

**STRENGTHENING OUR HEALTHCARE SYSTEM: LEG-
ISLATION TO REVERSE ACA SABOTAGE AND
ENSURE PREEXISTING CONDITIONS PROTEC-
TIONS**

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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**STRENGTHENING OUR HEALTHCARE SYSTEM:
LEGISLATION TO REVERSE ACA SABOTAGE
AND ENSURE PREEXISTING CONDITIONS
PROTECTIONS**

WEDNESDAY, FEBRUARY 13, 2019

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

The subcommittee met, pursuant to call, at 10:30 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

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

Also present: Representatives Schakowsky and Soto.

Staff present: Jeffrey C. Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Saha Khatezai, Professional Staff Member; Una Lee, Senior Health Counsel; Jourdan Lewis, Policy Analyst; Alivia Roberts, Press Assistant; C. J. Young, Press Secretary; Mike Bloomquist, Minority Staff Director; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel, Health; Jordan Davis, Minority Senior Advisor; Caleb Graff, Minority Professional Staff Member, Health; Peter Kiely, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; Brannon Rains, Minority Staff Assistant; Danielle Steele, Minority Counsel, Health.

Ms. ESHOO. The Subcommittee on Health will now come to order.

The Chair now recognizes herself for 5 minutes for an opening statement.

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

First of all, welcome to the first legislative hearing of the Health Subcommittee in the 116th Congress. Last week we heard testimony and examined what the devastating effects would be if the case *Texas v. United States* were to stand, most especially on those

who have preexisting conditions and the medically complex children who rely on the Affordable Care Act.

We also discussed how the Trump administration's sabotage of the ACA and the expansion of junk insurance plans are driving up cost by diverting the healthy out of the individual market and weakening patient protections with preexisting conditions.

Today, the four bills before us address short-term insurance plans, waivers to weaken insurance regulations on the private market, funding for marketing and outreach, and legislation that would require short-term insurance plans to carry an advisory informing consumers what the plan does not cover and what ACA requirements the plan does not meet.

It is a top priority of the majority to protect patients with preexisting conditions. On the campaign trail and in our hearing last week, our Republican colleagues voiced their support for preexisting condition protections. They asked for specific legislation, and that is what we are here to discuss today.

Our first bill will rescind the short-term limited duration insurance for junk insurance policies, regulation the Trump administration finalized last August, which expands these junk plans from the current 3-month limit, making them available for up to 3 years.

We know these plans do not cover preexisting conditions, they do not have out-of-pocket and lifetime limits, and they do not protect women from being charged more than men. Representative Castor's bill would rescind the rule that expanded these junk insurance plans.

Representative Kuster's bill revokes the Section 1332 waiver guidance issued by the administration last October, which weakens requirements of private insurance plans to provide comprehensive coverage at an affordable price.

Section 1332 of the Affordable Care Act requires States to meet standards for what qualifies as healthcare coverage. The Trump administration guidance changes these standards to be less comprehensive and less affordable for patients who rely on private insurance purchased on the individual market.

It also allows tax credits, Federal dollars, to be spent on these expanded and extended junk plans. My Republican colleagues have been highly critical about funding tax subsidies to help Americans afford comprehensive health insurance but support allowing more people to access Federal money for these short-term junk insurance plans that do not even cover basic services.

Representative Kuster's bill rescinds that guidance so that all Americans will have health insurance coverage that meets the same standards.

We are also considering the bill authored by Representative Lisa Blunt Rochester to restore the marketing and outreach funding the Trump administration cut by 90 percent in 2017 and banning this funding from being used to advertise the junk insurance plans.

An article published in Kaiser Health News earlier this month described how consumers searching online to enroll in comprehensive ACA plans are most often redirected to websites and brokers selling junk plans without disclosing that the coverage will not be comprehensive.

And I ask unanimous consent to enter this article into the record. Hearing no objections, we will do that.

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

Federal dollars should not support advertising coverage that will not protect patients with preexisting conditions.

The last bill, my legislation, will require junk insurance plans to display up front what is and what is not covered so that consumers will know exactly what they are buying. My bill also requires a disclosure that these plans do not meet the Affordable Care Act's requirements for cost sharing and lifetime limits and prohibits these plans from being sold during the individual market open enrollment.

I want to be clear about the following. I believe the Trump administration's rule that expanded the maximum duration of these so-called short-term plans up to a year and allows them to be renewed for up to 3 years should be rescinded.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Welcome to the first legislative hearing of the Health Subcommittee in the 116th Congress.

Last week we heard testimony and examined what the devastating effects would be if the case *Texas vs. United States* were to stand, most especially on those who have preexisting conditions and the medically complex children who rely on the Affordable Care Act.

We also discussed how the Trump administration's sabotage of the ACA and the expansion of junk insurance plans are driving up costs by diverting the healthy out of the individual market and weakening patient protections for those with preexisting conditions.

Today the four bills before us address short-term junk insurance plans, waivers to weaken insurance regulations in the private market, funding for marketing and outreach, and legislation that would require short-term insurance plans to carry an advisory informing consumers what the plan does not cover and what ACA requirements the plan does not meet.

It is a top priority of the majority to protect patients with preexisting conditions. On the campaign trail and in our hearing last week, our Republican colleagues voiced their support for preexisting condition protections.

They asked for specific legislation, and that's what we're here to discuss today.

Our first bill will rescind the short-term limited duration insurance—or junk insurance—regulation the Trump administration finalized last August which expands these junk plans from the current 3-month limit, making them available for up to 3 years.

We know these plans do not cover preexisting conditions, do not have out-of-pocket and lifetime limits, and do not protect women from being charged more than men.

Representative Castor's bill would rescind the rule that expanded these junk insurance plans.

Representative Kuster's bill revokes the Section 1332 waiver guidance issued by the Trump administration last October which weakens requirements of private insurance plans to provide comprehensive coverage at an affordable price.

Section 1332 of the Affordable Care Act requires States to meet standards for what qualifies as healthcare coverage. The Trump administration guidance changes these standards to be less comprehensive and less affordable for patients who rely on private insurance purchased on the individual market.

It also allows tax credits—Federal dollars—to be spent on these expanded and extended junk plans.

My Republican colleagues have been highly critical about funding tax subsidies to help Americans afford comprehensive health insurance, but support allowing more people to access Federal money for these short-term junk insurance plans that do not even cover basic services.

Rep. Kuster's bill rescinds that guidance so that all Americans will have health insurance coverage that meets the same standards.

We're also considering a bill authored by Representative Lisa Blunt Rochester to restore the marketing and outreach funding the Trump administration cut by 90 percent in 2017 and banning this funding from being used to advertise junk insurance plans.

An article published in Kaiser Health News earlier this month described how consumers searching online to enroll in comprehensive ACA plans are most often redirected to websites and brokers selling junk plans without disclosing that the coverage will not be comprehensive.

I ask unanimous consent to enter this article into the record.

Federal dollars should not support advertising coverage that will not protect patients with preexisting conditions.

The last bill, my legislation, will require junk insurance plans to display up front what is and what is not covered so that consumers will know exactly what they're buying.

My bill also requires a disclosure that these plans do not meet the Affordable Care Act's requirements for cost-sharing and lifetime limits and prohibits these plans from being sold during the individual market open enrollment period.

I've learned over the years that people know very well what they pay, but they don't always know what they're buying.

I want to be clear—I believe the Trump administration's rule that expanded the maximum duration of these so-called "short-term" plans up to a year and allows them to be renewed for up to 3 years should be rescinded.

But as long as short-term insurance plans are being sold, the American people should know what the policy does not cover and that information should be displayed prominently.

I'm pleased we're discussing legislation today that will protect Americans with preexisting conditions and address the sabotage of the Affordable Care Act. I hope these bills will be an opportunity to work across the aisle to help the American people.

Welcome to our witnesses and we look forward to your testimony.

Ms. ESHOO. I see that I am over my time, and at this point I would like to recognize Dr. Burgess, the ranking member of the subcommittee, 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. I thank you for the recognition, and today we have been convened once again to discuss issues that will not improve the affordability of health insurance for Americans.

Unsustainably high premiums and issues related to silver loading are increasingly becoming a reality for families that rely upon healthcare.gov for their insurance.

Yet, the bills before us today will not make a marked increase in the availability of reasonably priced plans. I am encouraged to see that we are at least discussing some legislative ideas today, unlike last week's hearing, which I think everyone agreed was an exercise in futility.

Once again, I would like to make it clear that there is bipartisan support for protecting coverage for individuals with preexisting conditions. Many on our side have expressed that sentiment.

Certainly, we have people that we know in our families or in our—amongst our employers when we—employees when we were—before we came to Congress or in our medical practices that are affected by the status of preexisting conditions.

But the constituents in my district are struggling to afford their health insurance, and I am sure the district I represent is not unique in that regard.

What good is health insurance if you are afraid to use it because you cannot afford your deductible? I have a lot of people that I rep-

resent who cannot afford a flat tire, let alone a \$6,800 deductible in the bronze plan sold by healthcare.gov.

This is the issue that I would like to see us tackle, and I am disappointed that none of the bills before us today will move that.

What I find most troubling about today's hearing is that our colleagues are questioning the flexibility that they put into their own law. Section 1332 of the Affordable Care Act provides States the opportunity to apply for State Innovation Waivers.

These waivers allow States to come up with inventive ways to insure their population while safeguarding their access to quality insurance. Section 1332 of the Affordable Care Act explicitly authorizes the Department of Health and Human Services and the Treasury Department to waive certain ACA coverage requirements it has written into law.

To be clear, I did not vote for this law, nor did I receive positive feedback from my constituents about the law's implementation.

However, States like Alaska have had success with these waivers, which gives States room to repair their markets that have been damaged by the Affordable Care Act.

This hearing is another attempt to distract from the Democratic Party's agenda to establish Government-run, single-payer healthcare. Last week it was said that there are other committees in the House that are holding hearings and drafting legislation to establish such a plan.

On February 7th, the magazine *Modern Healthcare* published an article that says a draft version of the House Democrats' upcoming Medicare-for-all bill proposes a national system that would prepay hospitals with lump sums while keeping fee-for-service models for individual physicians.

This news outlet obtained a 127-page draft that was dated January 14th, but I have yet to see such a draft. It is concerning that the media knows more than the members of this subcommittee about the details of this proposal.

Based on what I have read about the supposed draft, I am concerned. I will tell you, as a physician I know that the critical doctor-patient relationship is threatened, and I do not believe that the Government should hinder a doctor's ability to act in the best interest of his or her patient.

According to the *Modern Healthcare* article, this proposal would implement a global budget and, once that is set, hospitals and institutions would need to stick to it for all outpatient and inpatient treatment.

So that is what is truly concerning about this. What happens if the budget runs out? Are patients told, well, we are sorry we are out of money—maybe you could try this again next year.

This is a recipe for waiting lines. This is a recipe for rationing care, and the sooner people understand that the better. Meanwhile, there is a greater percentage of Americans in employer health coverage than at any time since the year 2000.

The number of Americans with employer-sponsored health coverage has increased by at least 2.5 million and probably much more than that since President Trump took office. Where are the CBO coverage figures on the expansion of employer-sponsored health

plans because more people are working now than there were before the President took the oath?

The President's Council of Economic Advisors projects that the administration's recent actions will create \$453 billion in net benefits for consumers and taxpayers over the next 10 years.

Again, as a holder of one of the so-called junk policies, I had a health savings account before the previous administration told me I didn't know what I was doing and couldn't manage it and took it away from me.

I welcome the fact that the administration has provided this flexibility, and I will yield back my time.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you, Chairwoman Eshoo. Today, we have been convened once again to discuss issues that will not improve the affordability of health insurance for Americans. Unsustainably high premiums and issues related to silver loading are increasingly becoming the reality for folks that rely upon individual market insurance, yet the bills before us today will not make a marked increase in the availability of reasonably priced plans. I am encouraged to see that we are at least discussing some legislative ideas today, unlike last week's hearing, which nearly all of the witnesses agreed was an unnecessary exercise.

Once again, I would like to make it clear that there is vast, bipartisan support for protecting coverage for individuals with preexisting conditions. Many of us on our side of the dais have experience with preexisting conditions in our own families, or providing insurance for the employees of their businesses.

The constituents in my district are struggling to afford their health insurance, and I am sure that my district is not the only one suffering from sky-high premiums and deductibles. What good is healthcare insurance if you are afraid to use it because you can't afford your deductible? This is an issue that I would like to see us tackle, and I am disappointed that none of the bills before us today will move that ball down the field.

What I find most troubling about today's hearing is that our Democratic colleagues are questioning the flexibility that they put in their own law. Section 1332 of the Affordable Care Act provided States with the opportunity to apply for State Innovation Waivers. These waivers allow States to come up with inventive ways to insure their populations while safeguarding their access to quality insurance.

Section 1332 of the ACA's text explicitly authorizes the Department of Health and Human Services and the Treasury Department to waive certain ACA coverage requirements. This is written into law. I did not vote for the law, nor did I receive positive feedback from my constituents about the law's implementation; however, States like Alaska have had success with these waivers, which give States room to repair their markets that have been damaged by the Affordable Care Act.

This hearing is another attempt to distract from the Democratic Party's agenda to establish Government-run, single-payer healthcare. As I said last week, there are other committees in the House that are holding hearings and drafting legislation to establish such a plan. On February 7th, Modern Healthcare published an article that says "A draft version of the House Democrats' upcoming Medicare for All bill proposes a national system that would prepay hospitals with lump sums while keeping a fee-for-service model for individual physicians."

The news outlet obtained a 127-page draft that was dated January 14th, but I have yet to see such a draft. It is concerning that the media knows more than the members of this committee about the details of this proposal. Based on what I have read about this supposed draft, I am concerned. As a physician, I know how critical the doctor-patient relationship is, and I do not believe that the Government should hinder a doctor's ability to act in the best interest of his or her patient. According to the Modern Healthcare article, Ms. Jayapal's proposal would implement a global budget and once that is set "hospitals and institutions would need to stick to it for all outpatient and inpatient treatment." That is what terrifies me. What happens if the budget runs out? Are patients told, "Sorry, we ran out of money, try again next year?"

Meanwhile, there is a greater percentage of Americans in employer health coverage than at any time since 2000. The number of Americans with employer health coverage has increased by more than 2.5 million since President Trump took office.

Additionally, the President's Council of Economic Advisers project that the administration's recent actions will create \$453 billion in net benefits for consumers and taxpayers over 10 years.

Again, while I appreciate the effort to consider legislation today, I believe that the bills before us do not actually address the root of the problems in our healthcare system today. I yield back.

Ms. ESHOO. I thank the ranking member.

Just something for the record to the ranking member: I don't agree with your characterization of the last hearing that we had. Everyone does not agree with your characterization. I think your side does, but our side doesn't.

With that, I would now like to recognize the chairman of the full committee, Mr. Pallone.

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

Mr. PALLONE. Thank you, Madam Chairwoman.

Today, this committee begins to fulfill the promise we made to reverse the repeated sabotage of our Nation's healthcare system by the Trump administration, in addition to make healthcare more affordable and to protect the more than 133 million Americans with preexisting conditions.

We will be discussing four bills that will make a real difference in people's lives. The first bill, introduced by Ms. Castor, would reverse the Trump administration's regulation to expand junk insurance plans known as short-term limited duration health insurance.

The Trump administration expanded these junk plans from the current 3-month term and made these plans available for up to 3 years. These junk plans are exactly that: junk.

They discriminate against people with preexisting conditions. They set higher premiums for people based on age, gender, and health status. They deny access to basic benefits like prescription drugs, maternity care, and mental health and substance abuse treatment, and they set arbitrary dollar limits for healthcare services, leading to huge surprise bills for consumers.

Expanding these junk plans also makes health insurance more expensive for people with preexisting conditions by undermining the market for comprehensive coverage. The business model of the companies that sell these junk plans is to spend as little as possible on the health of their enrollees.

They accomplish this by denying coverage of preexisting conditions, kicking people off their health insurance if they get sick or seek medical treatment, and pocketing their premium dollars as pure profit.

This profiteering at the expense of people's health is simply unacceptable. It is why we passed the Affordable Care Act in the first place—to rein in exactly these types of abuses by health insurance companies.

And yet, the Trump administration would give insurance companies the green light to once again discriminate against people with preexisting conditions.

Now, Ms. Castor's bill is an important step in strengthening the individual market and reversing the harm caused by the Trump

administration. Ms. Eshoo's bill requires these short-term plans to bear a consumer warning.

As we will hear from our witnesses today, junk plans are often deceptively marketed as comprehensive coverage, and consumers are not always aware of the fine print. This is about a consumer's right to know.

The bill would require issuers of these plans to display a clear, prominent warning advising consumers that the plan does not cover preexisting conditions, is temporary, and may not cover most healthcare costs, and that coverage can be terminated when someone gets sick or seeks medical treatment.

And I believe this bill works in conjunction with Ms. Castor's bill. While consumer disclosure is important, we must also prevent all of the problems associated with expanding these plans to 3 years.

We will also be discussing Ms. Kuster's bill to rescind the Trump administration's 1332 guidance. Section 1332 of the ACA was designed to give States the ability to examine system reforms that would improve the well-being of their residents.

The key word there is improve. States are also required to maintain the affordability and comprehensiveness of coverage and keep the same number of people insured as under the ACA.

But the Trump administration's 1332 guidance turns the statute on its head, giving States the green light to undermine protections for preexisting conditions. The guidance also gives States the green light to provide taxpayer subsidies for junk plans and reinvigorates ideas from the failed Republican repeal bill, such as the flat tax credits that do not keep up with rising premiums and shift costs onto working families.

This guidance is bad for consumers, bad for individuals with preexisting conditions, and bad for taxpayers. It exceeds the administration's authority and is contrary to congressional intent.

And, finally, we will be discussing Ms. Blunt Rochester's bill to restore consumer outreach and enrollment funding that is so important to making healthcare more accessible and affordable.

The Trump administration gutted funding for consumer outreach and marketing by 90 percent. The administration's refusal to invest in outreach and enrollment is making it harder for Americans to get healthcare, and this is leading to lower enrollment numbers.

The administration has overseen 3 consecutive years of decline in enrollment, and new enrollment is down by 50 percent. The administration's sabotage has resulted in the highest uninsured rate in 4 years.

So Ms. Blunt Rochester's bill would fund critical outreach and enrollment at \$100 million, which was the level before Trump's sabotage. Her bill also prevents the administration from using these funds to promote junk plans, and her bill is an important step in lowering healthcare costs and expanding coverage to more Americans.

Now, all four bills we are considering today are important first steps in lowering healthcare costs and protecting consumers with preexisting conditions, and I commend all four Members for their leadership and look forward to continuing to work with my colleagues as we make healthcare more affordable for all Americans.

And, again, I want to thank the chairwoman. I think this is a very important hearing and this will lead to legislation being passed.

Thank you, Madam Chair.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Today this committee begins to fulfill the promise we made to reverse the repeated sabotage of our Nation's healthcare system by the Trump administration, to make healthcare more affordable, and to protect the more than 133 million Americans with preexisting conditions.

We will be discussing four bills that will make a real difference in people's lives. The first bill, introduced by Ms. Castor, would reverse the Trump administration's regulation to expand junk insurance plans known as short-term limited duration health insurance. The Trump administration expanded these junk plans from the current 3-month term and made these plans available for up to 3 years.

These junk plans are exactly that: junk. They discriminate against people with preexisting conditions. They set higher premiums for people based on age, gender, and health status. They deny access to basic benefits like prescription drugs, maternity care, and mental health and substance abuse treatment. And they set arbitrary dollar limits for healthcare services, leading to huge surprise bills for consumers. Expanding these junk plans also makes health insurance more expensive for people with preexisting conditions, by undermining the market for comprehensive coverage.

The business model of the companies that sell these junk plans is to spend as little as possible on the health of their enrollees. They accomplish this by denying coverage of preexisting conditions, kicking people off their health insurance if they get sick or seek medical treatment, and pocketing their premium dollars as pure profit. This profiteering at the expense of peoples' health is unacceptable. It is why we passed the Affordable Care Act in the first place, to rein in exactly these types of abuses by health insurance companies. And yet the Trump administration would give insurance companies the green light to once again discriminate against people with preexisting conditions.

Ms. Castor's bill is an important step in strengthening the individual market and reversing the harm caused by the Trump administration.

Ms. Eshoo's bill requires these short-term plans to bear a consumer warning. As we will hear from our witnesses today, junk plans are often deceptively marketed as comprehensive coverage, and consumers are not always aware of the fine print. This is about a consumer's right to know. The bill would require issuers of these plans to display a clear, prominent warning, advising consumers that the plan does not cover preexisting conditions, is temporary and may not cover most healthcare costs, and that coverage can be terminated when someone gets sick or seeks medical treatment.

I believe this bill works in conjunction with Ms. Castor's bill. While consumer disclosure is important, we must also prevent all of the problems associated with expanding these plans to 3 years.

We will also be discussing Ms. Kuster's bill to rescind the Trump administration's 1332 guidance. Section 1332 of the ACA was designed to give States the ability to examine system reforms that would improve the well-being of their residents. The key word there is improve. States are also required to maintain the affordability and the comprehensiveness of coverage, and keep the same number of people insured as under the ACA. The Trump administration's 1332 guidance turns the statute on its head, giving States the green light to undermine protections for preexisting conditions. The guidance also gives States the green light to provide taxpayer subsidies for junk plans, and reinvigorates ideas from the failed Republican repeal bill, such as flat tax credits that do not keep up with rising premiums and shift costs onto working families. This guidance is bad for consumers, bad for individuals with preexisting conditions, and bad for taxpayers. It exceeds the administration's authority and is contrary to congressional intent.

Finally, we will be discussing Ms. Blunt Rochester's bill to restore consumer outreach and enrollment funding that is so important to making healthcare more accessible and affordable. The Trump administration gutted funding for consumer outreach and marketing by 90 percent. The administration's refusal to invest in outreach and enrollment is making it harder for Americans to get healthcare. This is leading to lower enrollment numbers. The administration has overseen 3 consecutive years of decline in enrollment and new enrollment is down by 50 percent. The

administration's sabotage efforts have resulted in the highest uninsured rate in 4 years. Ms. Blunt Rochester's bill would fund critical outreach and enrollment at \$100 million, which was the level before Trump's sabotage. Her bill also prevents the administration from using these funds to promote junk plans. Ms. Blunt Rochester's bill is an important step in lowering healthcare costs and expanding coverage to more Americans.

All four bills we are considering today are important first steps in lowering healthcare costs and protecting consumers with preexisting conditions. I commend all four Members for their leadership, and look forward to continuing to work with my colleagues as we make healthcare more affordable for all Americans.

I yield back.

Ms. ESHOO. I thank the chairman.

And now I would like to recognize the distinguished ranking member of the full committee, Mr. Walden, my friend.

Mr. WALDEN. Good morning, Madam Chair.

Ms. ESHOO. Good morning.

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

Mr. WALDEN. Thank you for having this hearing, and as I said in the hearing down below, I know the Dingell family is in all of our thoughts and prayers this morning as they cope with this terrible loss of our distinguished chairman for whom the big hearing room is named, and I know that he taught us all how to legislate and despite, as I said downstairs, our best attempts to emulate his yes-or-no questioning, nobody else pulls it off like John Dingell could pull it off. So he is in our thoughts.

