, those provisions would be repealed. This would create

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[1] https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/
[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard.html
[3] https://www.cms.gov/newsroom/press-releases/nearly-12-million-people-medicare-have-saved-over-26-billion-prescription-drugs-2010
[4] https://www.cms.gov/newsroom/press-releases/nearly-12-million-people-medicare-have-saved-over-26-billion-prescription-drugs-2010

significant confusion in the Medicare payment process as the law is fully incorporated into Medicare's underlying payment methodologies, and it would deprive CMS of tools that are lowering costs and improving the quality of care.

The Honorable Tony Cardenas (D-CA)

1. Ms. Linke Young, it is my understanding that some estimates have found as many as 27% of Americans under 65 have health conditions that could leave them without access to insurance after this court ruling. Is it correct that before the ACA preexisting conditions that have resulted in loss of coverage included: AIDS/HIV, lupus, alcohol abuse/drug abuse with recent treatment, severe mental disorders such as bipolar disorder or an eating disorder, Alzheimer's/dementia, multiple sclerosis, rheumatoid arthritis, fibromyalgia and other inflammatory joint disease, muscular dystrophy, cancer, severe obesity, cerebral palsy, organ transplant, congestive heart failure, paraplegia, coronary artery/heart disease, bypass surgery, paralysis, Crohn's disease/ulcerative colitis, Parkinson's disease, chronic obstructive pulmonary disease/emphysema, pending surgery or hospitalization, diabetes mellitus, pneumocystis pneumonia, epilepsy, pregnancy or expectant parent, hemophilia, sleep apnea, hepatitis C, stroke, kidney disease, renal failure, and gender dysphoria?

   Answer: Yes. Estimates suggest that has many as half of non-elderly adults have a pre-existing condition that could affect their insurance coverage if they had attempted to purchase coverage in the pre-ACA individual market.[5] Prior to enactment of the ACA, issuers in most states were able to deny coverage to an individual based on a health status factor; therefore, nearly any medical condition could potentially lead to a coverage denial. To get a sense of the kinds of health care conditions that typically led to coverage denials, exclusions, or higher charges, researchers have examined the underwriting guidelines in use prior to the ACA's enactment. All of the conditions noted in your question are described by these researchers as reflected in pre-ACA underwriting guidelines as common bases for coverage denials.

2. Is it true that before the ACA conditions that made it harder to purchase a health insurance plan included: Acne, allergies, anxiety, asthma, basal cell skin cancer, depression, ear infections, fractures, high cholesterol, hypertension, incontinence, joint injuries, kidney stones, menstrual irregularities, migraine headaches, being overweight, restless leg syndrome, tonsillitis, urinary tract infections, varicose veins, and vertigo?

   Answer: Yes, these conditions are described by researchers as reflected in pre-ACA underwriting guidelines as common bases for adverse underwriting actions.

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[5] *See* Emily Gee, Center for American Progress, Number of Americans with Pre-Existing Conditions by Congressional District, April 5, 2017, https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/. *See also* Center for Medicare & Medicaid Services, At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans, 2009, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting.html (estimating 19 to 50 percent of non-elderly Americans have some type of pre-existing health condition); Gary Claxton et al, Kaiser Family Foundation, Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA, December 12, 2016, https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca (estimating 27 percent of non-elderly Americans have a pre-existing condition).

3. Is it also correct that some plans before the ACA counted rape and domestic violence as preexisting conditions?

   Answer: Prior to enactment of the Affordable Care Act, some states had laws that prohibited issuers from considering past domestic violence as a health status factor that could lead to coverage denials, but others did not.[6] In states that did not prohibit the practice, issuers could consider domestic violence in the underwriting process.

[6] *See, e..g*, Les Blumenthal, *Domestic Violence as Pre-Existing Condition? 8 States Still Allow It*, McClatchy Newspapers, October 4, 2009, https://www.mcclatchydc.com/news/politics-government/article24557818.html.

The Honorable Debbie Dingell (D-MI)

1. Ms. Linke Young, your written testimony notes that the position of the state attorneys general in Texas v. U.S. would impact our entire health system, not just the individual market and Medicaid. Can you describe the different ways that individuals with pre-existing conditions who have employer-sponsored coverage would be affected?