So good morning, and given the title of today's hearing, I too am concerned for the second time is as many hearings in this subcommittee that we are really not addressing the real challenges the consumers are facing, which is the high cost of healthcare.

Madam Chair, I said it last week, I'll say it again. We need to work together to help States stabilize health markets damaged by the ACA, cut out-of-pocket costs that consumers are having to pay with these high deductibles, promote access to preventive services, encourage participation in private health insurance, and increase the number of options available through the market.

Unfortunately, today's hearing and these bills I don't think are adequately addressing any of these goals.

Why would our Democratic colleagues be opposed to States innovating on behalf of their citizens? Why would they be opposed to providing patients flexible and affordable insurance options that best fit those patients' needs? I just don't think it makes sense.

The administration is allowing 10 million Americans more choices and more affordable health insurance options. The Democrats' Medicare-for-all proposal would force over 150 million Americans to lose their employer- or their union-sponsored health insurance, and I think that is wrong.

You want to talk about sabotage, that is what we should be having a hearing on, is Medicare for all and what is coming. I also want to reiterate my call that the Energy and Commerce Committee hold hearings on that bill.

So today, instead of having a constructive, bipartisan dialogue about helping States innovate, about providing options for patients who are struggling to make ends meet, we are here for the second

time in as many weeks casting the blame of Obamacare's failures on the current President.

The fact is, we all support protecting people with preexisting conditions and we share a desire to stabilize the individual health insurance market. Last Congress, I advocated for policies that would achieve both of these goals, first through the AHCA's Patient and State Stability Fund, and I made two more attempts at bipartisan stabilization reforms last Congress, working with my colleagues in the Senate.

Unfortunately, House Democrats repeatedly blocked our creative solutions—solutions like improving 1332 waivers to better meet States' unique needs and modernize programs to stabilize premiums.

Now, my home State of Oregon, which celebrates its birthday tomorrow, we have an active 1332 waiver for a cost-based reinsurance program. I supported my home State's application and approval. I was the only Republican in our congressional delegation.

Why? Because it represents the very fabric of federalism. What works best for Oregon may not work best for California, Madam Chair.

Take Alaska, for example. In studying their individual market, they found that a conditions-based reinsurance program would better serve their residents. Before they received a waiver, 2017 rates were projected to increase 42 percent.

But after shifting individuals with one of 33 medical conditions into a separate pool, premiums for the lowest-cost bronze plan fell by an astounding 39 percent. And in Oregon, the reinsurance program kept premiums 6 percent below what they would have been without it.

These are real savings for patients in my State. Oregon and Alaska—one pretty traditionally blue, the other pretty traditionally red—found a way to take advantage of 1332 waivers to best serve their citizens.

They are not alone. Today, eight States have active waivers: Alaska, Hawaii, Minnesota, Maryland, Maine, New Jersey, Oregon, and Wisconsin. Eight diverse and unique States, but they have at least one thing in common, Madam Chair, and that is each of these eight active waivers were approved under the Obama administration's 1332 guidance.

Yet, today we are here to discuss nullifying the Trump administration's 1332 guidance. Why not first observe how States react and reform their markets through the new guidance?

We should understand that better. Perhaps a better use of our time would be spent discussing bipartisan solutions to reform and improve these waivers. We all want markets that work. We do.

We all want patients to have access to high-quality, affordable-priced health coverage. Unfortunately, the ironically named Affordable Care Act had made insurance for many unaffordable, and I heard it again yesterday from wheat growers in my district.

Together, and with the States as partners, not subordinates, we can achieve the shared goals of well-functioning and stable markets that provide Americans affordable healthcare options.

So one thing is clear: We need to guarantee our healthcare system works better for all Americans. That we can agree on, and that

is why our goal should be to advance solutions to protect patients, stabilize healthcare markets, encourage greater flexibility for States, and promote policies to help Americans get and keep coverage.

So, Madam Chair, thank you for having the hearing today. We look forward to working with you, and I yield back.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Good morning, Madam Chair. Given the title of today's hearing, I am concerned that for the second time in as many hearings in this subcommittee, we are not addressing the real challenges that consumers are facing, which is the high cost of healthcare.

Madam Chair, I said it last week, and I'll say it again: 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.

Unfortunately, today's hearing, and these bills are not adequately addressing these goals. Why would our Democratic colleagues be opposed to States innovating on behalf of their citizens? Why would they be opposed to providing patients flexible and affordable insurance options that best fit their needs? This just doesn't make sense.

The administration is allowing 10 million Americans more choices and more affordable health insurance options. The Democrats' Medicare for All proposal would force over 150 million Americans to lose their employer or union sponsored health insurance. You want to talk about sabotage, that is what we should be having a hearing on. I want to reiterate my call that Energy and Commerce hold hearings on this issue.

So today, instead of having a constructive, bipartisan dialogue about helping States innovate and providing options for patients who are struggling to make ends meet, we're here for the second time in as many weeks casting the blame of Obamacare's failures on our President.

The fact is we all support protecting people with preexisting conditions and we share a desire to stabilize the individual health insurance market.

Last Congress, I advocated for policies that would achieve this goal. First, through the ACA's Patient and State Stability Fund. And I made two more attempts at bipartisan stabilization reforms last Congress, working with our colleagues in the Senate. Unfortunately, House Democrats repeatedly blocked our creative solutions. Solutions like improving 1332 waivers to better meet States' unique needs and modernize programs to stabilize premiums.

In Oregon, we have an active 1332 waiver for a cost-based reinsurance program. I supported my home State's application and approval as the only Republican in our congressional delegation. Why? Because it represents the very fabric of federalism. What works best for Oregon may not work best for California, Madam Chair.

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Oregon and Alaska—one State traditionally blue, the other traditionally red—found a way to take advantage of 1332 waivers to best serve their citizens.

And they're not alone. To date, 8 States have active waivers: Alaska, Hawaii, Minnesota, Maryland, Maine, New Jersey, Oregon, and Wisconsin. Eight diverse and unique States. But they have at least one thing in common, Madam Chair. Each of these eight active waivers were approved under the Obama administration's 1332 guidance. Yet, today, we're here to discuss nullifying the Trump administration's 1332 guidance. Why not first observe how States react and reform their markets through the new guidance? Perhaps a better use of our time would be spent discussing bipartisan solutions to reform and improve these waivers.

We all want a market that works. We all want patients to have access to high-quality, affordably priced health coverage. Unfortunately, the ironically named Affordable Care Act has made insurance unaffordable for many Americans seeking individual insurance coverage. Together and with the States as partners, not subordi-

nates, we can achieve the shared goals of well-functioning and stable market places that provide Americans affordable health insurance options.

One thing is clear: We need to guarantee our healthcare system works better for all Americans. That's why our goal should be to advance solutions to protect patients, stabilize healthcare markets, encourage greater flexibility for States, and promote policies to help Americans get—and keep—coverage.

Ms. ESHOO. And I thank the gentleman.

I now would like to welcome our witnesses for today's hearing. First, Ms. Katie Keith, the associate research professor and adjunct professor of law at Georgetown University. Thank you for joining us.

Ms. Jessica Altman, commissioner, Pennsylvania Insurance Department. Very important job. Welcome to you.

And to Ms. Grace-Marie Turner, president of the Galen Institute, we thank you for accepting our invitation to join us today, and we look forward to your testimony.

And I am going to recognize each witness for 5 minutes to provide your opening statement, and just a little housekeeping. Our lighting system—what is in front of you is a series of lights. The light will initially be green, and then it will turn yellow when you have 1 minute to go, kind of like the League of Women Voters debates that we have all been in, right, with the lighting system. And we don't have a bell—we have a lighting system—and after that you will have 1 minute remaining, and at that point the light will turn red when your time expires—not when you expire, but when your time expires.

So let me begin with Ms. Katie Keith. You are recognized for 5 minutes, and welcome again and thank you to you.

STATEMENTS OF KATIE KEITH, ASSOCIATE RESEARCH PROFESSOR AND ADJUNCT PROFESSOR OF LAW, GEORGETOWN UNIVERSITY; JESSICA K. ALTMAN, COMMISSIONER, PENNSYLVANIA INSURANCE DEPARTMENT; GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

STATEMENT OF KATIE KEITH

Ms. KEITH. Thank you very much, Chairwoman Eshoo, Ranking Member Burgess, and members of the committee.

My name is Katie Keith, and I am a faculty member at Georgetown University, where I study private health insurance. I am also the author of the following: The ACA Blog Series for the Health Policy Journal of Health Affairs, where I am responsible for tracking and chronicling implementation of the Affordable Care Act, including many of the changes that the Trump administration has made in recent years.

My testimony today will focus on just three of those changes, although there have been many more than that, as you all know. The actions I will discuss today undermine the ACA risk pools, leave consumers who become sick without access to healthcare, and drive up premiums for people with preexisting conditions.

I will begin with short-term plans. Last August, three departments issues a new regulation allowing short-term plans to be sold for up to 12 months and extended for up to 3 years. Short-term plans do not have to comply with the Affordable Care Act, and they

are allowed to discriminate against patients with preexisting conditions.

These plans are medically underwritten and do not have to cover entire categories of benefits. A recent study showed that 43 percent of these plans do not cover mental health services. Seventy-one percent do not cover prescription drugs.

In the midst of an opioid crisis, 62 percent do not cover substance use services. And none of these plans covered maternity care.

Some had out-of-pocket maximums as high as \$30,000 and lifetime limits on care. These plans, which are highly profitable for the insurers that sell them, tend to only work for those who are healthy.

The harm to consumers from this new rule is twofold. First, these policies pose a significant risk to the individuals who enroll in them, only to find that the care that they need is not covered when they become sick.

Many newspapers are filled with stories these days of consumers who have enrolled in these plans only to wind up facing hundreds of thousands of dollars in unpaid medical bills.

Second, these policies drive up premiums for those with preexisting conditions, particularly for middle-income families who do not qualify for ACA subsidies.

Moving on to Section 1332, the Trump administration recently issued guidance that encourages States to offer skimpier coverage, including short-term plans. The new guidance relaxes the previous interpretation of what we refer to as the statutory guardrails under Section 1332.

This could result in State efforts to advance less comprehensive coverage and drive up premiums for people with preexisting conditions. It is worth noting that there have been questions raised about the legality of both the short-term plan rule and the Section 1332 guidance.

The short-term plan rule has already been challenged in court and a lawsuit brought by consumer and patient advocates, including the Little Lobbyists, who I believe testified before this subcommittee last week.

These patient advocates have sued over the rule because of its impact on people living with HIV, people with mental health issues, and people with other chronic conditions and disabilities.

The 1332 guidance has not yet been challenged, but approval of a waiver under that guidance would likely be challenged quickly.

Finally, the Trump administration has made dramatic cuts to funding for ACA marketing and outreach. This includes immediate cuts during the final week of the 2017 open enrollment period followed by a 90 percent reduction for 2018 from \$100 million to \$10 million.

Those cuts were maintained by CMS for 2019, and CMS has reduced funding for the navigator program by 84 percent. These funding decisions were made even though outreach and marketing helps bring in younger, healthier consumers, which in turn helps keep premiums stable.

At the same time, awareness of the marketplaces and the financial assistance that many people are eligible for remains low. We

are finding that enrollment of those key features is still low even after many years. That is particularly true among the uninsured.

We are also seeing that enrollment of new consumers, who tend to be younger and healthier, is down. Enrollment of new consumers has dropped by about 50 percent since 2016 alone.

According to one estimate, there are at least 2.3 million fewer new enrollees that would otherwise be in the marketplace due solely to cuts to outreach and advertising.

In closing, most people are healthy most of the time. But everyone eventually gets sick and needs access to comprehensive health insurance. The actions discussed today do nothing to advance high-quality affordable health insurance.

Instead, these actions divide the risk pool between the healthy and sick and increase premiums for people with preexisting conditions.

Thank you again for inviting me. It is an honor and privilege to be here, and I look forward to your questions.

[The prepared statement of Ms. Keith follows:]

Testimony of Katie Keith, J.D., M.P.H.
Associate Research Professor and Adjunct Professor of Law, Georgetown University

Hearing on “Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections”
U.S. House of Representatives
Committee on Energy & Commerce Subcommittee on Health
February 13, 2019

Good morning, Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, and thank you for the opportunity to testify today. I am Katie Keith, an Associate Research Professor and Adjunct Professor of Law at Georgetown University, where I study and teach courses on private health insurance and the Affordable Care Act (ACA). I am also the author of the “Following the ACA” blog series for *Health Affairs*, the leading journal of health policy thought and research, where I am responsible for tracking and chronicling ongoing implementation of the ACA at the federal and state levels.

Thank you again for inviting me to testify about three recent actions taken by the Trump administration and their impact on people with pre-existing conditions and state health insurance markets. The views I express today are my own and do not reflect those of Georgetown University or *Health Affairs*.

Threats to Progress Under the Affordable Care Act

The ACA has resulted in historic coverage gains: more than 20 million people have gained coverage since the law was enacted in 2010 and the uninsured rate has reached a record low of 8.8%.¹ Millions more Americans—especially those with pre-existing medical conditions—have benefited from ACA protections such as guaranteed availability of coverage, the coverage of preventive services without cost-sharing, the ability of a young adult to remain on their parent’s plan, and the ban on lifetime and annual dollar caps on care.

These historic gains and protections are, however, increasingly at risk due to efforts to undermine the ACA’s protections—in Congress, in court, and by the Trump administration. Even though enrollment through the ACA marketplaces has remained relatively stable over the past two years, recent studies show that progress in insuring more Americans has stalled, if not reversed, since 2016.²

The Trump administration has made many policy decisions that threaten the long-term stability of the ACA. This testimony will focus on three of those recent actions to 1) expand access to short-term, limited duration insurance, 2) allow states to potentially skirt ACA requirements, and 3) cut funding for ACA outreach and marketing. Each of these changes has or could leave consumers who become sick without access to the care they need and increase premiums for people with pre-existing conditions, especially middle-income Americans

¹ Robin A. Cohen et al., *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2018*, National Center for Health Statistics (Aug. 2018).

² See Katie Keith, “[New Survey Shows Highest Uninsured Rate Since 2014](#),” *Health Affairs Blog* (Jan. 24, 2019).

with health needs who do not qualify for premium tax credits. Higher ACA premiums also result in higher federal outlays to cover the cost of higher premium tax credits for those who qualify for subsidies.

Promoting Expanded Access to Short-Term, Limited Duration Insurance

Short-term, limited duration insurance (STLDI) is a type of limited insurance product marketed to individuals that was historically used to fill a temporary gap in coverage. Although these policies are meant to be temporary, some insurers offered STLDI that lasted 364 days, just shy of one year. In 2016, the Obama administration reduced the maximum duration of STLDI to no more than three months, citing concerns that these policies were being sold as primary coverage and adversely impacting the ACA risk pool.³ In August 2018, the Trump administration reversed—and further expanded—the sale of STLDI by allowing these policies to be sold for up to 12 months and renewed or extended for up to 36 months.⁴

Individuals who enroll in STLDI may face significant benefit gaps and high out-of-pocket costs if they become sick. This is because STLDI does not have to comply with the ACA's market reforms. As a result, STLDI insurers in most states can:

- Refuse to offer a policy to an individual with a pre-existing condition;
- Exclude coverage for pre-existing conditions;
- Charge higher monthly premiums based on health status and other factors such as age or gender;
- Impose annual or lifetime dollar limits on care;
- Opt not to cover entire categories of benefits (such as mental health services, prescription drugs, or maternity care);
- Retroactively cancel coverage once care is needed; and/or
- Impose much higher out-of-pocket costs than under the ACA.

These limitations mean, first, that STLDI is typically not an option for people with pre-existing conditions and, second, that even healthy people who develop a medical issue while enrolled in STLDI may see their claims denied or their policy cancelled. Such practices have resulted in lawsuits against STLDI insurers and multi-state enforcement actions by state regulators.⁵ STLDI is also not subject to the ACA's single risk pool requirement or medical loss ratio standards.

A recent Kaiser Family Foundation analysis of STLDI sold in 2018 shows that 43% did not cover mental health services, 62% did not cover services for substance abuse treatment, and 71% did not cover outpatient

³ Departments of the Treasury, Labor, and Health and Human Services, *Excepted Benefits: Lifetime and Annual Limits; and Short-Term, Limited Duration Insurance*, 81 Fed. Reg. 75316 (Oct. 31, 2016).

⁴ Departments of the Treasury, Labor, and Health and Human Services, *Short-Term, Limited Duration Insurance*, 83 Fed. Reg. 38212 (Aug. 3, 2018).

⁵ See, e.g., California Department of Insurance, "Investigation into Sale of Short-Term Health Policies Leads to \$5 Million Settlement with HCC Life Insurance Company," Press Release (Apr. 10, 2018); Declan Harty, "Tokio Marine HCC, Health Insurance Innovations Facing Class-Action Fraud Lawsuit," *S&P Global Market Intelligence* (Jan. 3, 2018).

prescription drugs.⁶ No plans covered maternity care, and, in seven states, STLDI covered none of these four benefit categories. These policies had out-of-pocket maximums as high as \$30,000 and lifetime limits on care ranging from \$250,000 to \$2 million. A separate study from colleagues at Georgetown University found that the best-selling STLDI policies in five states had out-of-pocket maximums from \$7,000 to \$20,000 for only three months (compared to the maximum of \$7,150 for 12 months for an ACA-compliant plan that year).⁷

Given limitations such as these—and the fact that the policies are medically underwritten—STLDI can be offered at far lower premiums than ACA-compliant coverage. One analysis shows that STLDI policies could have premiums up to 54% lower than ACA-compliant plans due largely to STLDI insurers' ability to exclude people with pre-existing conditions.⁸ With lower premiums and far less generous benefits, enrollment in STLDI skews younger and healthier.

Even with lower premiums, STLDI policies are highly profitable. Data from the National Association of Insurance Commissioners (NAIC) shows that STLDI insurers had an average loss ratio of 64.6% in 2017 (compared to 80% for ACA-compliant individual market policies).⁹ The three largest insurers offering STLDI had even lower loss ratios of 43.7%, 34.0%, and 52.1%. In other words, the majority of STLDI premium revenue for those insurers went to profit, marketing, and other expenses unrelated to medical care.

New Rule Expands Access to STLDI and Undermines the ACA's Single Risk Pool. The STLDI rule was issued in response to an Executive Order from President Trump that directed the agencies to expand the availability of STLDI as "an appealing and affordable alternative to government-run exchanges."¹⁰ Consistent with the Executive Order, the rule established a parallel STLDI market that competes with the traditional ACA market and allows STLDI insurers to segment younger, healthier consumers into a risk pool separate from older, less healthy consumers who remain in the ACA risk pool.

Stakeholders such as the American Academy of Actuaries, America's Health Insurance Plans, and the Blue Cross Blue Shield Association raised concerns about this parallel market and the risk of adverse selection. In fact, the vast majority of health care stakeholders who commented—more than 95%—criticized or opposed the STLDI rule.¹¹ The legality of the rule has also been challenged in court by a coalition of consumer advocates and a safety net health plan association. These organizations argue that the Trump administration has converted a narrow federal exemption for STLDI into a much larger loophole to allow a parallel market of non-ACA-compliant

⁶ Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 2018). Even when these benefits are covered by STLDI, they are subject to a number of limitations and exclusions, such as dollar limits on care.

⁷ Dania Palanker et al., *New Executive Order: Expanding Access to Short-Term Health Plans is Bad for Consumers and the Individual Market*, The Commonwealth Fund (Oct. 2017).

⁸ Larry Levitt et al., *Why Do Short-Term Health Insurance Plans Have Lower Premiums than Plans that Comply with the ACA?* Kaiser Family Foundation (Oct. 2018).

⁹ National Association of Insurance Commissioners, *2017 Accident and Health Policy Experience Report*, at 83 (2018).

¹⁰ President Donald J. Trump, *Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States* (Oct. 12, 2017). The same Executive Order directed federal agencies to expand the availability of non-ACA-compliant association health plans and the use of health reimbursement arrangements.

¹¹ Noam N. Levey, "Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments," *Los Angeles Times* (May 30, 2018).

plans. This will result in higher premiums and out-of-pocket costs that harm those the plaintiffs represent such as individuals with mental health issues, individuals living with HIV, women, and families with children who have complex medical needs and disabilities.

The Trump administration acknowledged that the new rule would raise premiums for ACA-compliant plans and could result in adverse selection against the individual market risk pool.¹² Separately, the independent chief actuary of the Centers for Medicare and Medicaid Services (CMS) estimated that average marketplace premiums would be 3% higher (about \$17 higher per month) in 2019 and 6% higher beginning in 2022 due to the rule.¹³ In a separate analysis, the Kaiser Family Foundation estimates that 2019 premiums are an average of 6% higher because of the combined impact of zeroing out of the individual mandate penalty and expansion of STLDI and non-ACA-compliant association health plans.¹⁴

Increased STLDI Enrollment in 2019. Early data suggest that the rule is achieving its goal of higher enrollment in STLDI, which will likely impact how insurers set their rates for 2020. A November 2018 report from eHealth, a prominent web broker, disclosed that 70% of its customers that do not qualify for marketplace subsidies enrolled in STLDI.¹⁵ This was an increase from 56% of consumers during the same period in 2017.

Increased enrollment in STLDI can also be attributed to the zeroing out of the individual mandate penalty. Prior to 2019, consumers who enrolled only in STLDI may have had to pay the individual mandate penalty because STLDI does not qualify as minimum essential coverage. The possibility of paying the penalty may have discouraged some consumers who would have otherwise enrolled in STLDI from doing so. Now that the penalty has been zeroed out and the new rule offers expanded access to STLDI, more consumers are expected to purchase STLDI over ACA-compliant policies, potentially exposing them to high out-of-pocket costs and resulting in higher premiums in the ACA risk pool.

Aggressive Marketing of STLDI and Consumer Confusion. A recent study further suggests that brokers use aggressive sales tactics for STLDI and that consumers may not be getting information about ACA-compliant coverage.¹⁶ Aggressive marketing is a particular concern because STLDI has been a source of confusion for consumers. Because these policies can mimic (or are deceptively marketed as) major medical coverage, consumers may be unaware that they are enrolling in a policy that will not cover certain medical needs until

¹² 83 Fed. Reg. at 38234. In the preamble to the rule, the agencies noted that those who purchase STLDI were “likely to be relatively young or relatively healthy” and that the rule “may weaken states’ individual market single risk pools.” The preamble went on to state that individual market insurers “could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market,” and that this rule “may further reduce choices for individuals remaining in those individual market single risk pools.” Although the agencies estimated that the rule would increase premiums by 1% in 2019 and by 5% by 2028, other independent analyses suggest that the agencies underestimated the impact of the rule on ACA premiums.

¹³ Chief Actuary Paul Spitalnic, *Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule*, Office of the Actuary (Apr. 6, 2018). Higher premiums would result in higher premium tax credits and thus higher federal outlays, with federal spending expected to increase by about \$1.2 billion in 2019 and about \$38.7 billion over the next 10 years.

¹⁴ Rabah Kamal et al., *How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums*, Kaiser Family Foundation (Oct. 2018).

¹⁵ eHealth, *Half-Time Report – The ACA Open Enrollment Period for 2019 Coverage* (Nov. 2018).

¹⁶ Sabrina Corlette et al., *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses* (Jan. 2019).

after they are sick. This confusion led a number of state insurance departments to issue alerts or warnings to inform consumers about the limitations of short-term policies and deceptive marketing practices.¹⁷

State Regulation of STLDI. States have the authority to regulate STLDI, but fewer than half have adopted stricter limits than the federal government.¹⁸ Some states and the NAIC had asked for a delay in the effective date of the new rule to 2020 to provide states with time to review their rules and seek changes to protect consumers and state markets. The Trump administration ignored this request, and the new rule went into effect on October 2, 2018 (less than one month before the 2019 open enrollment period began). This prevented many states from being able to consider new regulation of STLDI before the 2019 open enrollment period. Further, many state insurance departments lack the authority or capacity to prevent deceptive STLDI marketing before it occurs.¹⁹ State regulators may be further limited in their ability to regulate STLDI because many of these products are being marketed through out-of-state associations that are exempt from state regulation.²⁰

New Guidance on Section 1332 Waivers

The Trump administration did not stop at the STLDI rule. In new guidance issued in October 2018, the Departments of Health and Human Services and Treasury signaled a willingness to allow states to potentially subsidize the purchase of STLDI, and other non-ACA-compliant plans, using federal funds under a Section 1332 waiver.²¹ The new guidance also outlined the Departments' interpretation of Section 1332's "guardrails."

Section 1332 of the ACA allows states, with approval from the federal government, to waive certain provisions of the ACA in the interest of pursuing alternative coverage approaches that are consistent with the goals of the ACA.²² To help fund these efforts, the federal government can "pass through" to a state the funds that it would have otherwise spent on premium tax credits, cost-sharing reductions, and small employer tax credits for residents.

¹⁷ See Rachel Schwab & Maanasa Kona, *State Insurance Department Consumer Alerts on Short-Term Plans Come Up Short*, CHIR Blog (Dec. 17, 2018).

¹⁸ Justin Giovannelli et al., *What is Your State Doing to Affect Access to Adequate Health Insurance?*, The Commonwealth Fund (Feb. 2019).

¹⁹ Corlette et al., *supra* note 17.

²⁰ Emily Curran et al., *Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections*, The Commonwealth Fund (Jan. 2019).

²¹ Departments of the Treasury and Health and Human Services, *State Relief and Empowerment Waivers*, 83 Fed. Reg. 53575 (Oct. 24, 2018). Federal officials also hinted at this possibility in the final rule on STLDI. See 83 Fed. Reg. at 38218.

²² Section 1332 does not allow states to waive all or any provisions of the ACA. States are limited to waiving provisions in Parts I and II of subtitle D of Title I of the ACA (the rules regarding the regulation of qualified health plans); Section 1402 of the ACA (cost-sharing reductions); and Sections 36B, 4980H, and 5000A of the Internal Revenue Code (premium tax credits and the individual and employer mandates). Section 1332 does not allow a state to waive key market-wide provisions, such as the ACA's ban on preexisting condition exclusions or underwriting based on health status.

Even where ACA provisions can be waived, a state must meet certain procedural and substantive “guardrails” to be granted a waiver.²³ Federal officials can approve a Section 1332 waiver only if a state’s waiver proposal will:

1. Provide coverage that is at least as comprehensive as the coverage offered through the marketplaces;
2. Provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the ACA would provide;
3. Provide coverage to at least a comparable number of its residents as the ACA would provide; and
4. Not increase the federal deficit.

In the 2018 guidance, the Departments shifted away from the Obama-era approach in which the guardrails were considered collectively in assessing a waiver proposal (i.e., coverage under a state waiver must meet all four guardrails: comprehensiveness, affordability, number of people covered, *and* deficit neutrality). Instead, the Departments will essentially consider the guardrails separately. This means the Departments may approve waivers even if only *some* coverage under the waiver is as comprehensive, as affordable, and as available as coverage provided under the ACA. In a further shift, waivers will be evaluated based on whether residents have access to comprehensive and affordable coverage (even if they do not enroll in this coverage), and the Departments will assess a waiver’s aggregate effects instead of the effect on vulnerable individuals (such as those who are elderly, low-income, or with serious health issues).²⁴

The new guidance encourages states to consider waivers for less comprehensive coverage that likely would not meet the needs of those with pre-existing conditions.²⁵ In particular, the 2018 guidance encourages states to propose waivers that could:

- Define “coverage” to include plans that do not comply with the ACA, including STLDI and association health plans, that exclude coverage for pre-existing conditions and other key benefits;
- Increase the number of people with less comprehensive coverage relative to the ACA;
- Increase the number of consumers exposed to higher out-of-pocket costs relative to the ACA; or
- Impose coverage losses or higher out-of-pocket costs on vulnerable populations, such as older adults or low-income people.

It will be challenging to reconcile approval of these types of waivers with the text of Section 1332 or the ACA as a whole, and approval of a waiver that fails to meet the statutory guardrails is likely to face a legal challenge.²⁶

²³ Section 1332 requires states to have a law in place to authorize a waiver application and outlines certain procedural requirements that must be followed, such as opportunities for public comment. The 2018 guidance would no longer require states to adopt new legislation to authorize a Section 1332 waiver application. Instead, states may be able to rely on existing legislative and executive authority to authorize a waiver application. This may make it easier for at least some states to pursue Section 1332 waivers.

²⁴ States must still explain how their waiver will impact those with low incomes and high health care costs but these populations are no longer a focal point of the waiver approval analysis.

²⁵ See Jennifer Tolbert & Karen Pollitz, *New Rules for Section 1332 Waivers: Changes and Implications*, Kaiser Family Foundation (Dec. 2018).

²⁶ See Joel McElvain, “[The Administration’s Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act’s Statutory Guardrails.](#)” Take Care Blog (Dec. 7, 2018); Christen Linke Young, “[The Trump Administration Side-Stepped Rulemaking Processes on the ACA’s State Innovation Waivers—and It Could Make Their New Section 1332 Guidance Invalid.](#)” Brookings (Nov. 28, 2018); Katie Keith, “[Feds Dramatically Relax Section 1332 Waiver Guardrails.](#)” *Health Affairs Blog* (Oct. 23, 2018).

This is in part because the new guidance sets up the potential for an end-run around Section 1332 itself. Section 1332 cannot be used to waive every ACA provision. Yet, the new guidance opens up the possibility for states to waive non-waivable provisions by allowing (and potentially directing federal pass-through funding for) coverage options that do not cover pre-existing conditions and allow health status underwriting and gender rating.

The 2018 guidance went into effect immediately, meaning these criteria will be used by federal officials from now on in analyzing future waiver applications from states. Since then, the Trump administration has continued to encourage the use of Section 1332 waivers by releasing four new “waiver concepts” for states to consider.²⁷ These waiver concepts include components of bills to repeal the ACA that were considered in Congress in 2017, such as flat tax credits that would result in higher premiums for older and lower-income Americans. To my knowledge, no state has yet submitted a new waiver application under the 2018 guidance.

Cuts to ACA Marketing and Outreach

Beyond expanding access to STLDI and other non-ACA-compliant plans, the Trump administration has made dramatic cuts to funding for ACA marketing and outreach since 2017. Almost immediately, the Trump administration moved to cut outreach and advertising funding for the final week of the 2017 open enrollment period; this contributed to an estimated 500,000 fewer enrollees that week.²⁸

In August 2017, CMS reduced its ACA advertising budget by 90% from \$100 million for 2017 to about \$10 million for 2018.²⁹ This cut in advertising coincided with a reduction in the length of the 2018 open enrollment period, which was cut from 90 days to 45 days. CMS invested a similar \$10 million in advertising for the 2019 open enrollment period and has reduced funding for the navigator program—which provides unbiased, in-person outreach and enrollment assistance to consumers—by 84% since January 2017.³⁰

In justifying these cuts, the Trump administration asserted that the Obama administration spent too much on advertising and that robust outreach efforts are less needed because the public is more aware of options for private coverage. While this may be true relative to the initial open enrollment period that began in 2013, awareness of the timing of open enrollment itself remains low, particularly among the uninsured.

In October 2017, about 81% of uninsured adults were unaware of the deadline to enroll.³¹ A separate survey found that 40% of uninsured adults were still unaware of the marketplaces in 2017.³² A November 2018

²⁷ See Chris Fleming & Katie Keith, “CMS Releases New 1332 Waiver Concepts: A Summary,” *Health Affairs Blog* (Nov. 29, 2018); Katie Keith & Chris Fleming, “CMS Releases New 1332 Waiver Concepts: Implications,” *Health Affairs Blog* (Nov. 29, 2018). These waiver concepts are account-based subsidies, state-specific premium assistance, adjusted plan options, and risk stabilization strategies.

²⁸ Joshua Peck, “Trump Blocked Nearly 500,000 People from Getting Coverage,” *Medium* (Feb. 2, 2017).

²⁹ Timothy Jost, “CMS Cuts ACA Advertising by 90% Amid Other Cuts to Enrollment Outreach,” *Health Affairs Blog* (Aug. 31, 2017).

³⁰ Karen Pollitz et al., *Data Note: Further Reductions in Navigator Funding for Federal Marketplace States*, Kaiser Family Foundation (Sep. 2018).

³¹ Ashley Kirzinger et al., *Kaiser Health Tracking Poll—October 2017: Experiences of the Non-Group Marketplace Enrollees*, Kaiser Family Foundation (Oct. 18, 2017).

poll further confirmed that 61% of adults who are uninsured or purchase their own coverage were unaware of the December 15 enrollment deadline; another 8% offered the wrong date.³³ Only about 31% reported hearing or seeing information or ads about how to enroll in health insurance under the ACA.

Marketing and outreach is critical to helping ensure a balanced ACA risk pool and keeping premiums stable. While enrollment in the 39 states that use HealthCare.gov is down slightly, enrollment of new consumers is down by about 50% since 2016.³⁴ This is a troubling trend because new enrollees tend to be younger and healthier. Younger and healthier consumers are also more likely to benefit from marketing and outreach with reminders of the deadline and the availability of subsidies. In recent testimony before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, the former chief marketing officer for HealthCare.gov estimated that there have been at least 2.3 million fewer new enrollments due solely to cuts to outreach and advertising.

Conclusion

In conclusion, the ACA's historic coverage gains and protections, especially for those with pre-existing medical conditions, are increasingly at risk. The Trump administration's new rule to expand access to STLDI poses a significant risk to the individuals who enroll but are left without coverage for services they need when they become sick. The rule also undermines the ACA's single risk pool requirement and has had the demonstrated effect of increasing premiums for ACA plans that millions of people with pre-existing conditions rely on. In new guidance on Section 1332, the Trump administration has encouraged states to consider waivers for less comprehensive coverage that will not meet the needs of those with pre-existing conditions. And cuts to outreach and marketing are leaving consumers, especially younger and healthier consumers, behind when it comes to enrolling in ACA coverage.

³³ Sara R. Collins et al., *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?* The Commonwealth Fund (Sep. 2017).

³⁴ Ashley Kirzinger et al., *KFF Health Tracking Poll—November 2018: Priorities for New Congress and the Future of the ACA and Medicaid Expansion*, Kaiser Family Foundation (Nov. 28, 2018).

³⁵ Joshua Peck, "Week 7: Demand for Quality, Comprehensive Health Coverage Once Again Overcomes Trump Administration," *Medium* (Dec. 19, 2018).

Ms. ESHOO. Thank you, Professor Keith.

I now would like to recognize Ms. Jessica Altman, again, the commissioner from Pennsylvania Insurance Department. You have—you are recognized to present your testimony to us.

STATEMENT OF JESSICA K. ALTMAN

Ms. ALTMAN. Thank you, and good morning, Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee.

As mentioned, my name is Jessica Altman, and I am privileged to serve as insurance commissioner for the Commonwealth of Pennsylvania.

I want to thank you for convening today's important discussion regarding short-term plans and for the opportunity to voice concerns about the potential harms for consumers and for the health insurance market, more broadly.

As the name says, short-term plans were created to fill brief gaps in coverage. The plans generally have lower premiums but significant coverage limitations, as the protections of the Affordable Care Act, which I will call ACA, do not apply.

By recently extending the duration and renewability of short-term plans, the Federal administration is seeking to make short-term plans look and act like a viable alternative to comprehensive major medical insurance without extending the protections of the ACA.

Today, I will highlight my four primary concerns illustrated by actual consumer complaints and conclude by sharing with you a little bit about my department's approach to short-term plans. Please reference my testimony for a more thorough perspective.

The first primary concern with the plans that I raise today is one Katie covered well. They have very limited benefits and consumer protections. Short-term plans do not have to cover essential health benefits, and in Philadelphia the same study Katie mentioned found that less than 60 percent covered mental health, only one-third in the midst of the opioid crisis that is hitting Pennsylvania very hard covered substance use disorder treatment or prescription drugs, and none covered maternity care.

Short-term plans can impose lifetime and annual limits on coverage, do not include appeal rights, and are not subject to a medical loss ratio requirement that sets a floor for the percent of premium spent on actual medical care.

Instead, for the two short-term insurers with 80 percent market share, less than 50 cents of every dollar collected in premiums was spent on actual medical care.

Recently, my department worked with a woman who fainted at work and hit her head—something that could happen to any of us—and it resulted in emergency transport to the hospital.

The short-term plan paid \$200 for the ambulance, leaving the patient with \$1,250. At the ER, the plan provided \$250 while the bill was over \$2,400. Then she was admitted to the ICU, where the benefit was, again, \$1,250 for a bill that was \$9,300.

Finally, the plan paid another \$1,250 for an outpatient test while the bill was \$4,900. After considering cost sharing, the plan covered just over \$1,300, the consumer \$16,000.

My second concern is the lack of consumer disclosure regarding benefits and benefit exclusions. The plans are sold without a consumer's access to provider directories, formularies, sample coverage documents, summaries of benefits and coverage, and a uniform glossary, all of which are required to be provided with Affordable Care Act plans.

The lack of consumer disclosure is so troubling in the short-term market that we are creating our own consumer awareness campaign to try to cut through the noise of robocalls, well-placed online advertising, misleading website URLs, and a lot of fine print that are currently bombarding consumers across the country to purchase these plans.

A recent study found that consumers shopping online for health insurance, including those using search terms like "Obamacare" or "Enroll ACA," will most often be directed to websites and brokers selling short-term plans or other non-ACA-compliant coverage, and this is, of course, exacerbated by the lack of comprehensive ACA information, outreach, and enrollment.

The third issue is claims practices. I am most concerned by the use of a practice called postclaims underwriting, which often results in rescission or denial of coverage.

As short-term plans often exclude coverage for preexisting conditions, policy holders who get sick may be investigated by the insurer to determine whether a recently diagnosed condition could be considered preexisting and therefore excluded.

We are currently working with a consumer who purchased a short-term plan and was diagnosed with heart failure. After he filed a claim for services, he was denied coverage based on the preexisting condition. But he had never been diagnosed, never sought, and never received care for his heart.

But instead, the insurer indicated that the claim manifested in such a way that an ordinary, prudent individual would have sought medical treatment and advice in the year prior to purchasing the plan.

Through the course of working to resolve consumer complaints, the claims practices of short-term plans have repeatedly demonstrated an inclination to deny coverage rather than provide it.

Lastly—and I see my time ticking down so I will be quick—encouraging the proliferation of short-term plans has the potential to destabilize and drive up costs for the ACA market, especially for those with preexisting conditions, by segmenting healthier people out of the market.

The Federal Government does also continue to push for the proliferation of short-term plans through regulatory actions such as the 1332 guidance, and a waiver like that under the new guidance would not be one that Pennsylvania would pursue.

Thank you. I will shorten my remarks and welcome any of your questions.

[The prepared statement of Ms. Altman follows:]



Strengthening Our Health Care System: Legislation to Reverse
ACA Sabotage and Ensure Pre-Existing Conditions Protections
Testimony Before the House Energy and Commerce Committee
Subcommittee on Health
February 13, 2019

Presented by:
Jessica K. Altman
Commissioner
Pennsylvania Insurance Department
1326 Strawberry Square
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Good morning Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee of the House Energy and Commerce Committee. My name is Jessica Altman and I serve as the Insurance Commissioner for the Commonwealth of Pennsylvania. Thank you for convening today's important discussion regarding short-term limited duration insurance, and for the opportunity to voice concerns about the potential harms it may cause for consumers and the health insurance market more broadly. Pennsylvania supports all three pieces of legislation under discussion today, largely due to extensive concerns about the proliferation of short-term limited duration insurance outlined in my testimony.

As the primary regulator of health insurance in Pennsylvania's market, the Pennsylvania Insurance Department works to ensure consumers are protected and that insurers can compete in a stable, predictable market. Short-term limited duration insurance presents a challenge to both of these goals though, as our authority under state law regarding these plans is limited.

As its name plainly indicates, short-term limited duration insurance, or STLDI, was created to provide temporary health coverage to individuals who have an unexpected gap in coverage or need health insurance coverage for a brief period. The plans generally have lower premiums but significant coverage limitations, as the protections of the Affordable Care Act, or ACA, do not extend to STLDI.

By recently extending the duration and renewability of STLDI, the federal Administration is seeking to make short-term plans look and act like a viable alternative to purchasing comprehensive, major medical insurance without extending the protections of the ACA to STLDI. This is being reinforced by the rhetoric that these are "true alternatives" to comprehensive health insurance coverage. We reject the notion that STLDI is an affordable alternative to comprehensive insurance that includes the benefits and protections of the ACA. Consumers may experience an upfront savings in premiums, but the affordability of STLDI plans will likely prove to be illusory: those who need health care will run up against exclusions and limitations on coverage that, while making the purchase price more affordable, will do so only as a trade-off for benefit coverage and provider access.¹

Some advance the proposition that pushing STLDI into the individual marketplace will help to address affordability issues, especially for those individuals who do not receive subsidies to help pay for coverage. While we agree that we should be pursuing solutions to address affordability, we do not believe that STLDI is a plausible solution. Rather, STLDI has the potential to drive up costs, especially for individuals with pre-existing conditions. Of note, in Pennsylvania, over a quarter of the population is estimated to have a pre-existing condition. For these individuals, STLDI would not prove to be a meaningful option for coverage because of pre-existing condition exclusions, while coverage in the ACA individual market would guarantee that their pre-existing conditions are covered according to the benefits of their selected plan.

At the same time, the scenario in which healthier individuals pursue STLDI while those with pre-existing conditions remain on ACA coverage will result in higher premiums for that coverage and resulting instability in the ACA market. We recommend a different approach: focus on actual solutions to

¹ Department Comments on Proposed Rule, CMS-9924-P (April 20, 2018), <https://www.regulations.gov/document?D=CMS-2018-0015-8446>.

address affordability for consumers – not the perpetuation of substandard products that only cost less because they cover less.

In Pennsylvania, our efforts in these areas are working. Our final 2019 approved rates for the individual ACA market resulted in an aggregate statewide decrease of 2.3 percent. All insurers offering individual plans in 2018 continue to do so, and a new insurer entered our state. Governor Wolf's aggressive support for the ACA and expanded Medicaid has pushed our uninsured rate to an all-time low of 5.5 percent.

Benefit Limitations

Short-term policies generally cover some major-medical benefits, though limits often apply as the protections of the ACA do not extend to STLDI. For example, the plans are often medically underwritten: therefore, applicants with health conditions can be turned down or charged higher premiums, without limit, based on health status, gender, age, and other factors.

STLDI plans do not have to cover essential health benefits. Consequently, typical short-term policies do not cover maternity care, prescription drugs, mental health care, preventive care, and other important benefits such as substance use disorder services, which is exactly the opposite of what we should do as we battle the opioid crisis. STLDI plans may limit coverage in other ways. According to an April 2018 study performed by the Kaiser Family Foundation, of the STLDI plans sold in Philadelphia, only 57% of the plans included mental health benefits, 33% of the plans covered substance use disorder treatment, 33% of the plans covered prescription drugs and *none* of the plans covered maternity.²

The plans can also impose lifetime and annual limits. For example, many policies cap covered benefits at \$2 million or less. The plans are also not subject to cost sharing limits, and some short-term policies may require cost sharing in excess of \$20,000 per person per plan period, compared to the ACA-required annual cap on cost sharing of \$7,350 in 2018.

Appeal rights established by the ACA do not extend to STLDI, which means that the internal and external appeal opportunities presented to consumers enrolled in ACA compliant coverage do not extend to enrollees of STLDI plans. Consequently, following a denial of benefits, consumers enrolled in STLDI plans may find themselves without opportunity to challenge their benefit denial.

Finally, STLDI plans are not subject to other ACA market requirements, such as minimum medical loss ratios. For example, while ACA-compliant non-group policies are required to pay out at least 80% of premium revenue for claims and related expenses, the average loss ratio for individual market short-term medical policies in 2016 was 67%; while for the top two insurers, who together sold 80% of all short-term policies in this market, the average loss ratio was 50%.³ This means that for enrollees in those plans, less than .50 of every premium dollar went to pay claims.

Recently, my Department worked with an STLDI plan enrollee who fainted at work and hit her head, which resulted in an emergency transport to a local hospital's intensive care unit. The STLDI plan paid

² Kaiser Family Foundation analysis of short-term health insurance plans on eHealth and Agile Health Insurance websites, April 2018, available at: <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

³ National Association of Insurance Commissioners, Accident and Health Policy Experience Report for 2016, available at http://www.naic.org/prod_serv/AHP-LR-17.pdf.

\$200 for the ambulance services, leaving the patient responsible for \$1250 for the ride. At the emergency room, the plan provided a maximum payable benefit of \$250, while the bill for the emergency care was over \$2,400. Then, she was admitted to the inpatient intensive care unit, where the STLDI plan's maximum benefit was \$1,250, while the bill was \$9,300. Finally, the maximum payable benefit for the outpatient test was \$1,250, while the bill for the outpatient procedure was \$4,900. After considering cost-sharing, to include the payable benefits being applied to the consumer's deductible and coinsurance, the STLDI plan covered just over \$1,300 and the consumer was stuck with a bill of over \$16,000.

Consumer Disclosure

Our Department works tirelessly to inform consumers about their insurance coverage options to enable them to make the best decision for their specific circumstances. We believe that consumers should be armed with an in-depth understanding of how their insurance coverage will protect them in times of need *prior* to purchasing coverage, as the time when using insurance coverage is *not* the time to learn of its limitations. While the federal government required STLDI to include a brief notice which encourages consumers to check their policies carefully, the notice requirement has limited effect when not coupled with access to provider directories, formularies, sample coverage documents, summaries of benefits and coverage, and a uniform glossary – all of which are required by the ACA for comprehensive insurance, but none of which are required of STLDI.

Given the lack of access to such fundamental documents that explain the benefits of the underlying insurance plan, we have found that many consumers purchase STLDI without a full understanding of the product's limitations. We have received numerous complaints from consumers whose STLDI plans failed to provide coverage for services that were excluded based on the fine print of those policies. In fact, in the past two years, our Department has suspended the licenses of eight producers who misrepresented the coverage available to consumers who purchased STLDI. But, even in cases where there is no misrepresentation to consumers, it is difficult to understand the extent of the benefit limitations included in these plans until a consumer needs health care and tries to use them. We will continue to respond to consumer complaints about their lack of understanding of benefit limitations and take action when we learn of misleading information or misrepresentation.

The lack of consumer disclosure is so troubling in the STLDI market that we have undertaken the creation of a consumer awareness campaign to teach consumers the right questions to ask when contemplating purchasing STLDI coverage. In addition to easy-to-read brochures, we have more recently embarked upon the creation of a video campaign that will capture testimonials of individuals who have purchased STLDI and found the benefits to be illusory. By deploying such a strategy, we hope to arm consumers with the right questions to ask before purchasing a plan they later regret.