   Answer: If the lower court decision in *Texas v. United States* is upheld, the ACA's market reforms for those with employer-based coverage would be repealed. This includes:

   - Repeal of the requirement that health plans impose a maximum out-of-pocket limit on individuals' and families' total annual out-of-pocket costs.
   - Repeal of the prohibition on the use of annual and lifetime dollar limits on benefits received.
   - Repeal of the requirement that plans provide equitable coverage for emergency services received out-of-network.
   - Repeal of the requirement that plans cover preventive services with no cost-sharing.
   - Repeal of the requirement that plans provide information about their benefits in a standard format.
   - Repeal of the requirement that young adults be able to stay on their parents' plan until age 26.

Hearing: Texas v. U.S.: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions
Subcommittee on Health (Committee on Energy and Commerce)
February 6, 2019

Answers to Additional Questions from Subcommittee
Elena Hung, Co-founder of Little Lobbyists
March 19, 2019

1. The ACA prevents insurance companies from imposing annual or lifetime caps on coverage. Ms. Hung, you shared the stories of your daughter and other children who spent the first months of their lives receiving significant medical care.

> **a. Can you describe just how expensive this care can be and what would happen if insurance plans were once again allowed to impose lifetime or annual caps on coverage?**

Thank you, Congresswoman Dingell for your question on annual and lifetime caps on coverage.

In 2014, I had a healthy pregnancy and a great birth experience; but fifteen minutes after she was born, my daughter Xiomara required 100% supplemental oxygen support and was rushed to the Neonatal Intensive Care Unit, where she spent the next five months of her life. During that time, she required two major surgeries (placement of a tracheostomy and gastrostomy feeding tube), countless medical procedures and testing, and medications. Her hospital bills from these five months were close to $3 million, which was all covered by our insurance plan.

Many people do not understand how expensive high level medical care can be. I have heard from many Little Lobbyists families -- families with children with complex medical needs and disabilities -- that an extended hospitalization of more than 60 days in the intensive care unit can cost over a million dollars. Moreover, the need for high level medical care often continues for many of our children once they are discharged from the hospital and go home. They need follow up procedures, surgeries, medications, durable medical equipment, and ongoing medical care.

If insurance plans were once again allowed to impose lifetime or annual caps on coverage, many children like Xiomara could be kicked off their plans before they are even discharged from the hospital. This is actually one of the main reasons families like mine started speaking up and formed our organization in order to educate others.

My friend and Little Lobbyists co-founder Michelle Morrison understood firsthand how the cap on lifetime and annual limits saved her family from bankruptcy. Her son Timmy was about three months old when he surpassed $1 million worth of bills. He was still in the Neonatal Intensive

Care Unit at the time and would remain there for another three months. Because of the Affordable Care Act, his insurer covered everything and Timmy continued to receive the care he needed to survive and thrive.

For more on lifetime limits and Timmy's story, please see Sarah Kliff's Vox article: The Obamacare provision that saved thousands from bankruptcy (March 2, 2017) https://www.vox.com/policy-and-politics/2017/2/15/14563182/obamacare-lifetime-limits-ban

2. Ms. Hung, you noted Medicaid's importance for children with complex medical conditions, especially its ability to provide therapies and long-term services and supports that allow independence.

> **a. If Medicaid funding was significantly cut, what effect would that have on children with complex medical conditions and their independence?**

Thank you, Congresswoman Debbie Dingell for your question on Medicaid's importance for children with complex medical needs.

Medicaid is a life-saving program for children with complex medical needs and disabilities. I say this without exaggeration: Medicaid can be the difference between life and death.

Medicaid covers care that many private insurance plans do not. It covers therapies and long term services and supports that our children need to thrive. Therapies, including physical, occupational, speech, and feeding therapies, help children achieve independence.

Medicaid also covers private duty nursing, which is usually not included in insurance plans. Some medically complex children, like my daughter, require a skilled caregiver to be at their side at all times.