Reaching consumers and ensuring truly accurate representation in the marketplace remains an uphill battle. Between robo-calls, well-placed advertising, misleading website URLs, and a lot of fine print, consumers are being bombarded with solicitations to purchase these plans and are deprived of robust information to inform their purchasing decisions. A recent Georgetown University study found that consumers shopping online for health insurance, including those using search terms such as "Obamacare plans" or "ACA enroll," will most often be directed to websites and brokers selling STLDI or

other non-ACA compliant products.⁴ Unfortunately, this distraction campaign comes at a time when the federal government reduced funding for marketing and advertising in the federally-facilitated marketplace (FFM) by 90% and reduced funding for the navigator program by 84%. Marketing, outreach and navigator funding are some of the core functions of operating the FFM, and the federal government is falling short of meeting those expectations. In Pennsylvania, we have stepped up by funding and operationalizing our own open enrollment outreach campaign to make sure accurate information is reaching consumers, but not every federal marketplace state has the ability to do this and our state resources are more limited than the federal government's. The federal government should not only increase its efforts to inform consumers, it should focus on explaining the benefits of comprehensive coverage through the ACA, and alert consumers to the shortcomings of substandard coverage.

Monitoring and appropriately addressing all of these activities in the marketplace is and will continue to be challenging for even the most vigilant state, but even more so for states reliant on the FFM. I have committed my Department to doing all that it can to make sure that STLDI are accurately and appropriately represented to Pennsylvanians but remain concerned by the volume of untoward practices in the market.

Post-claims underwriting and claims practices

One of the most concerning aspects of STLDI plans is the use of a practice called post-claims underwriting, which often results in a rescission of coverage. As STLDI plans often exclude coverage for pre-existing conditions, policyholders who get sick may be investigated by the insurer to determine whether the recently-diagnosed condition could be considered pre-existing and so excluded from coverage.

We are currently working with a consumer who purchased an STLDI plan that did not include coverage for pre-existing conditions. During the term of the consumer's plan, he was diagnosed with heart failure. After he filed a claim for medical services, he was denied coverage based on the pre-existing condition exclusion. Even though the consumer had never sought or received care for his condition previously, the insurer indicated that the claim manifested in such a way that an ordinary prudent individual would have sought medical advice and treatment in the twelve months prior to purchasing the STLDI plan for that condition.

Through the course of working to resolve STLDI consumer complaints, the claims practices of STLD insurers have repeatedly demonstrated an inclination towards a denial of coverage rather than enabling policyholders to avail themselves of the benefits they pay for and deserve. In another example, we are currently working with a consumer who purchased STLDI for five consecutive terms and was hospitalized for a virus. The STLD insurer demanded three years of medical records to determine if the hospital admission in any way related to a pre-existing condition, significantly delaying payment of the consumer's claims. Claims payments totaling over \$42,000 were finally made on the consumer's behalf only after the involvement of our Department. The Department is troubled by the substandard benefits of STLDI plans, which is only exacerbated when we learn how difficult the insurers currently in the market often make it for consumers to access what little benefits are included in these plans.

⁴ Corlette S, Lucia K, Palanker D, and Hoppe O, *The Marketing of Short-Term Health Plans*, January 31, 2019, available at: <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html> .

Ramifications for the health insurance market

Encouraging the proliferation of STLDI has the potential to destabilize our individual market in the immediate and leave individuals without meaningful coverage options in the long term. If the healthiest individuals are lured into purchasing STLDI because of lower premium costs and the unhealthiest individuals are excluded from making that choice due to their pre-existing conditions, the ACA-compliant coverage risk pool becomes an *ad hoc* high-risk pool. This means premium costs will rise, with some projections indicating that rates in Pennsylvania will require a 19 percent increase.⁵ While many people that purchase coverage on their own are eligible for financial assistance through the ACA, about one in five are not. It is that population, and particularly the segment of that population with pre-existing conditions, that expanding access to STLDI purports to help, but that in fact may be most harmed by the resulting market segmentation and higher prices.

Equally concerning is the federal Administration's pairing of STLDI with financing mechanisms such as Health Reimbursement Accounts, or HRAs. Recently, the Departments of Health and Human Services, Labor and Treasury issued a proposed rule which, among other things, would create new "excepted benefit HRA" options that employees could use to pay premiums for STLDI.⁶ If the federal Administration continues its broader push to portray STLDI insurance as meaningful health insurance coverage, the potential destabilizing effects ripple beyond the individual market into the group markets as well.

Further, the federal government continues their push for the proliferation of STLDI in the section 1332 waiver guidance recently released by the federal government, which effectively recognizes STLDI as "coverage" for the purpose of evaluating whether a state's approach meets the guardrails of a waiver. The ACA created the section 1332 waiver concept to provide states the flexibility to innovate and to make changes to their health care system that reflect the unique needs and policy goals of an individual state. I am a firm believer that states know our markets best, that states will be and should be the incubators of new ideas in health policy, and that states should be given the opportunity to allocate resources in the way that best meets the needs of the people we represent. However, the ACA also contains a set of guardrails that are intended to ensure these innovations and changes reflect the goals many of us share and do not undermine the core principles of the ACA. These guardrails are to ensure coverage under the 1332 Waiver when compared to the coverage available through the ACA otherwise is at least as comprehensive in terms of benefits, covers at least as many people, is at least as affordable, and does not increase the federal deficit. The recent guidance diverges from these protections by allowing states to further increase access to STLDI or other non-ACA compliant insurance products and potentially even offer subsidies for the purchase of those types of products. Given our substantial concerns with STLDI, I do not believe such a waiver would be of benefit for Pennsylvania nor do I believe it is aligned with the intentions of the ACA's 1332 waivers.

⁵ Linda J. Blumberg, Matthew Buettgens, & Robin Wang. Potential Impact of Policies on Coverage, Premiums, Federal Spending, The Urban Institute (updated, Mar. 2018)(https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf).

⁶ Health Reimbursement Arrangements and Other Account-Based Group Health Plans, <https://www.govinfo.gov/content/pkg/FR-2018-10-29/pdf/2018-23183.pdf>.

The Pennsylvania Insurance Department's approach to STLDI

Pennsylvania state law does not currently contain restrictions on STLDI, so our Department is taking a two-fold approach to reviewing and monitoring STLDI. First, as the federal rule change required all STLDI to amend their policy form language, we are reviewing each STLDI plan that has been re-filed or newly filed with an eye toward clear consumer disclosures and proper explanation of the benefits covered by the plan, and possibly more importantly, the benefit limitations. We published filing guidance to explicitly outline for insurers our expectations of documents for review, including the schedule of benefits, marketing materials, and a summary of benefits and coverage. We recognize that STLDI is a necessary corollary to the ACA's open enrollment periods, as consumers who are not eligible for a special enrollment period but who, for various reasons – extenuating health or family circumstances or lack of awareness – did not enroll in comprehensive health insurance in the open enrollment season, may need some interim coverage. We view STLDI as a bridge to getting a consumer to the next ACA open enrollment season or their next source of coverage (such as employer-based coverage), and at least providing minimal protection when compared to living without health insurance through that short time period. Therefore, we created an expedited review path for policy filings that remained three months or less in duration and non-renewable, with the new required disclosure being the only change to the policy, to at least facilitate the presence of STLDI as an option in our marketplace until coverage through the ACA could be secured. For STLDI plans availing themselves of the longer duration permitted by the federal rule change and informed by the tragic complaints we are seeing all too often, we are reviewing the plans with an acute awareness of the confusion consumers may face when purchasing such a plan that is longer term, but yet does not include the comprehensive protections of the ACA.

Second, our Department is probing how STLDI is currently sold in our marketplace to make sure consumers are fully informed *prior* to their purchase of STLDI, while also monitoring the market for the sale of unapproved plans. We are monitoring the practices of producers who sell STLDI to ensure clear, understandable information is presented to consumers prior to commencement of the sale, especially in light of the fact that producer commissions for STLDI are typically higher than commissions for ACA plans, providing an incentive to those producers to sell STLDI plans. Additionally, we are using the strategic resources of our market conduct area to monitor the companies selling STLDI in our Commonwealth, as we have repeatedly learned of STLDI being sold within Pennsylvania that has not been approved by our Department. Where warranted, we have immediately acted to halt these sales.

In addition to using our authority to review STLDI before the sale of the products and take enforcement action when the products are out of compliance, as well as our consumer protection efforts, we also look forward to working with the Pennsylvania legislature to codify and strengthen protections for consumers with regard to STLDI. In addition to duration and renewability restrictions to alleviate confusion with major medical products, we would like to codify additional required consumer disclosures and a prohibition on post-claims underwriting.

Conclusion

To summarize, instead of providing more options at lower cost, STLDI actually increases premiums for consumers who have health care needs, while risking the deterioration of meaningful coverage options for people when they need it potentially leaving them to bear exorbitant medical bills. Consumers are

being harmed as they face confusing products and less transparency. Unfortunately, we fully expect an increase in consumer complaints on STLDI as consumers attempt to access benefits under their plan throughout this year, only to find that they've been misled to purchase a plan that has illusory benefits or that they are denied coverage because of the gimmicky exclusions of the plan. Simultaneously, the proliferation of STLDI risks generating harmful consequences for the comprehensive individual market, as insurers will have to account for potential adverse selection when calculating their individual market rates for truly comprehensive coverage.

To protect against the potential harms of STLDI, we recommend returning to previous guidance that facilitated a clearer delineation between STLDI and comprehensive major medical insurance.⁷ That guidance coordinated well with the construct of the ACA. By limiting the duration of STLDI and also preventing the renewability of these policies, the distinctions between STLDI and comprehensive health insurance will be more evident to the consumer. In addition, the individual market will be more stable, making more affordable and comprehensive coverage available to consumers. Thank you for the time to speak with you today and the opportunity to highlight our concerns with STLDI. I look forward to working with you to protect consumers and welcome any questions you may have.

⁷ Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75316 (October 31, 2016), <https://www.govinfo.gov/content/pkg/FR-2016-10-31/pdf/2016-26162.pdf>.

Ms. ESHOO. Thank you very much.

It is my understanding that Ms. Altman was an intern with Mr. Waxman of the Energy and Commerce Committee. So congratulations on your climb.

Ms. ALTMAN. Thank you.

Ms. ESHOO. And your great foundational learning here at our committee and, of course, thank you for your testimony.

Now I would like to recognize Ms. Grace-Marie Turner. You are recognized for 5 minutes, and welcome, and we look forward to hearing your testimony.

STATEMENT OF GRACE-MARIE TURNER

Ms. TURNER. Thank you, Chairwoman Eshoo. Thank you, Ranking Minority Member Burgess, and members of the committee for inviting me to testify today.

I am with the Galen Institute, a nonprofit organization focusing on ways to ensure access to affordable health coverage for all Americans. Enrollment in the individual health insurance market is falling. In 2018, 3 million fewer people had individual coverage than in 2015. The primary concern is the cost of coverage.

The administration's new 1332 guidance is designed to allow States to repurpose some ACA money and improve their markets to help those shut out because of high costs. Eight States have so far created programs to separately subsidize patients with the highest healthcare costs, lowering premiums and leading to increased enrollment.

In addition to Alaska and Oregon, Maryland is seeing huge price drops of 43 percent net this year. Putting the sickest pool of people in the same pool with others, as the ACA does, means premiums are higher, often much higher for those without subsidies.

Virginia State Senator Bryce Reeves told us of an email he received from a constituent in Fredericksburg who makes a good living and tried to provide for his family but said his insurance premiums now cost \$4,000 a month. "That is more than my mortgage," he told Senator Reeves, asking what he's supposed to do.

Cost relief is essential. The Trump administration last year did finalize rules to expand access to temporary bridge policies, short-term limited duration plans. These policies help people with gaps in employment, early retirees waiting to qualify for Medicare, young people and the gig economy, people returning to school, and entrepreneurs starting new businesses.

These short-term plans typically cost less than half of the cost of ACA plans. Under the Obama administration's previous rule, people would lose their short-term plans after just 3 months even if they acquired a medical condition within that period.

By extending the contract period to a year, people can be protected and have coverage until the next ACA open enrollment period. While consumers do need to be informed about these plans, for many they may mean the difference between having the security of coverage for a major medical event and being uninsured.

The Council of Economic Advisors issued a report just last week estimating that these policies produce an economic benefit of \$80 billion over the next 10 years.

I would like to turn to preexisting conditions. There is a strong bipartisan support for these protections, as Mr. Walden and Dr. Burgess both have ensured. The ACA assures that people cannot be turned down or have their policies canceled because of their health status, and these protections remain in place.

People with chronic conditions are vulnerable and do need protection. But a woman with a serious health problem provided us with a testimonial about why more changes are needed.

Janet reports that in 1999 she was diagnosed with hepatitis C. She lives in Colorado and applied for coverage in the State's high-risk pool and was accepted. Her premiums in 2010 were \$275 a month. Then her liver failed. She needed a transplant. The \$600,000 bill was covered 100 percent with \$2,500 out of pocket.

Colorado's high-risk pool, however, was closed when the ACA took effect. So she moved into the marketplace. Her premiums rose to \$450, and by 2018 they were \$1,100 a month with a deductible of \$6,300.

She said those of us who are self-employed but make more than the threshold of tax credits wind up footing the whole bill ourselves.

Finally, regarding navigators—legislation proposed by Representative Blunt Rochester would provide \$100 million a year for the navigator program. But CMS found that, in 2016, 78 percent of navigators failed to achieve their enrollment goals, and navigators enrolled fewer than 1 percent of enrollees while spending \$62 million that year.

CMS now funds navigators based upon their ability to meet their enrollment goals during the previous year and relies more on brokers and insurance agents, who enrolled 42 percent of enrollees.

California spent heavily on marketing last fall to increase enrollment in its State exchange, yet it experienced a 24 percent drop in new enrollees. Marketing doesn't work when the main reason that people don't sign up for coverage is because of cost.

I would welcome the opportunity to work with you in developing new ways to help lower the cost of health coverage while maintaining quality and consumer protections, including preexisting condition protections.

Thank you, Madam Chairman.

[The prepared statement of Ms. Turner follows:]



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

**Hearing before the
Committee on Energy and Commerce
Subcommittee on Health
2322 Rayburn House Office Building
February 13, 2019**

**“Strengthening Our Health Care System:
Legislation to Reverse ACA Sabotage and
Ensure Pre-Existing Conditions Protections”**

**Chairwoman Anna G. Eshoo
Ranking Member Michael Burgess**

**Testimony by Grace-Marie Turner
President
Galen Institute**

**Strengthening Our Health Care System:
Legislation to Reverse ACA Sabotage and
Ensure Pre-Existing Conditions Protections¹**

**Hearing before the Committee on Energy and Commerce,
Chairwoman Anna G. Eshoo**

Testimony by Grace-Marie Turner, President, Galen Institute

February 13, 2019

Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the opportunity to testify today on ways to strengthen our health care system.

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. We focus on ways to ensure access to affordable health coverage and care for all Americans, especially the most vulnerable. I also have served as an appointee to the Medicaid Commission, as a member of the Advisory Board of the Agency for Healthcare Research and Quality, and as a congressional appointee to the Long Term Care Commission.

Today, I will discuss

- The Trump administration's Section 1332 guidance
- The Short-Term Limited Duration Plan rule
- Commitment to pre-existing condition protections
- Navigator funding outreach and enrollment

New Section 1332 Guidelines: The Centers for Medicare and Medicaid Services in October issued guidance to give states more innovation authority under the Affordable

¹ **H.R. 986**, the "**Protecting Americans with Preexisting Conditions Act of 2019**", introduced by Rep. Ann M. Kuster (D-NH), would require the Trump Administration to rescind the Section 1332 guidance of the ACA promulgated in October of 2018;

H.R. 987, the "**Marketing and Outreach Restoration to Empower Health Education Act of 2019**" or the "**MORE Health Education Act**", introduced by Rep. Lisa Blunt Rochester (D-DE), will restore outreach and enrollment funding to assist consumers in signing up for health care, which has been slashed by the Trump Administration; and

H.R. 1010, **To provide that the rule entitled "Short-Term, Limited Duration Insurance" shall have no force or effect**, introduced by Rep. Kathy Castor (D-FL), will reverse the Trump Administration's expansion of junk insurance plans, also known as short-term, limited-duration insurance plans.

Care Act.² Under the revised guidance, states have new options to repurpose some ACA funding to improve their individual and small group markets while following guidelines in the law.

Section 1332 of the ACA gives states new options to lower costs and increase access to health insurance choices by better tailoring coverage to the needs of their residents. Several states have received waivers to create risk-mitigation programs. Under these waivers, the states separately subsidize patients with the highest health costs, thereby lowering premiums and increasing enrollment. They have seen in many cases dramatic results with no new federal spending.

Doug Badger, senior fellow at the Galen Institute, and Heritage senior research fellow Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.³ “Several states have successfully used a waiver to change market conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care,” they write.

Alaska was the first states to receive a waiver. It moved customers with one of 33 medical conditions into a separate insurance pool with medical claims funded in part by a portion of federal premium-subsidy payments diverted to the pool. As a result, premiums for the lowest-cost Bronze plans fell by 39% in 2018, Badger and Haislmaier report.

In Oregon premiums for the lowest-cost Bronze plans fell by 5% in 2018, and premiums for the highest-cost Bronze plans plunged by 20%. In Minnesota, the third state with an approved waiver, premiums also dropped in both 2018 and 2019. Average premiums for ACA coverage in 2019 will be lower with every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.⁴

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

² <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-state-relief-and-empowerment-waivers-give-states-flexibility-lower>

³ Doug Badger, Ed Haislmaier, “State Innovation: The Key to Affordable Health Care Choices,” The Heritage Foundation, September 27, 2018. <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>

⁴ Grace-Marie Turner, Doug Badger, “Several States Have Found Ways To Mitigate Obamacare’s Damage To Their Health Insurance Markets,” *Forbes*, October 3, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/10/03/several-states-have-found-ways-to-mitigate-obamacares-damage-to-their-health-insurance-markets/#56d1b71730da>

premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.”

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

Putting the sickest people in the same pool with others, as the ACA requires, means premiums are higher for everyone, often much higher, especially for those without subsidies. Virginia State Sen. Bryce Reeves told us of an email from a constituent in Fredericksburg: He made a good living and tried to provide for his family but said his insurance premiums cost \$4,000 a month! “That’s more than my mortgage,” he told Sen. Reeves. “What am I supposed to do?”⁵

Cost relief is essential. Unfortunately, more and more healthy people are dropping out of the individual exchange market.

Premiums have risen sharply since exchange coverage began in January of 2014. Average premiums more than doubled between 2013 and 2017.⁶ HHS reports that premiums for the lowest-cost plan available to a 27-year-old in states using the healthcare.gov platform rose by an additional 17% in 2018.⁷

Not surprisingly, enrollment in the individual health insurance markets is falling . A net of three million people dropped coverage in the individual health insurance market between 2015 and 2018. According to a study published by the Kaiser Family on “Changes in Enrollment in the Individual Health Insurance Market,” there were 17.4 million policyholders in the individual market in 2015, dropping to 14.4 million by the first quarter of 2018.⁸

⁵ Grace-Marie Turner, “Health Care Choices Proposal: A New Generation of Health Reform,” *Forbes*, June 22, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation-of-health-reform/#1106ce6664f1>

⁶ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Individual Market Premium Changes: 2013–2017,” Data Point, May 23, 2017.

⁷ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange,” https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf (accessed September 21, 2018).

⁸ Ashley Semanskee, Larry Levitt, Cynthia Cox, “Changes in Enrollment in the Individual Health Insurance Market,” July 31, 2018, Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/>

Short-Term Limited Duration Plans: The Trump administration last year finalized a rule to expand access to short-term, limited-duration plans to give Americans access to health insurance coverage that better fits their needs. The Obama Administration had limited the policies to three months of coverage and prohibited their renewal. Under the new rule, these plans can be offered for up to 364 days and renewed for up to 36 months, subject to state regulation.

Short-term plans⁹ are helpful to people with gaps in employment, to early retirees who no longer have employer-sponsored health insurance and need bridge coverage before they qualify for Medicare, people between jobs, young people who no longer have coverage from their parents and are working in the gig economy, people who are leaving the workforce temporarily to attend school or training programs, and entrepreneurs starting new businesses. Premiums for short-term health plans typically are less than half those of ACA plans.

The administration's rule also extended consumer protections. Under the Obama administration's previous 2016 rule, people could lose their coverage after three months if they acquired a medical condition during the three-month period. By extending the contract period, people can be protected from a period of uninsurance until the next ACA open enrollment period.

The plans are not required to cover the comprehensive list of benefits required by the ACA, and consumers education is important in understanding how they differ from ACA-compliant plans.

An estimated 1.7 million people who would otherwise be uninsured are expected to enroll in an STLD plans.¹⁰ Several states limit their residents' access to STLD plans, but in so doing, they deny them what may be their only realistic option for coverage.¹¹

Council of Economic Advisers: A new White House report on "Deregulating Health Insurance Markets: Value to Market Participants"¹² provides important data showing the positive impact of this consumer-friendly health policy change. They estimate that

⁹ <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>

¹⁰ Linda J. Blumberg, Matthew Buettgens, Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 2018. https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

¹¹ Doug Badger and Whitney Jones, "Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternatives to Obamacare Policies," The Heritage Foundation, April 26, 2018. <https://www.heritage.org/health-care-reform/report/five-steps-policy-makers-can-take-permit-the-sale-and-renewal-affordable>

¹² Council of Economic Advisers, "Deregulating Health Insurance Markets: Value to Market Participants," February 2019. <https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf>

STLDs would produce a marginal social benefit of \$80 billion over ten years, even taking into account concerns that they might raise premiums for some people with ACA-compliant coverage.

While some say that STLD plans are “junk” insurance that sabotages the ACA, this report provides solid evidence that consumers will benefit, both in expanded coverage and lower costs. The Trump administration believes this policy option, together with other deregulatory reforms, will generate benefits to Americans that are worth an estimated \$450 billion over the next 10 years.

Protection for Pre-Existing Conditions. There is strong bi-partisan support for pre-existing condition protections.¹³ A number of provisions were included in the Affordable Care Act (ACA) to ensure that coverage is available and affordable to those with pre-existing conditions.¹⁴ The law stipulates that people cannot be turned down or have their policies cancelled because of pre-existing conditions and that they are able to purchase policies without facing huge spikes in premium costs because of their health status. These protections are still in place.

Legislation passed by the House of Representatives in 2017 preserved pre-existing condition protections, and other legislative and policy proposals offered since then to improve the private health insurance market also provide pre-existing condition protections.¹⁵

Last week, at a hearing before this committee on pre-existing conditions, you heard Energy and Commerce Committee Republican Leader Greg Walden affirm on behalf of his colleagues: “We fully support protecting Americans with pre-existing conditions. We’ve said this repeatedly, 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 pre-existing conditions.”¹⁶

At a separate hearing on this issue, also last week, before the House Education and Labor Committee, Ranking Member Virginia Foxx said in her [opening statement](#), “Americans with pre-existing conditions need health insurance. This is a fact and a value that Congress and the President have affirmed countless times.

¹³ Morning Consult+POLITICO, National Tracking Poll, Sept. 6-9, 2018. https://morningconsult.com/wp-content/uploads/2018/09/180919_crosstabs_POLITICO_v1_DK.pdf

¹⁴ Karen Pollitz, Testimony before the House Committee on Ways and Means on pre-existing conditions and health insurance, January 29, 2019. <http://files.kff.org/attachment/Testimony-of-Karen-Pollitz-Committee-on-Ways%20and-Means-Pre-existing-Conditions-and-Health-Insurance>

¹⁵ See for example, the Health Policy Consensus Group’s Health Care Choices Plan, June 2018, www.HealthCareChoices2020.org

¹⁶ <https://republicans-energycommerce.house.gov/news/press-release/republicans-fully-support-protecting-americans-with-pre-existing-conditions/>

“It’s also the law,” she affirmed. “Insurance companies are prohibited from denying or not renewing health coverage due to a pre-existing condition. Insurance companies are banned from rescinding coverage based on a pre-existing condition. Insurance companies are banned from excluding benefits based on a pre-existing condition. Insurance companies are prevented from raising premiums on individuals with pre-existing conditions who maintain continuous coverage.”

She cited existing protections under the Health Insurance Portability and Accountability Act (HIPAA)¹⁷ and Republican support for further protections in the House-passed American Health Care Act of 2017.¹⁸

As Ranking Member Walden detailed, under the AHCA:

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

More than 300 million Americans are in plans that protect them from pre-existing condition exclusions:

- About 173 million Americans are covered through employer-sponsored health insurance plans¹⁹ and have further protections if they leave their employer.²⁰
- Nearly 60 million seniors and disabled people are on Medicare, which provides solid guarantees of continued coverage regardless of health status.²¹

¹⁷ <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

¹⁸ <https://www.congress.gov/bill/115th-congress/house-bill/1628>

¹⁹ Doug Badger, “Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers,” Galen Institute, December 2018. <https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf>

²⁰ If an employee leaves their employer, they can continue their coverage through COBRA, and if they are continually insured and move to a new group, they cannot be denied coverage for a pre-existing condition.

²¹ CMS Fast Facts based upon CMS/Office of Enterprise Data & Analytics/Office of the Actuary. July 2018

- 75 million are on Medicaid. Same protections.
- Nearly 5 million children are on the Children’s Health Insurance Program. Same.
- Still others have coverage under Department of Veterans Affairs, the Indian Health Service, etc. All provide built-in guarantees of protection for chronic, pre-existing conditions.

Only 5 percent of Americans got their policies through the individual market in 2018—about 15 million people—according to the Congressional Budget Office.²² This would be the only segment of the market subject to a *Texas v Azar* decision.²³

Republicans strongly support maintaining protections for them. Surely Congress can come to bi-partisan agreement to protect them without disrupting coverage for well over 300 million Americans who already have built-in coverage.

Guaranteed protection programs are key for policymakers to protect those with pre-existing conditions and also to ensure access to affordable coverage for those who need insurance to guard against future health risks. A woman with serious health problems provided a testimonial about why further reforms are needed.²⁴ Janet reported to us:

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

“My premiums in 2010 were \$275/month with a total out of pocket of \$2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved without a question. My \$600,000 transplant was covered 100% with a \$2,500 out of pocket maximum!”

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

“The thing I noticed from the start was that instead of full coverage, almost everything I

²² CBO 2018b projections

²³ One recommendation to assure protection for Americans subject to this decision would be for Congress to pass a simple bill saying that the individual mandate is severable from the Affordable Care Act and therefore the rest of the law would stand should higher courts agree with the district court about the unconstitutionality of the individual mandate absent the tax penalty for non compliance.

²⁴ From HealthCareChoices2020.org testimonials:
<https://www.healthcarereform2018.org/testimonial/janets-story-high-medical-costs-worse-coverage/>

needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the basic care I needed.

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

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

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

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

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

The current system is not working for Janet and others like her in receiving the care she needs.

Navigators

The Centers for Medicare and Medicaid Services says it is focusing on spending taxpayer dollars effectively. An analysis by the Centers for Medicare and Medicaid Services (CMS) showed the high cost of the Navigator program relative to signups. During the 2016 open enrollment period, Navigators received more than \$62 million in federal grants while enrolling 81,426 individuals—or fewer than one percent of all enrollees. Seventeen of these Navigators enrolled fewer than 100 people each at an average cost of \$5,000 per each enrollee.²⁵

The top 10 most-costly Navigators spent a total of \$2.77 million to enroll 314 people. One grantee received \$200,000 and enrolled ONE person, enough to have covered more than 30 people for the whole year.²⁶

²⁵ <https://www.cms.gov/newsroom/press-releases/cms-announcement-aca-navigator-program-and-promotion-upcoming-open-enrollment>

²⁶ <https://www.cnbc.com/2017/11/22/obamacare-assistance-group-got-200000-in-funds-signed-up-one.html>

Seventy-eight percent of Navigators failed to achieve their enrollment goals while spending more than \$50 million.

Since then, CMS set up a system in which Navigator grantees receive funding based on their ability to meet their enrollment goals during the previous year.

Enrollment began to decline before any changes in Navigator grants by the Trump administration. “The subsidized and unsubsidized enrollment report shows enrollment began to decline in some states between 2015 and 2016, and in particular among the unsubsidized portion of the market. Over that period, 23 states experienced a decline in unsubsidized enrollment, with 10 states experiencing double-digit declines,” according to a CMS study.²⁷

CMS believes that independent agents and brokers can be more cost-efficient in assisting people in obtaining exchange coverage.

“CMS increased efforts to leverage the capabilities of the private sector by expanding the role of health insurance agents and brokers who supported 3,660,668 health plan enrollments, 42 percent of plan-year 2018 open enrollments on Federal platform Exchanges. In contrast, Navigators enrolled less than 1 percent of total enrollees,” the report found.

Because many people on the exchanges are automatically reenrolled, there is less need for assistance than when the program was new. The “effectuated enrollment” report shows that enrollment through the Exchanges remained steady for subsidized people who were automatically re-enrolled in plan year 2018 and paid their first month’s premium. In February 2018, 10.6 million individuals had effectuated their coverage through the Exchanges.²⁸

Finally, California spent heavily on marketing to increase enrollment in its state-based exchange last fall, yet it experienced a 23.8% drop in new enrollees over 2018.²⁹ Covered California is encouraging the state to establish an individual mandate. But it is hard to boost enrollment through added spending on marketing or using the mandate club when the main reason people are not signing up is the high cost of premiums and sky-high deductibles.

²⁷ <https://www.cms.gov/newsroom/press-releases/centers-medicare-and-medicaid-services-releases-reports-performance-exchanges-and-individual-health>

²⁸ *Ibid.*

²⁹ Covered California had 388,344 new enrollees for the 2018 coverage year but only 295,980 enrollees as of January 31, 2019, a decline of nearly 24% or more than 92,000 enrollees, according to the California exchange website. <https://www.coveredca.com/newsroom/news-releases/2019/01/30/covered-california-plan-selections-remain-steady-at-1-5-million-but-a-significant-drop-in-new-consumers-signals-need-to-restore-penalty/>

I appreciate your invitation to testify today. I would welcome the opportunity to work with you in developing more ways to help lower the costs of health coverage, providing employers and employees and those in the individual market with more choices of affordable health coverage while maintaining quality and consumer protections, including pre-existing condition protections.

APPENDIX

The Trump administration is providing two additional options for consumers to obtain more affordable health coverage options, Association Health Plans and Health Reimbursement Arrangements.

Association Health Plans: A new White House report on “Deregulating Health Insurance Markets: Value to Market Participants”³⁰ provides important data showing the positive impact of major consumer-friendly health policy changes made by the Trump administration. It explains:

On October 12, 2017, President Trump signed Executive Order 13813, “Promoting Healthcare Choice and Competition Across the United States” (White House 2017b), which directed the Secretary of Labor to consider proposing regulations to ease employers’ abilities to form Association Health Plans (AHPs) that allow small businesses to group together to self-insure or purchase large group insurance. AHPs enable employers to band together, which decreases administrative costs through economies of scale. The Department of Labor finalized this new rule on June 21, 2018, pursuant to its authority under the Employee Retirement Income Security Act (known as ERISA).

Small and medium-sized firms have new options through the administration’s new Association Health Plans rule.³¹ This rule expands an organization’s ability to offer AHPs on the basis of common geography or industry and offers other options for enrollees.

The ACA required small businesses to cover all of the law’s expensive essential health benefits—more benefits than larger employers are required to cover. That, coupled with higher administrative costs, had put health insurance increasingly out of reach of many small businesses. Association Health Plans provide them an option by organizing to receive the same economies of scale and ability to tailor benefits as larger companies. A recent study found that AHP insurance is comparable to the comprehensive coverage provided by these larger companies.³²

The Washington Post reported recently that: “Chambers of commerce and trade associations have launched more than two dozen of these ‘association health plans’ in 13 states in the seven months since the Labor Department finalized new rules making it

³⁰ Council of Economic Advisers, “Deregulating Health Insurance Markets: Value to Market Participants,” February 2019. <https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf>

³¹ <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/association-health-plans.pdf>

³² Kev Coleman, “First Phase of New Association Health Plans Reveal Promising Trends,” Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces.”³³

The February 2019 Council of Economic Advisors report found that 28 AHPs have formed already, with more under development. Some AHPs show up to 30% savings on premiums.

The Las Vegas Chamber of Commerce is in the process of signing up 500 employers for an AHP, with expected savings of \$2,000 per year. The Georgia Chamber of Commerce is in the process of setting up a self-insured AHP that it expects may eventually enroll 800,000 people. Most, if not all, are using established insurance companies to manage their AHPs.

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.³⁴ “We’re not seeing skinny plans,” he said.

According to the CEA report:

Noting the greater flexibility to form larger AHPs, we assume that the AHP rule will increase the average AHP group size by 100 percent. Based on the relationship between group size and administrative costs, this implies that the AHP rule will reduce the share of premiums accounted for by administrative costs by 27 percent. Assuming that before the rule the average administrative cost share was 15 percent, this corresponds to a reduction of about 4 percentage points.

Beyond just AHP plans, the report shows that short-term plans, association health plans, and repeal of the individual mandate penalty together will yield \$450 billion in economic benefits over ten years. This means an average of \$3,500 in net benefits per household over that time period. CBO projected that more than 6 million people will enroll in AHPs options, including one million who would otherwise be uninsured

They used data from the Congressional Budget Office and other reliable statistical sources for the analysis and found “the reduction of the individual mandate penalty to

³³ Paige Winfield Cunningham, “The Health 202: Association health plans expanded under Trump look promising so far,” January 30, 2019, *The Washington Post*. https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm_term=.6435676a70d4

³⁴ Kev Coleman, “First Phase of New Association Health Plans Reveal Promising Trends,” Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

zero accounts for \$14 billion per year; the AHP rule accounts for \$8 billion per year; the STLDI reform accounts for \$8 billion per year; and the reduction in the excess burdens of labor taxation accounts for \$15 billion per year.”

Health Reimbursement Arrangements: The administration also is finalizing a rule to enhance employer and employee options through Health Reimbursement Arrangements (HRAs), originally created by the Bush administration to give employers more options in their benefit offerings. Under those rules, HRAs, which are tax-preferred, notional accounts, can be integrated with group health coverage sponsored by the employer. They cannot be integrated with individual health insurance coverage. Many workers who are offered health coverage at work do not participate in their employer plans, often because of costs, and therefore are more likely to be uninsured.

In a 2017 executive order, President Trump directed administration officials to “increase the usability of HRAs, to expand employers’ ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.”³⁵

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.³⁶

The Galen Institute submitted public comments encouraging the administration to take the rule one step further by allowing spouses to integrate HRA funds to obtain a family plan.³⁷ We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.³⁸

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

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

³⁵ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>

³⁶ <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

³⁷ <https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/>

³⁸ Doug Badger and Grace-Marie Turner, “Give Working Families A Break,” *RealClearHealth*, January 7, 2019. https://www.realclearhealth.com/articles/2019/01/07/give_working_families_a_break_110856.html

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

Ms. ESHOO. Thank you, Ms. Turner, for your testimony, and we have now concluded the opening statements. We are going to move to Members' questions, and I will start by recognizing myself for 5 minutes.

I have a lot of things in front of me that have been suggested that I ask. But after listening to your verbal testimony, I want to mix this up a little bit.

We heard the first two witnesses, Ms. Keith and Ms. Altman, talk about the shortcoming of these short-term plans and the plan of the administration to stretch them out over 3 years.

Now, Ms. Turner, you said we have a commitment to preexisting conditions in the coverage. Why is it not included in these short-term plans?

I would also like to give 30 seconds to Ms. Keith and Ms. Altman to ask any questions that they would like of Ms. Turner because there is a difference between your testimony and Ms. Turner's.

But first, can you talk about what—I think the word commitment is conflated in its use. There is a difference between a commitment to and actually practicing what you say you have a commitment to.

So I don't see these very important insurance reforms that we brought about with the ACA and you say that you have a commitment to preexisting conditions and the other insurance reforms.

So can you just in a minute or less explain why there is a difference between your commitment and what is in these plans?

Ms. TURNER. Short-term plans are really gap coverage. People buy them because they can't afford coverage that has all of the ACA protections.

Ms. ESHOO. Let me ask you this: Are you opposed to an advisory in plain English on the cover of these policies to inform the potential consumer what is not included so that it is very clear about what they are buying?

Ms. TURNER. Oh, absolutely. Absolutely. I think consumers very, very much need to be informed about their policy.

Ms. ESHOO. OK. Good. Good.

All right. Now, Ms. Keith, do you want to ask a question or have a comment?

Ms. KEITH. Yes. I don't have a question. Thank you, Chairwoman. What I would say is something that did not get brought up in my oral statement yet, is that the limitations of these plans, there is no magic about why these short-term plans are cheaper than ACA plans.

They are, on average, about 54 percent less expensive. There is no secret to that. The reason is because they can exclude people with preexisting conditions. That fact alone allows them to be 38 percent cheaper than ACA plans.

When you add in some of the benefit gaps and out-of-pocket costs, that is what makes them half the cost of ACA plans. And so the idea of giving people coverage, you know, is the product worth buying if it doesn't cover anything when you need to use it, I think might be the question.

Ms. ESHOO. Ms. Altman?

Ms. ALTMAN. I was going to bring up the same study, and to put it another way, 70 percent of the price difference between short-

term plans and traditional ACA plans is due to preexisting condition exclusions. The story you told—

Ms. ESHOO. Can you say that again?

Ms. ALTMAN. Seventy percent of the difference in price between short-term plans and Affordable Care Act coverage is due to excluding preexisting conditions.

You know, the story you told from Colorado was incredibly compelling and, to me, it really reinforces why people need comprehensive coverage so that you can get coverage for that expensive transplant and you can get coverage for your liver failure and your hepatitis C.

You know, my only question is today you talked about how the purpose of short-term plans is to fill gaps in coverage and that is the intended purpose, and I suppose my question is, If it is meant to fill a gap, why would it need to be 3 years?

Ms. ESHOO. Can you answer that, Ms. Turner?

Ms. TURNER. I think that that is really up to consumers. Many of the people who are uninsured now—many of the 3 million are uninsured because they simply can't afford coverage.

State Senator Reeves' constituent desperately wants to provide for his family until another option is better. So he can't know how long he is going to need to have this protection.

One of the reasons that the new rule extended that coverage is because 3 months just is too short a time to give anybody the security that they need coverage, and in Colorado Janet is actually now in an ACA plan. Her meds are not covered under the plan that she is in under the ACA, so she has \$19,000 out of pocket now.

Ms. ESHOO. Well, I think—if I might say this, I think it is important for consumers to have choice. I am not opposed to that.

What I am worried about is, I found this out in healthcare the two basic things. Everyone knows what they pay in a premium. Most people don't know what they are buying—what they are getting—and this can be a really slippery slope for a lot of people and—or maybe for a few that is going to make them, especially if they are healthy and they are young, they are betting on their immortality and that nothing is ever going to happen to them. But it is—there are a lot of questions, so thank you.

My time has certainly expired. I now would like to recognize Mr. Griffith for his 5 minutes of questioning.

Mr. GRIFFITH. Thank you, ma'am. Right here beside you.

Ms. ESHOO. Yes. Right. Sitting right next to me.

Mr. GRIFFITH. I am glad to hear, Madam Chair, that you are for consumers having choices. I think that is very important. I also look forward to working with you on your bill—1147, I believe—that deals with making sure that consumers have the information that they need.

I would say, as we work forward on that piece of legislation, it looks to me right now that it includes such a huge volume that many consumers probably wouldn't read it.

So what we have to do is try to figure out where the sweet spot is, and I look forward to working with you on that because I do think it is important that consumers know, if they are buying an alternative product, that, A, it is an alternative product and, B, that it doesn't cover everything but here is what it does cover, be-

cause, as you pointed out, Ms. Turner, many folks are looking for something because they cannot afford the plans that fall under the ACA with all the mandates that are there.

Could you repeat the quote from Senator Bryce Reeves? Since I am from Virginia, he is—while his district is about 4 hours away, I do think it is instructive to hear from him again. Could you repeat that for us?

Ms. TURNER. Yes. Senator Reeves was at an event—speaking at an event. He had just gotten an email from a constituent saying that he had just received his healthcare bill to provide for his family, and the premium was \$4,000 a month, which he said, “That is more than my mortgage. What am I supposed to do?”

Mr. GRIFFITH. Yes. We hear stories similar to that 4 hours away on the other side of Virginia. I represent the southwest portion of the State.

We hear of a lot of people who can’t afford the out-of-pockets and the deductibles—that that is forcing them to look at bankruptcy options—the same complaints we heard before that the Affordable Care Act was supposed to fix. Hasn’t worked for my constituents.

It, clearly, hasn’t worked on the other side of the Commonwealth of Virginia. I can’t speak to the country as a whole. But from anecdotal evidence, it seems that the same is out there.

And as you pointed out in your testimony, this is one of the reasons why people are looking at some of these alternatives. I think they ought to know what they are getting because some people will just buy something because it is cheaper. But some people buy something that doesn’t cover everything because they are desperate. Is that true?

Ms. TURNER. That is true and, unfortunately, in many parts of the country and especially Virginia, if you live in one county you may not have a choice. This constituent had no other choice in Fredericksburg, and so people are looking exactly for that—to find other ways they can have health insurance they can afford and protect their families but not have it—not be able to pay their mortgage.

Mr. GRIFFITH. It is interesting that you raise that point about the choice because, under the ACA—I represent 29 different geopolitical subdivisions, and for those that aren’t from Virginia, we have separate cities.

So some of those are small cities as well as counties. But I have 29. A fair number of those have but one provider. They just—the market is just not there to support it.

I am surprised that that is the case in the Fredericksburg area, because that is a much bigger area populationwise than some of my jurisdiction. But you are saying they have that problem too—there was just one provider of insurance?

Ms. TURNER. Yes, and I would hope that Virginia would look at the Section 1332 waivers to figure out how they can attract more competitors back into the markets.

Mr. GRIFFITH. And I would hope that that would be the case, too. Let us talk about the woman you spoke of, Janet with hepatitis C. Could you go over the numbers again of how much she was paying under the plan that resembled the—what the House was trying to do last year, or 2 years ago now, to do our repeal and replace—with

the high-risk pool? She was only paying \$275, I think you said, a month for her insurance?

Ms. TURNER. When she was first diagnosed with hepatitis C in 1999, her premiums in the State's high-risk pool were \$275 a month, and then they rose. When she had to first enroll, that high-risk pool was closed so she had—

Mr. GRIFFITH. So hang on. But before that high-risk pool was closed, you indicated, she had to have a liver transplant?

Ms. TURNER. She had to have—her liver failed and she had to have a \$600,000 liver transplant.

Mr. GRIFFITH. And that was covered?

Ms. TURNER. Totally covered by the high-risk pool. She had \$2,500 out of pocket. But then when the ACA took effect, her premiums rose to \$450, and by 2018 they were \$1,100 a month, and one of the things I didn't mention in my testimony is that none of her antirejection drugs are covered under the new plan. So she has to pay out of pocket \$19,000 a year.

Mr. GRIFFITH. Wow. Plus, there was a \$6,300 deductible, I think you mentioned.

Ms. TURNER. Correct.

Mr. GRIFFITH. And so what you are saying is that this high-risk pool, which was an alternative before the ACA, was an alternative to the ACA which would work for some people and we should probably have more choice. Wouldn't you agree, yes or no?

Ms. TURNER. She said—yes—and she said, "I want the high-risk pool back."

Mr. GRIFFITH. All right. I thank you very much, and I yield back.

Ms. TURNER. Thank you, Mr. Griffith.

Ms. ESHOO. I thank the gentleman.

I will now recognize the chairman of the full committee, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Madam Chair, and I just, you know, want to reiterate that, of course, in my opinion the problems that we face with, you know, more people becoming uninsured and increased costs are directly related to the sabotage that the Trump administration has implemented, and that is why we are having this hearing and trying to deal with these—with the sabotage and coming up with legislation that would turn that around.

But I wanted to talk about the 1332—Section 1332 of the ACA. Ms. Turner—my questions are of Ms. Keith—but Ms. Turner's testimony appears to conflate the October 2018 Trump guidance with the Section 1332 reinsurance waivers that were approved both under Obama initially and then now under Trump.

So, Ms. Keith, can you walk us through the Section 1332 reinsurance waivers? Those are the ones that, you know, were initially under Obama, now under Trump. What are they, and how long have they been in existence, and have those reinsurance been successful in reducing premiums in the States that have—where they have been enacted? Including my own, I guess.

Ms. KEITH. Thank you, Chairman.

Yes. So a number of States—seven of the eight States with an approved Section 1332 waiver now have done that for a State-based reinsurance program. I think this is evidence that Section 1332 as is, is working—you know, Congressman Griffith mentioned this,

Ms. Turner has mentioned this—using those Section 1332 waivers that we already have. The Federal Government has passed through about—almost \$1 billion in Federal funds to help States come up with these solutions that have brought down premiums, ranging from 7 percent on the low end to more than 30 percent at the high end, and more States, I would expect, are considering that this year to bring those programs to their States as well. There has certainly been bipartisan support, as you can tell, from States ranging from Wisconsin to Maryland to Oregon to Alaska.

Mr. PALLONE. And I agree with you, and certainly my State is an example of what you said. But now I want to turn to the Trump administration's recent 1332 guidance, which it issued in October of 2018, and these are entirely unrelated to the reinsurance waivers you just discussed.

The Trump administration's recent 1332 guidance creates new standards that are wholly inconsistent, in my opinion, with congressional intent, and the Trump guidance would allow States to increase consumer costs, reduce coverage, and undermine protections for people living with preexisting conditions—in other words, more Trump sabotage.

So, Ms. Keith, do you believe that the new Trump changes to the guidance are consistent with the law and the clear statutory directive that States must provide coverage that is as comprehensive and affordable as under the ACA?

Ms. KEITH. Thank you for that question.

In my opinion, I think the guidance is quite inconsistent with Section 1332 itself. Section 1332 absolutely gives States the flexibility to be innovative, but it directs them to do so in a way that builds upon the ACA and is consistent with the goals of the law, which is to improve access to affordable quality coverage, not to undermine it. The guidance itself, by allowing or at least encouraging States to consider options like subsidizing short-term plans, plans that do not cover preexisting conditions, as we have discussed, to me flies in the face of Section 1332 and what it was designed to allow States to do.