A Medicaid program, sometimes known as the "Katie Beckett waiver," enable children who would otherwise be hospitalized and are certified as requiring hospital or nursing facility level of care to receive medically necessary and appropriate services in the community.

Without this level of home care services, our children face the alternative of unnecessary prolonged stays in hospitals, nursing facilities, or other long-term facilities. Notably, the cost of these community-based services is also less than the cost of institutional care.

If Medicaid funding was significantly cut, children with complex medical needs and disabilities would be severely harmed. They would miss out on medically necessary care that enable their independence. They would be unable to live at home with their families, unable to participate in their community, unable to go to school with their peers.

Our children deserve a shot at life and Medicaid provides that.

Thomas P. Miller, Responses to Member Questions for the Record

February 5, 2019 Hearing, "Texas v. U.S.: The Republican Lawsuit and Its Impacts on Americans with Pre-Existing Conditions"

The Honorable Michael C. Burgess, M.D. (R-TX)

1. Mr. Miller, your testimony points out that this lawsuit is in its relatively early stages, projecting that the final decisions could be as much as another 16 months away.
    a. It's true that the Texas judge stayed the decision while the case is appealed, correct?

Thomas P. Miller

Yes, Dr. Burgess. Judge O'Connor on December 30, 2018 issued a stay of the court's December 14, 2018 Order, and the Partial Final Judgment severing Court I of the state plaintiffs' complaint and finalizing that Order, during the pendency of the Order's appeal.

The Honorable Michael C. Burgess, M.D. (R-TX)

    b. In a time when liberal courts are rampantly legislating from the bench by issuing nationwide injunctions, do you believe this judge demonstrated judicial restraint by issuing a stay?

Thomas P. Miller

Judge O'Connor already had provided no inclination to issue a nationwide (let alone *any)* injunction, so his ruling technically would be limited in any case to the Northern District of Texas, United States District Court, and to the parties directly involved (including 20 states as plaintiffs, and several federal government agencies as defendants). You are correct in pointing out the exercise of more expansive, overreaching judicial actions in recent years by some other federal court judges in issuing nationwide injunctions on a more sweeping basis. Judge O'Connor's decision was more in keeping with traditional views of the limits of the powers of federal district court judges. In that sense, it demonstrated a more appropriate degree of judicial "restraint" in recognizing the roles of other courts, particularly at the appellate level, in reaching more conclusive rulings on a regional, and ultimately national, basis. He also took into account such factors as the potential for disruption to healthcare markets if immediate implementation of his ruling was required, as well as the fact that coverage decisions by many individuals for 2019 (particularly those facing open season time limits for ACA exchange coverage) already had been made.

The Honorable Michael C. Burgess, M.D. (R-TX)

c. And would you please walk us through the remaining steps to get to an ultimate decision?

Thomas P. Miller

Although there are a wider number of future possibilities ahead, a simplified overview of the stages ahead would include:

- Scheduling of briefing and oral argument for the appeal in the 5th Circuit of the district court's final order for partial summary judgment
- A ruling by a 5th Circuit three-judge panel, either on the merits of the case, or perhaps a different ruling on standing of the appellees/plaintiffs
- The possibility of an en banc review of that panel's decision, by the entire roster of 5th Circuit judges, which could either affirm or overturn the previous ruling.
- Disposition of a petition for certiorari, by the losing parties at the 5th Circuit level, for final appellate review by the Supreme Court of United States. Given the projected unlikelihood of any other potentially similar cases in other federal appellate courts reaching that stages near a similar time as this one, the reasonable forecast would be that SCOTUS would be much more likely to grant cert for a final 5th Circuit ruling that affirmed some, if not all, of the original states/plaintiffs' claims and determined that very limited, if any, severability would apply to findings of an unconstitutional provision in the Affordable Care Act.
- If the case reached this stage, scheduling for briefing and oral argument at the Supreme Court would further extend the timeline for a final decision to as late as June 2020.
- Even if SCOTUS issued a final ruling more favorable to the state plaintiffs, the Court might then consider further transitional delays in structuring such judicial relief, in order to accommodate necessary adjustment time needed for federal policymakers and health care markets.
- At any time before such a final decision, other parties (primarily Congress) would preempt some, if not all, of the issues before the courts by changing the underlying ACA law, such as its previous (and current) findings of fact regarding the connection between the individual mandate and other ACA provisions, or perhaps reconsidering the status of the individual mandate and its potential tax penalties.