Mr. PALLONE. All right, and I just want to have you repeat what you said with regard to junk plans specifically. I understand that the Trump guidance would allow States to redefine what counts as coverage to include junk plans. Is that correct?

Ms. KEITH. It would allow—it encourages States to bring forth proposals that would allow that, yes.

Mr. PALLONE. And then do you believe—obviously, you have said you don't believe that this new definition of coverage is consistent with the law, correct?

Ms. KEITH. That is right.

Mr. PALLONE. And then I also understand that the guidance allows States to direct the ACA's affordability subsidies towards junk plans, so subsidizing junk plans. Do you think that is consistent with the law?

Ms. KEITH. I do not. Section 1332 cannot be used to waive any and all provisions of the Affordable Care Act. In particular, it cannot be used to allow States to waive community rating, guaranteed issue, protections for preexisting conditions.

If a State were to try to subsidize plans that did do that, I think it would be an end run around Section 1332 itself and what the law requires.

Mr. PALLONE. I thank you, and I agree with you. I think that the Trump administration's guidance is blatantly unlawful, contrary to the plain reading of the statute and wholly inconsistent with congressional intent. It is part of the Trump administration's ideologically motivated efforts to sabotage Americans' healthcare coverage, and I want to commend Ms. Kuster for her work on this important legislation to rescind this guidance and hope that our Republican colleagues will join us in these efforts.

And I just wanted to say, Madam Chair, you know, most—a lot of the sabotage—most of the sabotage that the Trump administration is doing, in my opinion, is totally illegal. So you might say, well, then why are we trying to move and have hearings on legislation if you don't think it is legal to begin with?

Well, I guess that is a good question. But the bottom line is that we are going to do it because we've got to make the point that, you know, that their interpretation—the Trump administration interpretation of the law is to allow all this stuff that sabotage the ACA, so we are going to come back and say, you know, that is not allowed under the law, but we are still going to clarify it by moving forward legislation that would make that clear and improve it.

Thank you.

Ms. ESHOO. I thank the chairman of the full committee.

And now I would like to recognize the gentleman from Kentucky, Mr. Guthrie, for 5 minutes.

Mr. GUTHRIE. Thank you, Madam Chair. I really appreciate it and appreciate all of you being here, and I want to start by what I heard from Dr. Burgess and echo some of his opening remarks on the cost of plans and talk about how it affects people—people outside of being subsidized that—just looking for alternatives to have some—have coverage because they can't afford—you may have all the mandates and all the guaranteed issues, but if they can't afford it, they can't afford it.

And, particularly, I have a constituent named Dustin Jones—he is a resident of Glasgow, Kentucky—who has called and said he had the coverage that he liked before the Affordable Care Act. Now he is going to have to go uninsured because he says he is just at the point he can't afford insurance anymore.

And so I will be honest, I have had people stop me and say, because of Medicaid expansion in Kentucky, they have had coverage they haven't had before. So there are people—everybody can point to cases such as that.

But I think all of us have people like Mr. Jones that are in that middle-income area that health insurance has just become unaffordable because so many of the mandates that are there.

And we want to cover people with preexisting conditions, and we need to do it in a way that is affordable. I think Ms. Altman said that plans are 70 percent cheaper because they don't do preexisting conditions, so I guess there is that inverse, it would be 70 percent more expensive because—and that is what we wanted to do in the Affordable Care Act, replace that we looked at.

We got highly criticized, but it was examples—I think Wisconsin had a highly functioning high-risk pool and people said they were better off before where you socialize the cost of preexisting conditions across the State instead of just people in the individual market, because it puts people like Mr. Jones out of being able to afford health insurance.

And so the—and the bottom line was that everybody was covered with preexisting conditions. It was just a way to do it that didn't put the burden on just people in the individual market. It socialized those costs across the State.

But, Ms. Turner, in your testimony you mentioned the additional consumer protection that the Trump administration added for short-term limited duration plans. Just give you an open to explain that further, the additional consumer protections that the Trump administration added.

Ms. TURNER. You mean in terms of allowing people to keep these policies for a longer period of time—that they previously, under the Obama administration, were limited to just 3 months.

And for many people who may be retiring at age 63 or 64 and they need gap coverage until they qualify for Medicare, people who are starting a new company, people between jobs, that just wasn't long enough and being able to give them the opportunity to purchase these short-term bridge policies was very helpful.

And I agree that people need to be informed consumers. But I think they do understand this is not permanent coverage. This is to fill a need in a particular time for an estimated 2 million people.

Mr. GUTHRIE. So it is not only the Trump administration giving the patients more healthcare products to choose from, they are doing so in a way that has additional consumer protections.

So I just want to—also, Ms. Turner, you mentioned how States are working within the 1332 waiver to innovate as laboratories of democracy. We have already seen eight States get approved under the strict Obama administration guidance.

Do you anticipate even more innovation as States review and reform their markets in compliance with the Trump administration policies?

Ms. TURNER. Yes, absolutely, and the States are doing everything they can under the ACA to try to provide access for people who are shut out of the market.

These are people in the individual market who generally don't qualify for the subsidies under the ACA trying to afford health insurance for their family like Senator Reeves' constituent in Fredericksburg to try to provide a policy that they can afford.

And there are other provisions that the administration is providing as well: the association health plans so small companies can aggregate to get some of the benefits and the lower costs of larger companies; the new health reimbursement arrangement rule that would allow companies to provide a stipend to employees that may have the opportunity to get coverage outside the market, maybe a spouse's coverage, and be able to buy into that policy to get a family plan.

So they are really looking for ways to give people more options and to give States more options to use the existing ACA money in a way that works better for their citizens.

Mr. GUTHRIE. OK. Thank you very much.

Just one more example—a person who does transmission work on cars—hopefully, you never have to do that, but if you do that I—that I use and been to. It is a single-person shop, and he runs his own shop and he told me—it was about 6 months ago—that he closes from—he doesn’t open until, like, 9:00 and then he closes from 3:00 to 5:00 and then comes back and does an evening, and what he’s doing, he is driving a school bus to pay for his health insurance.

And he said by the fact that he went to work for the county system driving a school bus, by the time he does all of his premiums he really doesn’t make any money doing it but he said, “But I am making \$1,600 a month, because that is what I am saving in my health insurance.”

So there are people really struggling with this, and we need to be mindful of the Affordable Care Act didn’t solve everybody’s problem.

So thank you very much, and I yield back my time.

Ms. TURNER. Thank you, Congressman.

Ms. ESHOO. I thank the gentleman from Kentucky.

Now I am pleased to recognize the gentlewoman from California, Ms. Matsui.

Ms. MATSUI. Thank you very much, Madam Chair, and I want to thank the witnesses for being here today. It has been very enlightening and interesting here.

The topic of this hearing is incredibly important to me and my constituents and actually all Americans whose lives have been changed by the Affordable Care Act.

Just last week, this committee heard testimony from families whose lives have been fundamentally changed by the protections of the ACA, and that brings us to today’s discussion, and, very sadly, the sabotage of the Trump administration disguised in a disingenuous attempt to expand coverage is shameful.

This administration has done nothing to expand coverage. Rather, they have undermined the progress made by the ACA, leading to further market destabilization and harming patients along the way.

Now, these junk insurance plans sound good. However, they discriminate against people with preexisting conditions and set higher premiums based on age, gender, and health status.

Promoting the use of junk insurance plans is particularly frustrating when this administration has also slashed outreach funding for open enrollment into healthcare marketplaces.

Expanding junk insurance will undermine the market, taking young, healthy individuals out of the risk pool and making health insurance less affordable for consumers with preexisting conditions.

The Trump administration has even acknowledged that the new rule would raise premiums for ACA-compliant plans and could result in adverse selection against individual market risk pool.

Ms. Altman, according to the Kaiser Family Foundation, if an individual loses coverage under a short-term policy, then they may not be eligible for a special enrollment period under the ACA.

In other words, the individual would experience a lapse in coverage. Given this information, I am concerned that these junk insurance plans could put many more individuals at risk.

Could you reiterate to the committee how—before the implementation of the ACA—how a lapse in insurance coverage impacted your financial situation and physical health?

Ms. ALTMAN. Certainly. I think before the ACA, lack of insurance coverage or lack of comprehensive insurance coverage impacted people in the same way that it could today: Their inability to seek the care that they need, their inability to afford the care that they need, and potentially financial devastating debt.

I think one of the perhaps less talked about benefits of the Affordable Care Act has been reductions in Americans going into debt due to medical bills and the reductions in uncompensated care and the burden that is on the economy and on our healthcare system as well.

Ms. MATSUI. Right. Could I just say this too? And I hear from my constituents, both patients and physicians, who are frustrated they are receiving high unexpected medical bills, and part of this is because they are enrolled in a junk insurance plan like we are discussing today that have an incredibly high deductible.

A \$10,000 deductible doesn't count as real insurance if you have to spend \$10,000 out of your pocket before your insurance kicks in. What does that really buy you, and shouldn't consumers fully understand what they are signing up for?

Now, Ms. Altman, your testimony talking about this—what steps does your department take to alert consumers to the fine print of these plans?

Ms. ALTMAN. Thank you for that question.

One of the greatest challenges with these plans is trying to counter all of the noise in the marketplace. A lot of the marketing is very aggressive. Some of it is outright untrue, and some of it is in a gray area and misleading, at best.

We have undergone a number of efforts to try and get accurate education out in the marketplace, accurate information about short-term plans, about the Affordable Care Act, about the difference about when to enroll—all of those questions.

But it is definitely an uphill battle as consumers are being bombarded with the marketing that is out there. We are now working on our own campaign that will highlight the questions consumers should be asking themselves and try to be proactive in getting that level of information out in the marketplace.

Ms. MATSUI. And shouldn't CMS be a part of this, in essence, to educate the public about all the plans, in essence, of junk plans included, about what they include or do not include?

And I have just got a short question here. I think it was brought up—the extension of a plan to 3 years, it was said, actually helps consumers. How could it help consumers if they can be kicked off the plan at any time?

Ms. Keith?

Ms. KEITH. Sure. Thank you for that question. I do think that is the right question—how is being in a plan for a longer period of time that offers what can sometimes be illusory coverage. So the idea that these plans are offering coverage but can at any time ex-

clude coverage because of a preexisting condition or engage in postclaims underwriting—the idea of extending those plans when the coverage may not be there when the person really needs it, I wouldn’t call that a consumer protection.

Ms. MATSUI. OK. Thank you. I have run out of time.

I yield back.

Ms. ESHOO. I thank the gentlewoman.

Now I would like to recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes.

Mr. SHIMKUS. Thank you, Madam Chairman.

When my colleague from California was talking about that plan, I thought she was talking about an Obamacare plan.

In March 26th, 2018, I got this email from Ms. Penny from Centralia, who said, “We are a small company that employs five people. We just received our new health insurance premiums for 2018 with a rate increase of \$650 per month”—that was an increase of \$650 per month—“and a higher deductible ranging from \$3,200 to \$4,000.

“Nothing has been done to resolve the health”—and then she goes—just complains about being forced to buy an insurance product that she can’t use.

And in rural America we heard this quite a bit. Small businesses forced to buy insurance they can’t use because they can’t use—it costs so much and then the deductible is so high that they’re not covered.

So that is why this is a really important discussion. I am also glad finally my colleagues—I was up at a telecom, or down at a telecom hearing so I missed some of this debate. But it sounds like we are talking about, quote, unquote, “junk plans.” So let us—what are—what are these junk plans?

Well, we will see. The Trump administration has permitted workers in small businesses to pull together to buy insurance known as association health plans. I have always been a supporter of that. Farm bureau, manufacturing association, chamber of commerce—bigger pools negotiating.

Obviously, my colleagues call all these junk plans, even though most of these so-called junk plans comply with ACA mandates. They aren’t charging people different premiums based upon health conditions, and they are not banning people with preexisting conditions from enrolling.

So, Ms. Turner, do you think labeling association health plans as junk is a fair description for coverage that many hardworking Americans seek out and choose to buy for their family?

Ms. TURNER. I am very supportive of giving small companies in particular more options for health insurance, which is what association health plans do, and individuals also need other options, which is what the short-term limited duration plans provide.

There was a study recently—I think just last week—about association health plans, and they were in fact providing coverage as comprehensive as larger companies, and they were not excluding people with preexisting conditions.

Mr. SHIMKUS. I think one of the things that fired us up so much about this debate was the debate who is to determine what policies we have. When we thought this was going to go to the Supreme

Court, we thought it would stand on the inability of the National Government to tell you what you had to buy.

In fact, when this was debated here in the halls of Congress, that was the arguing point. We said this is not constitutional.

Then the administration fought for constitutionality based upon not the right of the individual to make a choice what they want to buy, but on the right to tax.

So that is why it was upheld, not on the individual being forced to buy something, especially my constituents were being forced to buy something that they can't use, as Ms. Penny has highlighted here, and she is trying to provide for her employees and she can't do it.

So the employees across the country are already taking advantage of this option to provide more affordable insurance to their workers. In fact, 28 AHPs have formed already with some showing up to 30 percent savings on premiums.

The Las Vegas Chamber of Commerce is in the process of signing up 500 employees for an AHP, which could save some employees more than \$2,000 per year.

Ms. Turner, do you—again, if these plans are junk, why are they so attractive to business owners and their employees?

Ms. TURNER. People are just desperate for choices. They feel shut out of the market not only because of the premiums under the comprehensive coverage under the ACA but also because of the deductibles, which can be \$10,000 a year in the ACA plans.

And so people are looking for other options—short-term limited duration plans or bridge coverage and other ways to get economies of scale through association health plans and letting States have more power through their 1332 options.

Mr. SHIMKUS. Yes, and I will end this. I appreciate it.

We Republicans believe in markets and competition, not centralized control dictates from the National Government authority, and that is why we are—I am glad we are having this hearing today, and I look forward to more discussions.

And with that, Madam Chairman, I yield back my time.

Ms. ESHOO. I thank the gentleman. Just for the record, this hearing is not about association health plans. We are talking about the short-term, what they cover, what they don't. And so I think it would be wise to stay away from conflating things and putting words in other people's mouths that they haven't uttered.

Mr. SHIMKUS. Will the gentlelady—will the gentlelady yield—

Ms. ESHOO. No, I want to move on.

Mr. SHIMKUS [continuing]. For discussion?

Ms. ESHOO. No, because this hearing is on these short-term plans, not on association health plans. So I think it is important to—

Mr. SHIMKUS. So you appreciate association health plans? Is that—

Ms. ESHOO. I Do—

Mr. SHIMKUS. OK. Very good.

Ms. ESHOO [continuing]. Except for what the administration is doing to some of them. We can have a hearing on that. But today's hearing is not about association health plans.

I now would like to recognize the gentlewoman from Florida, a valuable member of our committee always, Ms. Castor, for 5 minutes of questioning.

Ms. CASTOR. Well, thank you, Madam Chair. Thank you for holding this very important hearing on our legislation to address the Trump administration's sabotage on affordable healthcare for our families back home, including my bill, H.R. 1010, that will stop the expansion of these junk health insurance plans.

See, working families across America, they remember well the attempt by the Trump administration and Republicans in Congress to repeal the ACA in its entirety, including the protection on pre-existing conditions.

What the Congress—the Republican Congress was not able to accomplish, here they are now trying to accomplish through administrative rule, and that is where they have now adopted an administrative rule that would expand the use of these junk insurance plans that do allow discrimination for—if you have a preexisting condition like a cancer diagnosis or diabetes or asthma or something like that.

These junk plans also deny basic health benefits. So that is why I filed H.R. 1010 along with my colleagues, Congresswoman Barragán and other Members, to address these plans that really don't protect our neighbors as they should.

It really is difficult to understand why the administration is promoting plans that do not provide adequate coverage. It really appears to be a cynical ploy to lure families into these plans that were too prevalent before the Affordable Care Act, where benefits were excluded and families faced massive healthcare bills.

I am very concerned that the public is being snookered here, and Commissioner Altman, I would like to ask you a few questions about this—about these junk plans. I understand that these plans often impose lifetime and annual limits on care. Is that right?

Ms. ALTMAN. That is correct.

Ms. CASTOR. So can you describe what these plans typically look like, how they are marketed, what kind of coverage they provide?

Ms. ALTMAN. Sure. I think to the average consumer the plans can look like they cover a lot of things. They have coverage for hospitalization, coverage for ambulance transport, coverage for doctor's visits—some of those things.

But when you begin to look beneath that, first of all, there are many exclusions, both in terms of certain benefit categories like mental health and prescription drugs and maternity, but also for any care related to a preexisting condition, whether determined before the plan was issued or after, exclusions for any injury that results from sports activities or other risky activities—things like that.

Then you have cost sharing, high deductibles, copayments, coinsurance. Then you have annual limits on coverage—potentially lifetime limits on coverage—although as a short-term plan, it is unlikely someone would be able to retain this plan for a lifetime.

And then you get into what they actually cover within those categories of benefits. I think the story I shared in my testimony is very indicative of the fact that the coverage levels are not reflective of the cost of services.

So a consumer may see it covers \$100 or \$200 for an ambulance ride, and that may sound reasonable to them and, like, coverage. But, of course, we know an ambulance ride generally costs well over \$1,000.

Ms. CASTOR. So then they are stuck paying that?

Ms. ALTMAN. Correct.

Ms. CASTOR. Unlike an Affordable Care Act policy. So we have heard a lot of discussion about choice here today, and choice is important—that under the Affordable Care Act individual market policies in your State, I read in the testimony you actually have more—had another insurer come into the marketplace. Is there adequate choice among those policies that are being offered in Pennsylvania right now?

Ms. ALTMAN. That is correct. We have put in a lot of work to get our individual market in a very good place. I approved statewide average decreases this year. We have—

Ms. CASTOR. Wait. Wait. You have increased competition and choice, and Pennsylvania is now lowering costs?

Ms. ALTMAN. Correct. We have a new entrant. Thirty of Pennsylvania's 67 counties had more insurers offering coverage this past year compared to the year before, and we reduced our single-care counties from 20 to 10 simply by working to make the market a place for—

Ms. CASTOR. But if we had more junk health plans, it would seem that that would be a false choice for folks because they would be on the hook for substantial costs. Is that right? Do you agree with that?

Ms. ALTMAN. If they chose that route and, of course, for over one in four Pennsylvanians who have preexisting conditions, those plans are no choice at all.

Ms. CASTOR. And I would like to offer the groups that are now endorsing H.R. 1010. If folks are confused by some of the debate here today, here are some trusted organizations that now support the expansion of junk health plans: American Heart Association, American Lung Association, AARP, Cystic Fibrosis Foundation, March of Dimes, to name a few.

Thank you, and I yield back.

Ms. ESHOO. I thank the gentlewoman. I thank her for the legislation that she is offering.

It is now my pleasure to recognize the ranking member of the full committee, Mr. Walden, of Oregon.

Mr. WALDEN. Good morning again.

Ms. ESHOO. Yes.

Mr. WALDEN. You must be torn as I am with the other hearing going on downstairs. I know your passion for telecommunications issues as well.

Ms. ESHOO. In fact, I am going to ask Ms. Castor to come to this chair, take the gavel, and have you proceed.

Mr. WALDEN. Perfect. Thank you.

Thank you, Madam Chair, and I want to thank our witnesses. This is a really important issue for all of us to contemplate, and I know—I met with some wheat growers from my district yesterday, as fate would have it, and guess what issue came up? It was high cost of healthcare and health insurance—both the cost of indi-

vidual items in the healthcare continuum, but also the health insurance.

And I am trying to remember—I should have made a note on it—but I think one of the growers talked to me about how his rates per month had gone from, like, \$300 to \$600 to \$900. Now, it is, like, \$1,000 a month for him and his wife, and the deductible, I am going to say, was somewhere between \$6,000 and \$8,000.

So to my friend's comment about the consumer picking up the difference in charge, there are a lot of consumers now as a result of these enormously high deductibles you have to do to get a premium you might be able to afford, you are paying it out of pocket through your deductible.

And so I think what I am trying to get at, and Republicans are, is how do we have choices out there that fit families that they can afford that will actually give them first dollar—not first, but an affordable family dollar health insurance and not something that amounts to something that is catastrophic.

I do hope we do hearings on association health plans. I do think we have the right to talk about them in the context of this hearing, by the way, and I do hope we will eventually hear from the majority—Democrats—about a hearing on Medicare for all, because we know by the estimates that would cost \$3.2 trillion and do away with the health insurance that 150-plus million Americans have through their unions or their employers. And with the strength of the economy, more and more people are showing up on those plans and probably fewer on the others.

And maybe, Ms. Turner, you could address this. My understanding is, under the Obama administration, there was a 3-month period for short-term limited duration plans. The Trump administration simply said to States, you can go up to 12. But States have the right to step in here and regulate as they see fit, right? Is that correct?

Ms. TURNER. Yes, absolutely.

Mr. WALDEN. And so there are some 33 States that have left the door open for this innovation to occur, correct?

Ms. TURNER. Yes.

Mr. WALDEN. And so, when you're looking at options people can afford that work for them, do these plans that are out there, do you think they give them options that work, or not?

Ms. TURNER. Consumers will determine that, and I absolutely agree that having State flexibility allows the States to—I mean, they are much better, frankly, at regulating local health insurance markets in their State than Washington can be and really figuring out what other consumers need—more information about these plans—

Mr. WALDEN. Right.

Ms. TURNER [continuing]. To make sure they are buying insurance that works for them and that they are smart, informed buyers.

Mr. WALDEN. Uh-huh.

Ms. Altman, I am intrigued that the rates went down in Pennsylvania, correct? Is that right? So that is this year? Was that for all the plans?

Ms. ALTMAN. In the individual market.

Mr. WALDEN. In the individual market. How much over the last five—

Ms. ALTMAN. But that is the statewide average. Not all of the plans were done on their own, but on average, yes.

Mr. WALDEN. Yes. Understood. Yes.

Over the last, say, 5 years, what has happened in terms of rates in Pennsylvania in the individual market, on average?

Ms. ALTMAN. Sure. There is no question that rates have gone up in this market. I think there are—

Mr. WALDEN. How much?

Ms. ALTMAN. I don't know off the top of my head the increase.

Mr. WALDEN. How much did they go up the year before?

Ms. ALTMAN. So the year before, they went up around 25 to 30 percent.

Mr. WALDEN. And how much did they—

Ms. ALTMAN. But that is an important year, because they should have gone up 6 percent, and in that year the reason they did not was because of the decision to cease paying cost-sharing reductions and uncertainty created by the—

Mr. WALDEN. How much did they go up the year before that?

Ms. ALTMAN. Around I want to say—you are testing my memory—about 15 percent and about 8 the year before that.

Mr. WALDEN. So 8, 15, 20, what?

Ms. ALTMAN. And then at 20—

Mr. WALDEN. Twenty.

Ms. ALTMAN [continuing]. And then minus two.

Mr. WALDEN. And minus two. So they went down, but they went down 2 percent after they had gone up. I am trying to remember that first year with the cost-sharing deal. Twenty-five percent they went up?

Ms. ALTMAN. Sure. It should have been 15.

Mr. WALDEN. Fifteen and 8. I am a journalism major, so I will let somebody else do the math. But the long and the short of it is, consumers didn't get a \$2,500-per-year reduction in their premiums along the way, right?

Ms. ALTMAN. Well, of course, 80 percent of consumers in that market received financial assistance that largely shields them from those—

Mr. WALDEN. Correct. And so my wheat grower friends that aren't eligible for that are small entrepreneurs. They have gotten socked with rate increases. They don't get the subsidies. They are the kind of working middle-class folks that are just off the subsidy side because they are just at that realm.

I had a town hall 1, 2 years ago in Arlington, Oregon, and actually we had this debate there, and this farmer got up and talked about what his family had faced, and this person who was very much in support of the ACA—Obamacare—went up to him afterwards and said, "I didn't know people like you existed." He was very serious about it.

So we have this gap out there that some of us are trying to figure out a way to fill, and that is what Republicans are talking about—how do we fill that gap for those people that don't get the subsidies you get on the exchange if you are the right income but you are still left out with a high deductible and premiums off the charts?

My time has expired, Madam Chair? Thank you for your indulgence.

Ms. CASTOR [presiding]. Thank you.

Mr. Schrader is recognized for 5 minutes.

Mr. SCHRADER. Thank you, Madam Chair, and I appreciate the previous gentleman's discussion—the ranking member of the committee—and there has been a lot of discussion about the cost of the premiums, the deductibles, in the individual marketplace.

I think it is important for America and a lot of people here to understand that that is only one facet of the Affordable Care Act, and the rest of the Affordable Care Act, ostensibly, is working very well.

We heard last Congress of the repeal-and-replace debate that, frankly, a lot of red State people were very pleased that the Medicaid situation changed dramatically for them.

Many millions of Americans had healthcare for the first time. So I guess I would like to look to my colleagues and say, “Hey, let us work on the individual marketplace.” I am fine with that, and I think there is an opportunity for us to work together and maybe adjust the cost-sharing stuff, the reinsurance issues or risk pools or—and maybe expand the 1332 waivers, but under constraints.

You know, the people forget—I come from Oregon—people forget that the goal of healthcare is to provide better health. It is not to get insurance. And, ostensibly, getting better health means you don't have to read the fine print all the time.

There is some commonality in these plans that are out there, and you have the opportunity to buy a product that covers what people would call essential health benefits—that overall that someone had a mother, someone has got a daughter out there. I mean, you know, being a woman and having maternity care should be an option.

I mean, everyone benefits from that over the long haul, and the goal of insurance—to provide healthcare—is to prevent people from getting too sick to begin with, and that has gotten lost, I think, in a lot of the debate.

So I am hoping that we actually get to that.

Ms. Turner, real quickly, with these short-term plans and the expansion of the short-term plans, how do you actually justify that when the rules of the road clearly state that the waivers that are granted under 1332 are only supposed to be for those plans that provide coverage that is at least as comprehensive as the coverage under the exchanges and that the coverage and cost-sharing protections are as affordable?

In other words, they go together—again, getting at the fact the undermining of these essential benefits I think is disingenuous to a lot of American consumers. What is the justification for doing that in these newer short-term plans the administration has put forward?

Ms. TURNER. The administration has spent I think about a year with a lot of career Federal officials looking at this and how can you write the rule in a way that is compliant with the text of the ACA to make sure they are comprehensive, they don't increase the deficit, they are at least as affordable to make sure that that would be allowed. So the rules would have to allow to make sure if people did buy short-term plan that it fit these criteria.

So all the short-term plans are not junk plans. In fact, I think very few of them are. Buyer beware. People need to be aware, they need to be informed, and there are protections if they are going to use a subsidy for these plans to make sure that they are compliant with the ACA.

Mr. SCHRADER. Well, and I think you write the rules in the way you would like to write the rules, and I think that is challengeable and we are going to see, I think, that reverse either in the courts or in this particular Congress.

Ms. Altman, a lot of discussion about 1332 waivers and the ability for them to give States the opportunity to innovate. I totally agree with that. Oregon has been doing that for years.

The Affordable Care Act really, I think, points that out as a great opportunity for States. I don't think there is any disagreement with that, and it is being done and has been done prior to this current administration very successfully. But it has been with these essential health benefits in play, and it hasn't been, I think, a curse or restrictive.

Please talk a little bit about the role those essential health benefits play in the waiver programs.

Ms. ALTMAN. Sure. So essential health benefits are sort of 10 categories of core benefits that the Affordable Care Act was supposed to guarantee access to so that people with healthcare needs could have the benefits that they need to get the treatment they need regardless of the type of condition that they have.

Those are what ensure that whether you have a mental health issue, a physical health issue, an emergency or cancer, those benefits will be available, and they were intended through the guardrails in the ACA to be extended to any coverage offered through the 1332 waivers.

Mr. SCHRADER. Thank you.

And Ms. Keith, I mean, given the fact that ostensibly the Health and Human Services Department of the United States of America's goal is to help Americans get quality, affordable healthcare, how do you think the current administration justifies curtailing the enrollment outreach programs? That makes no sense to me.

Ms. KEITH. I won't try to speak for them or on their behalf. My understanding is they think this is a more cost-efficient way, and that they believe that outreach in enrollment funding is not cost effective.

I would counter there have been other examples from other States—Covered California is an example—that attributes a decline in 6 to 8 percent of premiums just from the outreach and marketing work that they did to bring in healthy consumers. So it does, certainly—has been shown to help stabilize premiums.

Mr. SCHRADER. Thank you very much, and I yield back.

Ms. CASTOR. Thank you.

Mr. Long is recognized for 5 minutes.

Mr. LONG. Thank you, Madam Chairwoman.

Ms. Turner, I would like to talk about the roles that navigators and independent agents and brokers played. You note in the plan in year—you note that for the plan year 2017 navigators received more than \$62 million in Federal grants while enrolling less than

1 percent of all enrollees. Seventeen of these navigators enrolled fewer than 100 each at an average cost of \$5,000 per enrollee.

The top 10 most costly navigators spent over \$2.5 million to enroll 314 people. One grantee received \$200,000 and enrolled one person, and over three-quarters of navigators failed to achieve their enrollment goals while spending more than \$50 million.

Ms. Turner, under the Trump administration CMS has changed how navigators receive funding based on performance measures. Do you think that these changes help ensure accountability within the navigator program?

Ms. TURNER. CMS has said in its report that it really is trying to respect that taxpayer dollars be spent wisely and, basically, they are making the following year's grant contingent on a navigator meeting their previous year enrollment goals.

And as you say, even with this generous funding, the navigators enrolled fewer than 1 percent of all enrollees in healthcare.gov. And so I think that does need to—we need to look at how can we get the best benefit, and they looked at private brokers and agents who live and breathe in this space, and they were much more successful, enrolling 42 percent of enrollees.

Mr. LONG. The subject of this hearing is about reversing ACA's sabotage. Do you consider these efforts by CMS as sabotaging the ACA?

Ms. TURNER. No, and the navigators were particularly—when the ACA was new, people didn't even know what a deductible was. So people needed to be educated about the fundamental principles of insurance.

But now that we see in California, for example, there has been a 24 percent drop in new enrollees, despite their spending \$100 million on marketing navigators last fall. But they are finding many more people are having their coverage renewed and sometimes automatically renewed.

So we are in a different space now with the ACA.

Mr. LONG. According to the Missouri Department of Insurance, since 2011 the annual cost of coverage per individual has increased by an estimated 235 percent in the individual market, and now there is only one option on the marketplace for my entire district—7th District of Missouri.

Do you see the efforts of the Trump administration to give States more flexibility to lower premiums and provide more insurance options for individuals as positive steps that can benefit consumers?

Ms. TURNER. Absolutely, and I think that is what they are trying to do both with the bridge plans as well as the association health plans, and as well as the Section 1332 flexibility.

Being able to tailor the insurance funding to the needs of their citizens is something that States can do much more effectively than the Federal Government.

Mr. LONG. So I am assuming you don't consider these efforts as sabotaging the ACA?

Ms. TURNER. I think they are really trying to give consumers new options, particularly those who are shut out of the market because of costs, and even many of the people with ACA coverage say, "I might as well not have coverage because I can't afford the \$6,000 to \$10,000 deductible."

Mr. LONG. Thank you.

And before I yield back, as a point of personal privilege, I was born in 1955. John Dingell was sworn into Congress in 1955. I had the great honor to serve with him for two terms.

Of course, the room downstairs is named after him. Yesterday morning, after an hour delay because of weather, we loaded up two planeloads of congressmen, headed to his funeral in Dearborn, and got up there and circled for an hour waiting for the temperature to raise 1 degree.

If it would have raised one degree we would have made it, and we didn't. We were low on fuel, and so a legend in his own time, John Lewis—Representative John Lewis—and Speaker Pelosi, who weren't on the flight, along with Chairman Upton, Chairman Walden was there, Anna Eshoo.

I am not going to name all the names because I will leave people out. But we held an impromptu service for John at 30,000 feet, and I just want to send out my best to Debbie. I know that John followed his father in Congress and Debbie has followed him and she has done an outstanding job on this committee, and I just wanted to send my best and thoughts and prayers out to Debbie and the entire Dingell family because we are sure going to miss him.

I yield back.

Ms. CASTOR. Thank you, Mr. Long, for your comments about the Dean of the House, John Dingell.

Mr. Ruiz is recognized for 5 minutes.

Mr. RUIZ. Thank you, Ms. Chairwoman.

I, and everybody in this room, agrees that we need to do something about costs. The premiums are skyrocketing in the exchange. That is not the issue that we are debating here.

When we look back at why the costs have gone up so much, all we have to do is listen to the insurance companies themselves, which have said and have warned that if we don't pay the cost-sharing reduction subsidies, they are going to increase costs.

The other thing is they talked about the changes that were made by Senate Republicans to the risk corridors. They increased costs because of those. The other is because of the expired reinsurance programs, et cetera, and all of these have been a part of the repeal efforts of the ACA.

So when we look at the junk plans, this is not a solution to the problem of high costs. In fact, these junk plans will make costs higher in the exchange because this will siphon low, healthy, high-corporate-profit-type patients into this lower-risk pool—junk plans—leaving behind the higher-risk, more expensive type of patients for everybody else.

So healthcare costs for everybody else will go up, and if there is something that I have learned as an emergency physician, is that not every healthy person stays healthy forever.

So I have seen a 48-year-old man in a motor vehicle collision who was previously completely healthy who will now have traumatic brain injury, symptomologies for the rest of their lives, and be paralyzed and require very expensive care and lots of medications.

I have seen a 52-year-old man who comes in with yellow eyes and yellow skin who has been newly diagnosed with severe liver

problems due to hepatitis, which is going to require expensive medications.

And I have seen young and healthy 30-year-old women who come in with anxiety or depression with new diagnoses of clinical depression and also with a mass in their breast with a working diagnosis of breast cancer that has metastasized, which would require expensive chemotherapy.

So, even if those younger and healthy individuals buy this junk plan, healthcare costs will be more expensive for them because under these junk plans they can choose not to cover their medication. They can choose not to cover their mental health coverage. They can start implementing a cap in lifetime coverage for these individuals that will need more care for longer periods of time.

We are not invincible. The whole purpose of health insurance is, what if you get sick, what if you get injured during an accident? And I have seen them and I have counseled family members and patients about their terrible diagnoses or their terrible prognoses, and it is not a fun thing to do.

So I have some questions in regards to costs. Ms. Keith, would junk plans increase costs for everybody else and can you explain it further, please?

Ms. KEITH. Yes, that is correct. Every analysis, including the Trump administration's own analysis, has found that expansion of these short-term plans through this new rule are increasing premiums in the ACA marketplaces.

A study by the Kaiser Family Foundation that looked at what insurance companies actually said about their premiums for 2019 showed that short-term plans, the individual mandate, repeal and the association health plan have increased premiums on average by 6 percent in 2019.

Mr. RUIZ. And so, you know, in one way I am hearing this opposing kind of arguments—yes, we are for preexisting, but we need a reduced cost—but it seems like by this junk plan they are going to eliminate protections for preexisting illnesses in order to keep costs down because corporate insurance companies would love not to cover the sick. They would like to cover the wealthy and healthy.

So can you have it both ways in this junk plan? I mean, do they discriminate with people with preexisting illnesses?

Ms. KEITH. They absolutely do. I believe that is their business model, yes.

Mr. RUIZ. So if you support junk plans you are supporting the idea that—to take us back to a time where health insurances were allowed to deny or charge higher premiums or charge for higher—or not cover certain procedures for those conditions. Is that correct?

Ms. KEITH. Yes, it is.

Mr. RUIZ. Can you describe the medical underwriting process that Americans are subject to under these plans?

Ms. KEITH. Sure. So it varies by insurance company but, essentially, if you are applying to enroll in a short-term plan, you would fill out a very detailed health questionnaire about your own health, about the health of your family members and maybe a medical history.

You would also grant that insurance company access to all of your medical records. They would look at what prescription drugs

you have taken. They would look at what medical exams you have taken.

They would take that information and they would give you a price, or they would decline to cover you at all, or they would use that to dictate what benefits they will and will not cover.

Mr. RUIZ. Thank you.

Ms. CASTOR. Thank you.

Dr. Bucshon, you are recognized for 5 minutes.

Mr. BUCSHON. Thank you, and just in light of my friend Dr. Ruiz's comments, it is about choice. If you have a preexisting condition, don't choose a short-term health plan that is cheap. They don't discriminate at all, because it is a consumer choice. So to say that a plan specifically discriminates against people, that is just factually not true. They don't discriminate, because it is about consumer choice.

We are here today discussing legislative proposals that really do nothing, in my opinion, to address the high cost of healthcare and the lack of affordable insurance options for patients.

One thing—again, Congress is here discussing the cost of health insurance plans but, again, we are not really addressing the true problem, in my view, which is the cost of the product is too expensive.

And so if we all continue to chase a product that is too expensive and try to cover it, we are never going to catch up, in my view.

The other thing is, is insurance is about risk. That is what insurance is about. So your description, Ms. Keith, of all of these things—about being assessed for what your risk is—that is what insurance is about. And so we need to figure out a way to cover people who have a lot of risk, and that is what Republicans did in our healthcare bill.

We did it with high-risk pools. What is it, 4 percent of the people or 5 percent of the people in the country are 40 to 50 percent of the healthcare costs?

So we want to cover people with preexisting conditions, but we just want to do it in a different way. If you put everybody in the same pool, there is no way, based on the history of insurance and how it works, that actuaries will tell you that you can get the costs down for everybody and keep the costs low. It just doesn't work.

So we want to cover people with preexisting conditions. I was a physician before. I had people that I took care of that didn't have coverage. That is wrong. We just want to do it in a different way.

So, Ms. Turner, do you think that any of the legislative proposals today would address the high cost of healthcare plans?

Ms. TURNER. I actually think they would. They would remove options for many consumers. Three million people had dropped out of the individual market before the first short-term limited duration plan under the Trump administration rules was available.

People are dropping out of coverage because they couldn't afford it. They want some options, and bridge coverage through the short-term plans provides many people an option. They should definitely be informed about these policies.

But if they buy a policy and they—say they buy a year policy and they are diagnosed with cancer when they have that coverage, they

are covered, and if they didn't have that option, they would be completely exposed to those costs.

Mr. BUCSHON. Yes. I think everyone here agrees on both sides of the aisle we need more probably disclosure to consumers and make sure consumers—like someone mentioned, have it in big print right on the front page—you know, what your choice is here—you know, what the cost is, number one, but number two, what actually is included in these plans, right.

And it may—you are right, if you have—if you are underwritten and you are high risk, you are probably not going to be able to get insurance through one of these plans. That is not the point. That is not what we were trying to cover.

But under the Affordable Care Act, I hear from constituents all the time that the plans are just not affordable in the Affordable Care Act, and so we need to work together to try to find a way to improve that and, you know, one of the things I think that we can do is work on the cost to the product, and I keep saying that because Congress always works on trying to provide coverage but not trying to get the cost of healthcare down.

So, Ms. Turner, how do you think repealing the Trump administration's guidance on Section 1332 innovation waivers would impact the affordability for patients in States with waivers?

Ms. TURNER. The States that have received waivers so far have been able to reduce premiums anywhere from 43 percent to 7 percent in the States so far that we have numbers for, and so those citizens would definitely be adversely impacted by being thrown back into the same pools that don't provide States with the same flexibility and the same options that they would have under this new guidance to be able to provide more affordable options for their residents.

And about the essential benefits, the essential benefits in the ACA may not be everything that somebody needs. Janet, that I talked about in my example—

Mr. BUCSHON. Right.

Ms. TURNER [continuing]. Needed to have her antirejection medicines covered, and they were not covered under her ACA-compliant plan. So States need to be able to make sure the plans work for their citizens.

Mr. BUCSHON. I want to briefly talk about cost-sharing reduction payments, which everyone is saying is sabotage of the ACA. That was a bailout, in my opinion, put into the law so that if the pools didn't work—insurance companies were losing money—they had a Federal backstop with taxpayers footing the bill.

I yield back.

Ms. CASTOR. Thank you.

Ms. Kuster is recognized for 5 minutes.

Ms. KUSTER. Thank you, and thank you for your testimony. I appreciate it.

I want to join my colleagues in honoring John Dingell and our mile-high memorial yesterday for him, and we will all be together with Debbie Dingell, our colleague, and her family tomorrow.

I just want to move on to the Section 1332 and direct my questions, if I could, to Professor Keith. There is clear statutory directive in Section 1332 that States must provide comprehensible and

affordable coverage to a comparable number of residents under the ACA.

But, unfortunately, last fall the Trump administration issued new guidance, and I am afraid that that is going to hurt people with preexisting conditions like my dear friend Bodie, who is a young man with spinal muscular atrophy in my district, necessitating a wheelchair to get around.

Thanks to the ACA, there is no longer broad-based exclusions to wheelchairs or to all the other affordable healthcare that helps Bodie lead a fulfilling life.

But for Americans like Bodie, this concerns me in this Trump guidance because it runs counter to the statutory directives. So last week, I introduced H.R. 986, the Protecting Americans with Preexisting Conditions Act, to nullify the new guidance.

I have heard from my Republican colleagues this morning that they want to protect Americans with preexisting conditions, and I would encourage them to sign on to my bill.

If I could, Professor Keith, I would like to suggest a quick lightning round about my concerns of these short-term limited duration insurance products so that Americans will understand our concerns.

If you could just respond—under these plans are insurers allowed to refuse to offer a policy to an individual with a preexisting condition?

Ms. KEITH. Yes, they are.

Ms. KUSTER. And are insurers allowed to exclude coverage for preexisting conditions?

Ms. KEITH. Yes.

Ms. KUSTER. And are insurers allowed to charge higher monthly premiums based on health status and factors such as age and gender?

Ms. KEITH. That is correct.

Ms. KUSTER. And are insurers allowed to impose annual or lifetime dollar limits on care?

Ms. KEITH. Yes.

Ms. KUSTER. And are insurers allowed to opt not to cover entire categories of benefits? Here, I am thinking of mental health services, prescription drugs, or maternity care.

Ms. KEITH. That is correct.

Ms. KUSTER. And are insurers—even in States like Pennsylvania, New Hampshire, West Virginia, that had been so hard hit by this opioid epidemic—allowed to offer policies that do not include coverage for substance abuse treatment?

Ms. KEITH. That is correct.

Ms. KUSTER. And are insurers allowed to retroactively cancel coverage once care is needed?

Ms. KEITH. Yes. That has been one of the biggest abuses and something that the Affordable Care Act prohibited.

Ms. KUSTER. And are insurers allowed to impose much higher out-of-pocket costs than under the Affordable Care Act?

Ms. KEITH. That is correct.

Ms. KUSTER. And so I would simply ask you or Commissioner Altman, if you could, we have heard from Ms. Turner about her opinion that these plans protect consumers and bring down costs.

Are there alternatives—waivers such as reinsurance products that could bring down costs for consumers?

Ms. ALTMAN. Absolutely. There are other mechanisms out there—and reinsurance is a great example—that can lower costs for those to help afford premiums without putting people in the position of having to choose between no coverage or substandard coverage like the short-term plans provide.

Ms. KUSTER. So it is your professional opinion that rather than this list that we have gone through this morning of ways that insurance companies are choosing to make higher profits—and I believe you have testified the profits are as high as 50 percent of every premium dollar?

Ms. ALTMAN. Actually, there are some even higher than that. The two largest carriers, with 80 percent of the market, do spend less than 50 cents of every premium dollar on care. The rest is some administrative cost, and the rest profit.

Ms. KUSTER. Which is shocking to the American people. Rather than all that premium dollar going into profit while families are put at risk, you believe there is alternative that this committee could consider to focus on reinsurance or risk pools?

Ms. ALTMAN. I do, so that no one has to choose between their health and their financial well-being.

Ms. KUSTER. Thank you. My time is up, but I very much appreciate that.

Ms. ALTMAN. You are welcome.

Ms. KUSTER. I yield back.

Ms. CASTOR. Thank you.

Mr. Gianforte is recognized for 5 minutes.

Mr. GIANFORTE. Thank you, Madam Chair, and I thank the panelists for being here and your testimony.

Hardworking Montanans regularly tell me how their healthcare costs continue to rise and benefits shrink. I just had a town hall this week, and individuals in Missoula and Livingstone, Montana, both raised this very issue. It is a real burden on families in Montana.

Obamacare has not provided an affordable option for many Montanans. In the first year of Obamacare, more than 20,000 Montanans lost their coverage because of the law, and in the first 3 years under Obamacare, Montanans' premiums have shot up 66 percent, and we had testimony you have had similar experience in Pennsylvania.

Unfortunately, premiums continue to skyrocket for Montanans and Americans across the country under the current scheme. Thankfully, the Trump administration is empowering States to address these rising healthcare costs by allowing States greater flexibility with the strict Federal mandates of Obamacare.

The Department of Health and Human Services is effectively allowing more Americans to get coverage that best suits their needs. The administration has implemented rule changes that expand State Innovation Waivers to improve access to short-term limited duration insurance plans, eliminate the costly individual mandate penalty, expand association healthcare plans. These measures entrust consumers to pick the best healthcare for their family.

Let us be frank. Obamacare has robbed consumers of choice. Obamacare asserted that a Washington bureaucrat knows an individual's healthcare needs better than she does. The Trump administration changes are empowering consumers so they can make healthcare decisions that work best for themselves and their families, providing waivers, empower States to promote innovation that benefits patients and consumers.

The State Innovation Waivers, originally born in the Obama administration and expanded under President Trump, allow States to be creative with healthcare solutions while saving money and lowering premiums, which is the issue I hear over and over again as I travel our State.

Alaska has taken advantage of the waivers. We have talked about this. They saw premiums drop in some plans by over 40 percent. We heard testimony today—similar experience in Maryland and other States.

Unfortunately, for a second week in a row, members of the majority here have put on a political theater. They want the American people to believe that there are lawmakers who oppose protections for Americans with preexisting conditions.

I don't know of any Democrats or Republicans on this committee that are in favor of this, who want to strip protections for Americans with preexisting conditions. We all agree on that. There is broad bipartisan support here.

I think we should work together to find permanent legislative solutions that protect people with preexisting conditions.

I also think we should work together to continue empowering States to innovate and address healthcare affordability—I know that is the issue back in Montana—and we should encourage innovation and affordability, not terminate efforts to improve healthcare and make it more affordable.

Ms. TURNER, these State Innovation Waivers that allow for flexibility and creativity for the States who want to find cost-saving solutions, do you think that we would continue to see this sort of cost savings and innovation if we move to a single-payer, Government-run, Medicare-for-all program?

Ms. TURNER. No, and I think what we would find is that the American people would see—they would not have any choice. It would be the single-payer Government program, whatever form that takes.