In short, a potentially long, winding, and uncertain road for further litigation remains ahead.

The Honorable Michael C. Burgess, M.D. (R-TX)

2. Mr. Miller, I'd like to highlight an excerpt from your written testimony. This is a direct quote: "Poorly drafted bills, full of complex and ambiguous terms and overly ambitious but untested mechanisms that lack sufficient and sustainable political support but are pushed into law by whatever means are necessary have substantial negative spillover effects."

3. Now, I understand that you also followed and contributed to previous challenges to the constitutionality of Obamacare. One of those challenges, NFIB v. Sebelius, is relevant to this case.

4. Here's an excerpt from Justice Roberts' opinion: "The Affordable Care Act contains more than a few examples of inartful drafting. (*To cite just one, the Act creates three separate Section 1563s. See 124 Stat. 270, 911, 912.) Several features of the Act's passage contributed to that unfortunate reality. Congress wrote key parts of the Act behind closed doors, rather than through "the traditional legislative process."*

a. Now, Mr. Miller, is it your view that a traditional legislative process – one that includes a subcommittee hearing, subcommittee markup, full committee markup, Rules committee markup, and floor consideration – could have limited the judicial scrutiny of the constitutionality of Obamacare?

Thomas P. Miller

A more traditional process would have helped limit, though not eliminate, some of the flaws in the final ACA law narrowly approved by Congress in March 2010. However, textualist judges tend to rely much less on such secondary sources of "legislative intent" in interpreting the meaning of statutory provisions under constitutional challenge. Of course, the ACA exhibited an unusually large number of ambiguous, contradictory, or poorly drafted provisions. The House-side of its development had its flaws, including extensive rewriting behind closed doors in the Speaker's office as reaching agreement after the work of three separate committees bogged down in the fall of 2009. But the Senate process was far worse, and its unrefined final product, also the result of extensive late-stage rewriting in the Majority Leader's office – narrowly passed in late December 2009 within the constraints of a 60-partisan-vote requirement, became the unfortunate incubator of many legal problems to come.

When the then-Democratic congressional leadership decided to pass a final bill by any means necessary to bypass a Senate Republican filibuster in early 2010, it had to swallow many of the evasions, ambiguities, and contradictions embedded in the final Senate bill and then hope for the best later through executive branch reinterpretations and administrative work-arounds. The decision to bypass any House-Senate conference committee process, as well as a conference report providing a better understanding of what Congress actually intended, transferred ultimate resolution of important decisions to the creative vagaries of administrative rulemaking and extensive litigation; most notably in the King v. Burwell line of court cases. The "clean up" of the Senate's work in December 2009 never happened, apart from very limited changes in the

HCERA reconciliation bill that accompanied the final ACA in March 2010. Without enough votes to reopen Senate consideration of changes to its older bill, the Democratic Congress and the Obama White House chose to accept the ACA, warts and all, as an unfinished product that was the only thing they could enact into final law.

The primary constitutional challenges to the ACA, involving the individual mandate and the Medicaid expansion, would have developed in any case. They were less issues of "interpretation" than those of political judgments regarding what would (or even needed to) pass constitutional muster. The then-Democratic majorities in Congress had a different view of binding constitutional limits than several courts later determined.

In general, a more thorough and better-documented legislative process is most valuable in subjecting questionable or less-workable mechanisms and assumptions to greater scrutiny and challenge, so that they become more realistic, resilient, and practical; as well as more politically acceptable. Both sides of the partisan divide in Congress have yet to absorb that lesson, in seeking quicker procedural end-runs around the need to assemble more sustainable majorities to support complex and controversial legislative products. Real compromises involving sweeping health policy legislation are clearly difficult to achieve, but they prove far more sustainable than the ACA's desperate struggle to reach a then-unpopular and chronically-unworkable finish line.

The Honorable Michael C. Burgess, M.D. (R-TX)

> 5. The 11 members of this subcommittee who helped write Medicare for All last Congress have yet to show the American people their bill this year.
>
> > a. Mr. Miller, in an attempt to avoid continued judicial scrutiny of Democrats' radical health care agenda, do you think a better use of today's time would be to start the traditional legislative process on Medicare for All, so America can learn how the 11 members of this subcommittee want to dangerously change health care in America?

Thomas P. Miller

That's a tough call. I usually leave it up to members of Congress as to how they might wish to waste their time…and in some ways, the less time spent on Medicare for All, the better! The leaders of the House majority and its committees certainly have the right to set their own agendas and legislative priorities. That's what elections help determine, at least every two years in the case of the House.

Of course, in the larger sense, greater transparency and debate over what is involved beyond simplistic rhetorical phrases would be more helpful to voters and other potentially affected parties. Many members of Congress have yet to learn the lessons of the past few decades that unveiling complicated and divisive legislative provisions near the last minute, with only limited vetting and feedback from the general public, is particularly unwise and counterproductive when it comes to health policy. A good bit more stress testing, and political reality checks, in advance can limit, if not avert, future disasters.

The Honorable Michael C. Burgess, M.D. (R-TX)

6. Mr. Miller, one portion of your written testimony really resonated with me. I'm going to highlight a few points. This is taken directly from your testimony: "When congressional action produces a flawed legislative product, justified in large part by mistaken premises and misrepresentations, it won't work well."

7. I'm concerned that Democrats are once again moving towards a flawed legislative product based on mistaken premises and misrepresentations -- that being the government-run, single-payer Medicare for All.

a. Mr. Miller, do you believe the rhetoric of Medicare for All matches the reality of what the proposal would do to America's health care system?

Thomas P. Miller

No, it does not. That's not unusual per se when it comes to most initial iterations of what are termed "national health care reform." However, the gap between Medicare for All's inflated and unworkable rhetoric and its hidden realities may help set new records. The longest leaps tend to involve cost estimates, structural disruptiveness, implementation challenges, transition times, degrees of coerciveness, political acceptability, and the consequences of rerouting a much larger share of our society's resources through already overloaded political channels.

The Honorable Michael C. Burgess, M.D. (R-TX)

8. It's my understanding that the bill 11 Democratic members of this subcommittee helped write last Congress would lead to the largest tax increase in American history, pave the way to close the VA, and Indian Health Service, eliminate private health insurance – for employees and unions – and possibly lead to wait times and delays in access.

a. Is this your understanding of Medicare for All, Mr. Miller?

Thomas P. Miller

Those all are plausible starting assumptions, but I'm a little uncertain whether those are considered to be "features" or "bugs" by Medicare for All advocates. In any case, it remains the case that the closer one gets to considering actual approval of Medicare for All legislative proposals, as opposed to vague slogans, the further away decisive majorities will decide to run.

The Honorable Michael C. Burgess, M.D. (R-TX)

9. You go on to write, and here's another quote: "The ACA's architects and proponents oversold the effectiveness and attractiveness of the individual mandate, touting it as an essential part of the balancing act of subsidies and regulation that could hold the law's insurance coverage provisions together…"

10. This sounds strikingly familiar – like the chairwoman of this committee, who along with 11 members of this subcommittee helped write Medicare for All last Congress, are overselling the effectiveness and attractiveness of Medicare for All without fully explaining how Medicare for All works.

a. Mr. Miller, since you've explained that this lawsuit is stayed and it could be as many as 16 months until a final decision is issued, would a better use of this subcommittee's time be to educate the American people on Medicare for All?

Thomas P. Miller

Particularly when it comes to national health care legislation, the best surprise is no surprise, because early debate and review at least can help head off last-minute mishaps built on untested assumptions. But based on past experience, the American people may have to rely on wider and more diverse sources of information that what has been developed through the congressional committee process alone. In fact, they first may need to educate subcommittee members about the type of health care system they not only need and prefer, but that they can accept and afford. THAT process seems to be a never-ending challenge, but it certainly appears likely to take more than 16 months for both sides of that equation to reach a better solution, in any case.

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