And what we are seeing is the States are so much better able to be able to fine tune funding to the needs of their citizens. The American Health Care Act that this Congress passed in 2017 provided specific money to the States, \$123 billion, to be able to help with those high-cost patients. So they had better protection than being thrown into the same pool and often having benefits denied.

Mr. GIANFORTE. Yes. So what would the effect be of stopping the State Relief and Empowerment Waivers on individuals in the States where that ability to innovate was taken away?

Ms. TURNER. The States would basically become functionaries for the Federal Government. It would really undermine our system of government, I think, in giving the Federal Government so much control.

One of the things that we have learned through these waivers and through the 70-changes-plus that have been made to the ACA so far is that we need to have more flexibility and more State control.

Mr. GIANFORTE. OK. Thank you, and I yield back.

Ms. CASTOR. Thank you.

Mr. Sarbanes, you are recognized for 5 minutes.

Mr. SARBANES. Thank you, Madam Chair. I thank the panel for your testimony.

Ms. Altman and Ms. Keith, maybe you could tell me—the short-term plans that we have been talking about, the people offering those plans can and do deny people or reject people based on a pre-existing condition, do they not, in some instances?

Ms. KEITH. They do. That is correct.

Mr. SARBANES. Yes. So it is incompatible, it seems to me, to claim, as we are hearing from a lot of the Members on the other side, that they absolutely want to protect people against discrimination based on preexisting conditions, on the one hand, but to defend these short-term limited duration plans on the other hand, because those plans actually put people in that position of being able to be denied, based on that situation. Would you agree there is some incompatibility there?

Ms. KEITH. I think that is correct, and these short-term plans exacerbate, I think, many of the out-of-pocket costs that everyone in this hearing has said they are concerned about. So folks who maybe are healthy enough to enroll in a short-term plan but then become sick can face catastrophic costs that should concern all of us.

Mr. SARBANES. It is this distinction that we were able to focus on when we put the ACA together originally, where people are seduced into thinking that they have got their health situation covered and are doing that relatively inexpensively, only to then find if they do get sick that they are out of luck because the deductibles are incredibly high or the benefits that they thought they would be entitled to are not available to them. There were the caps that the insurance industry would place on how much it would cover.

So, in a sense, you are buying the healthcare equivalent of a pig in a poke when you are buying these short-term limited duration plans.

Why, by expanding the duration of them up to a year, we wouldn't view that as going back to the bad old days, which produced all these stories of heartache that motivated us to try to make these changes, I can't—I can't understand for a moment why anyone would support that kind of a policy shift.

But I wanted to ask you a specific question, which is that these short-term junk plans, as we are calling them over here on this side, where they can reject a beneficiary based on HIV status, based on weight, pregnancy, other kinds of things, could somebody apply for one of those plans, check a box saying they don't have a preexisting condition because they are not aware?

And that was the other things we discovered when we were doing this. How many things qualify as preexisting conditions that no one would ever imagine would disqualify them from coverage?

So somebody could get into a plan and then, when they go to get the benefits of it, they would discover then that they are not qualified for those based on this preexisting condition disqualification.

Could that happen? And so then you are trying to access it and, boom, you can't access it and you are—and not only that, you are thrown off the plan at that point because they say “Oh, you know, you weren't qualified in the first place” after you have paid premiums for I don't know how many months, and I don't know whether you would get those back. But is that a fair dilemma that people can find themselves in?

Ms. KEITH. That is absolutely correct. What you are describing is something called postclaims underwriting that an insurance company would use to go back and see if there is something that the consumer did not disclose or something, in their view, they omitted.

What the insurance company would typically do is retroactively cancel the policy altogether.

Mr. SARBANES. Yes. So basically these—did you want to comment?

Ms. ALTMAN. I am just going to add I think it is important to note that we are not talking about cases where patients intentionally did not disclose—

Mr. SARBANES. Right. Right.

Ms. ALTMAN [continuing]. Because fraud—true fraud has always been a reason. Cases where something was noted on a medical record that they may not have remembered, potentially didn't even know about because their doctor—

Mr. SARBANES. Right.

Ms. ALTMAN [continuing]. Wrote it in the notes without explaining to them, or in the case that I listed in my testimony, they were never diagnosed or sought care but experienced symptoms for which the insurer deems they should have sought care.

Mr. SARBANES. I mean, this is—I have to yield back my time, but just to say we are inviting people back into a world with mirrors and trapdoors that was exactly the place we wanted to get away from when we passed the ACA. So we got to really push back against these junk plans.

And with that, I yield back my time.

Ms. ESHOO [presiding]. Thank you, Mr. Sarbanes.

I now would like to recognize the gentleman from Georgia, Mr. Carter.

Mr. CARTER. Thank you, Madam Chair, and thank all of you for being here. Certainly an important area that is affordable healthcare costs.

You know, before I became a Member of Congress I practiced pharmacy for over 30 years. I started when I was 2. But, nevertheless, you know, one of the things that I heard so often was the cost of healthcare and particularly the cost of insurance, and that is something that I was committed to work on and I am committed to work on and continue to work on as a Member of Congress.

Ms. Turner, I read an article in Axios the other day that said that 42 percent of people participating in the individual marketplace weren't able to use their insurance because out-of-pocket costs were so high or their deductible was so high.

And it is my understanding that that is why we have the 1332 waivers, is so that States can actually address this issue. I believe in your testimony you gave examples of some States where it has actually worked—maybe Alaska, Oregon.

Can you repeat that for me, please?

Ms. TURNER. Yes, Congressman.

The 1332 waivers really are designed to give States flexibility to separately subsidize the people with predictably high healthcare costs that are driving up the premiums for everyone else.

They are the ones who are causing premiums to go up as the healthy people drop out. And a number of States have applied for waivers to in different ways subsidize them.

Alaska said, we will look at these 33 categories and if people qualify for those, then they will be able to get separate subsidies. Others have reinsurance, high-risk pools, invisible high-risk pools.

States are working to figure out how to do this, with dramatic results. We see, for example, in Alaska that premiums went down by almost 20 percent. Enrollment went up by 7 percent. In Minnesota, premiums went down again by almost 20 percent. Enrollment went up by 13, 14 percent, and on and on where you see—

Mr. CARTER. And that is the point I am trying to make. I mean, obviously, this has helped. It has helped tremendously, and expanding it has helped. Yet, the impetus for the hearing today is a set of bills that are actually going to constrict this, so we are not going to have the ability to expand on this like—and enjoy the benefits of it working like it has worked.

I am really confused by that because this is our second hearing in the committee that has the broadest jurisdiction over healthcare costs of any other committee in Congress, and I am just trying to figure out where we are going.

The first week we had a hearing on a lawsuit that is still in litigation. It has not been settled yet and may not impact anyone.

Here we are having a hearing this week on what is going on and how we can actually constrict the affordability and make healthcare costs even more expensive for people. And yet, when I go—when I am in my district people are talking about, what about prescription drug pricing.

We haven't even discussed prescription drug pricing yet. Yet, there are other committees in this House—the Ways and Means Committee yesterday had a hearing on prescription drug pricing, the Oversight and Government Reform Committee has already had a hearing on drug pricing—and yet here we are in the most broadest jurisdiction of healthcare, and we haven't had a prescription drug pricing hearing yet.

Madam Chair, I certainly hope that we will get to that at some point here, because it is extremely important. The point here is that people being able to buy health insurance doesn't help anyone if they can't use it.

You know, when I first went into business I read something and it said, When is a deal not a deal? It is not a deal when you buy something you don't need or you can't use, and that is what people were being forced to do: buy insurance that they can't afford to use. That is not helping them, and that is what we need to be addressing here and what I hope that we can address.

Let me ask you, Ms. Turner—when folks have a gap in coverage and employment or people who retire and are not yet eligible for Medicare, what are the options for them?

Ms. TURNER. Previously under the Obama administration they had the option to buy a short-term plan. These have been around for decades. But it had to—it could only last for 3 months, and people generally, if they are in gaps in coverage, they need coverage for longer than that. So this is what the Trump administration did. They said that you can have the policy for up to a year and it can be renewable for another 2 years.

Mr. CARTER. And in these plans there are options. So they give these people who are in this gap, if you will, the ability to actually fill in that gap and the ability to have coverage, which we all want.

Ms. Turner, I really appreciate all of you being here and appreciate this opportunity, and Madam Chair, again, I look forward to the hearings that we are going to have on prescription drug pricing, and I yield back.

Ms. ESHOO. I thank the gentleman. I look forward to them as well.

I now would like to recognize the gentlewoman from Illinois, Ms. Kelly.

Ms. KELLY. Thank you, Madam Chair, and thank you to all the witnesses, and I too want to salute Congressman John Dingell for all of his work, and he will be sorely missed.

The Trump administration has recklessly expanded junk health plans that do not offer comprehensive coverage. These junk plans could unwittingly leave, as we have heard, families on the hook for thousands of dollars of healthcare costs.

According to an article in the New York Times, Kevin Conroy, a patient from California, had a heart attack and underwent triple bypass surgery 2 months after enrolling in a short-term junk plan. His insurance company refused to pay for any of his treatment, leaving him with a \$900,000 bill.

In another case, United Health refused to cover a patient's breast cancer treatment, leaving her with a \$400,000 bill. The insurance company claimed that breast cancer was a preexisting condition even though the patient was not diagnosed with cancer until after she bought the junk plan.

Ms. Altman, according to your testimony, I understand that in your State several consumers have been stuck with large unpaid medical bills because a short-term policy denied coverage even for medical conditions arising after an individual enrolled in a policy.

These conditions should, theoretically, be covered since they arose after individuals enrolled in the plan, but often the insurance company, as we have discussed, that sell these junk plans refuse to pay out.

You have explained about postclaims underwriting, and also we talked about how consumers need to be more educated. But I want to know where does all the money go if these insurance companies are not using premium dollars to pay for healthcare?

Ms. ALTMAN. Sure. So, as we have talked a little bit about, Affordable Care Act plans are subject to a medical loss ratio that ensures that they spend at least 80 cents of every premium dollar on care with the remainder going to administrative costs and profit,

and if they don't meet that standard they are required to refund dollars to their policy holders.

The short-term market, on the other hand, averages, based on a study, 64 cents on every dollar, the largest carriers average less than 50 cents a dollar spent on care, with one of those carrier spending only 34 cents on the dollar.

So the remaining funds would go some to administrative costs and the remainder to profit. I think all evidence points to these being very profitable lines of business for the insurers that sell them.

Ms. KELLY. Thank you.

And also I agree with my colleagues. I would—I want us to work together too and get something done for the American people. But, as I recall, in the last years all I have been given the opportunity to do is vote to repeal the Affordable Care Act or tear up some part of it.

And, Ms. Turner, I know you have been more negative about the navigators but also besides the marketing the time period was cut so short so people—it was harder for people to register.

And we talk about the economy is better, so I would like to think we went down some because people got jobs and so they did have health insurance. So I just want to know from you, do you think the ACA has been helpful to anybody?

Ms. TURNER. Oh, absolutely, and actually California extended its enrollment period to I think the middle of January, and they still were down 24 percent in new enrollment.

So I think that the real issue is how do we make these plans more attractive to people so that they can afford both the premiums, especially if they are not in the subsidized market, as well as the deductibles are low enough that they feel they could actually access the insurance, and that is what I am hopeful that States will take advantage of the 1332 flexibility in the law to allow that.

Ms. KELLY. OK. Thank you for your answer.

I just want us to also recognize that there were many, many millions of people that had no insurance, and just like people can talk about the stories they are hearing there are many stories that, even in my own family, how people that weren't insured have insurance and they are very happy.

Ms. TURNER. And they are grateful, yes.

Ms. KELLY. I yield back.

Ms. ESHOO. I thank the gentlewoman from Illinois.

And I now am pleased to recognize the gentleman from North Carolina, Mr. Hudson.

Mr. HUDSON. Thank you, Chairman Eshoo, and this is my first chance to publicly congratulate you on taking the gavel. I look forward to finding common ground and working with you throughout this Congress.

When I noticed today's hearing title, "Strengthen Our Healthcare System: Legislation to Reverse ACA Sabotage and Ensure Pre-existing Conditions Protections," one word really stood out to me—the word "sabotage."

I know my colleagues and I on this panel agree that we should strengthen our healthcare system. I talk to constituents of mine every time I am home who need better access to more affordable

care, and I know my colleagues and I want to ensure protections for preexisting conditions. That was universally accepted at our hearing last week.

But the word “sabotage” really stuck out at me. Unfortunately, this conversation around healthcare has become increasingly partisan. We saw this with the Affordable Care Act, and we saw it again with the American Health Care Act last Congress.

But this conversation should be bipartisan because healthcare is an issue that affects every single American. From the time we are born until the time we die, there will never be a time when the healthcare industry doesn’t touch our lives.

I was talking to a constituent last week who—he and his wife are in their 50s—he told me his wife couldn’t afford to buy health insurance on the exchanges. But, because of the short-term insurance plans now being offered, she was finally able to purchase insurance that they could afford.

He noted that on a previous insurance, if they paid all their premiums and met their deductible, they would have spent \$18,000 out of pocket before they accessed the first bit of healthcare.

So that brings me to today and this word “sabotage.” I don’t think these short-term plans are a long-term solution for people buying health insurance, and the administration agrees with that, which is why they are only available for up to 3 years.

But they do help provide option for folks back home who feel like they have no place else to go. I definitely don’t see them as sabotaging the ACA—more so as enhancing the intent, however misguided the execution of the ACA, of providing more people with health insurance.

Ms. Turner, in your testimony you noted these plans were helpful for early retirees like my constituent who needed to bridge the gap after losing employer-sponsored healthcare. I think that is definitely true with the folks I have talked to.

But one criticism of the short-term plans I have heard today has been that consumers may not be sufficiently educated on the restrictions and limitations that come with these policies. They may not understand the tradeoffs for lower premiums.

In my conversation with my constituent, he recognized his wife did not have coverage for everything but that the plan covered everything they needed.

Ms. Turner, yes or no: The final rule provides a disclosure notice that must be prominently featured on the insurance materials. Is that correct?

Ms. TURNER. Yes, sir.

Mr. HUDSON. It appears from my anecdotal experience that those disclosure notices are working. Would you agree with that?

Ms. TURNER. Yes, sir.

Mr. HUDSON. I appreciate that. One other issue that has been raised—and if I could stick with the John Dingell yes-or-no answers—Ms. Keith, I believe New Jersey and California have limited or banned the sale of short-term limited duration insurance plans. Is that correct? Yes or no.

Ms. KEITH. That is correct, yes.

Mr. HUDSON. And Commissioner Altman, do other States have the authority under the Trump administration's action to limit or ban short-term limited duration plans if they choose?

Ms. ALTMAN. Yes.

Mr. HUDSON. So if that is true, then, that if any State doesn't like the new arrangements, they are free to pass their own laws limiting or banning short-term limited duration insurance plans.

I think that is just important to note for the record that, you know, States have the option here and States are looking for solutions for their constituents, a lot of them in the cases like the one I described of my constituents who are just trying to bridge a gap, who are trying to find a way to afford insurance for their families.

So I think it is important to note that we are not forcing anyone into this. We are giving flexibility to the States, and I would love to see us do an extended hearing, Madam Chair, where we bring in some folks from the States to talk about are these plans really working.

We hear a lot of discussion from the other side about this could do that, it could be that. But let us look at what the facts are and what is really happening on the States. I think that would be really important.

So with that, I will yield back.

Ms. ESHOO. I thank the gentleman.

I now would like to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, a new member of the committee. We are thrilled that you are here. You are recognized for 5 big minutes.

Ms. BLUNT ROCHESTER. Thank you, Madam Chairwoman, and also thank you to the witnesses today. I also would like to send my condolences to the Dingell family on the passing of such a legend as John Dingell.

In 2017 in January, the Trump administration halted all ACA marketplace outreach for the final week of the 2017 open enrollment and then slashed ACA enrollment funding for advertising and outreach by a staggering 90 percent—90 percent.

Delaware's marketplace, forced to do more with hundreds of thousands of dollars less in funding, saw a decrease in enrollment every year since then, down 20 percent since the State's peak enrollment in 2016.

The administration's repeal efforts and damage to the Affordable Care Act have resulted in new enrollments going down and costs going up for the over 22,000 Delawareans and 8.5 million Americans receiving their health insurance through the individual marketplace.

These Delawareans are now paying more than \$100 in premium costs over what they paid before over the national average, and I really—I heard my colleague Mr. Hudson's point about the word "sabotage," and as I was sitting here thinking of what I would even say, you know, the saying "If it walks like a duck and quacks like a duck, it must be a duck" came into my head.

And it came into my head because, when you shorten the amount of time that people have to apply and then you couple that with slashing information and outreach to people, it appears and it feels like sabotage, and I am really proud to have been able to introduce

the MORE Health Education Act to restore funding for educational outreach.

All of the bills that we are discussing here today will help Americans enroll in quality comprehensive plans in the marketplace, and they will ultimately lower costs. But, more importantly, the goal is to make Americans healthier.

And so my first question is, number one, I just want to clarify, Ms. Turner, that this particular bill was for marketing and outreach and not the navigators. But you will probably see more coming forward.

But I wanted to ask Ms. Keith to clarify something that was stated, that marketing doesn't work. Can you just talk about, does marketing work? People say, "We already know about the ACA, why do we need to have marketing?"

Can you share a little bit about that?

Ms. KEITH. Thank you for that question. It is very important.

Multiple studies, including studies conducted by CMS itself, have shown the value of advertising and marketing outreach under the ACA in particular. One of the changes by making such dramatic cuts to the advertising budget is that, beginning in 2018, CMS ran no TV advertisements, even though that was one of the most cost-efficient ways of reaching people and had a measurable impact on people enrolling.

I think Ms. Turner has cited California having lower new enrollees this year. I think it is worth noting that California has had the same enrollment overall, and I think part of that is that new enrollees—California had strong enrollment of new enrollees in previous years, and I think the State would point to things like loss of the individual mandate as reasons why perhaps new enrollment is lower. But I did want to clarify that, that enrollment in California is stable.

Ms. BLUNT ROCHESTER. Got you. Great. And also, I wanted to follow up with that. Why do you think we still need outreach and marketing?

Ms. KEITH. Awareness remains low. Documented studies have shown this. Even as of November of last year there were about 69 percent of uninsured consumers and consumers who had purchased individual coverage who did not know the deadline was December 15th or had the date wrong. Sixty-nine percent of folks who we are trying to reach for this type of coverage who would be eligible are not aware of their options, and outreach and marketing plays a key role in that.

I would just emphasize that we are seeing very aggressive marketing of the short-term plans as well, and so, as we have seen cuts to ACA outreach and marketing, it is being filled, this void is being filled by these short-term plans, and it is very confusing for many consumers.

Ms. BLUNT ROCHESTER. And Commissioner Altman, can you talk about the State of Pennsylvania and what impact these kinds of cuts have had?

Ms. ALTMAN. Sure. So Pennsylvania, under a prior administration, chose to use the Federal exchange. So we rely on CMS and the Federal Government to operate our exchange, and marketing and outreach are supposed to be a core element of that.

And so, in my perspective, when the Federal Government ceased doing that and ceased trying to reach out to Pennsylvanians, they weren't meeting those obligations. But they still needed to be met because people are not aware—the number of consumers I talk to who don't know basic information.

We have tried to fill that gap with our own campaign, but our resources are certainly limited.

Ms. BLUNT ROCHESTER. Great. Thank you so much for your questions.

I would yield back my time in a minute just to say that, even as a Member of Congress, we were limited in what we could say. So I applaud the work of the committee, and I yield back the balance of my time.

Ms. ESHOO. I thank the gentlewoman, and we are thrilled that you are part of the committee.

It is a real pleasure to recognize the gentlewoman from Indiana, a wonderful colleague and a good friend, value added no matter where she is in the Congress—Mrs. Brooks.

Mrs. BROOKS. Thank you, Madam Chairwoman, and I just want to also have the opportunity—this is my first opportunity to publicly congratulate you on leading this important committee, and I look forward to continuing our work that we have done in the past, particularly on Pandemic All-Hazard Preparedness Act and many other areas, and look forward to your work and working with you on this most important subcommittee.

I want to focus a little bit on the marketing, because my colleague talked about marketing and, Ms. Turner, marketing and outreach is an incredibly important aspect of any product. I assume you would agree with that.

However, the more products and the more choices there are, marketing—there have to have products that people want to consume and/or want to—and/or understand what it is they are consuming.

And, like so many others, I have many Hoosiers who have shared with me that the high cost of the premiums and the high deductibles are what so many—you know, their barriers have been to purchasing a lot of the products.

So can you help us understand why having more choices—however, it needs to be informed choices, and I agree that there is a concern whether it is with different types of products—people have to understand what they are buying, and that is, I think, what the biggest problem is with these short-term products, is they don't quite understand what is covered and what is not covered.

Can you please talk with us about why having more choices is better for healthcare overall for consumers regardless of their health status?

Ms. TURNER. It does give them options. It gives them options of networks, doctors, the hospitals that are available to them and, unfortunately, and I think about half of counties, people in ACA coverage have a choice of one plan. It is take it or leave it, so there is really no choice there at all.

And people who can't afford that coverage are now being given other options through short-term plans and other administrative ideas.

Mrs. BROOKS. Can you share with us a little bit about how the Federal Government might be able to increase enrollment? Are there other ideas that any of you might have as to how the Federal Government might be able to increase enrollment in health insurance aside from spending money on marketing and navigators?

Ms. TURNER. If the policies were more affordable, if there were more competition in the market so that the one provider doesn't have the opportunity to buy up all the doctors and hospitals and charge higher premiums, giving people more competition in these markets—so looking at the anticompetitive monopolies that some of these hospitals and systems have is important, but also providing more options through Section 1332 for States to tailor their risk models so that the highest-risk people are not in the same pool with everybody else and driving up premiums, driving the healthy people out. I think this has got to be a State-based solution and the 1332 that was a part of the original ACA was envisioned to give States that flexibility.

Mrs. BROOKS. Talking a bit more about that, how have Section 1332 waivers—have they increased access to care in the States that have approved waivers, and can you give any examples—

Ms. TURNER. Absolutely.

Mrs. BROOKS [continuing]. Of access to care?

Ms. TURNER. Access to care—and which is, of course, in many people's case it is access to coverage to help finance that care. But in Arkansas, Minnesota, Oregon, Maryland, Maine, New Jersey, Wisconsin, those are many of the States that already have requested waivers to spend some part of the ACA money themselves in a way that does a better job of risk mitigation—high-risk pools, reinsurance, invisible high-risk pools—to give—to separately subsidize the people who have the highest costs so that you can then lower premiums for others in the individual market and attract more people, which then further lowers premiums.

Everybody wants more healthy people in these insurance pools. The ACA is working against that. Section 1332 gives States tools to be able to get more healthy people into their markets.

Mrs. BROOKS. Thank you. I yield back the balance of my time.

Ms. ESHOO. I thank the gentlewoman.

And it is a pleasure to recognize from California another new member of our subcommittee, and she is so welcome, the gentlewoman Ms. Barragán.

Ms. BARRAGÁN. Thank you, Madam Chairwoman.

I want to thank you all for joining us here today. We have heard a lot about these junk plans in my first term as a first—as a new Member of Congress. It feels like we just had all kinds of conversations about healthcare and it was centered around repealing the Affordable Care Act, which would limit access to healthcare to people.

So it is nice to be able to have this conversation and actually have a debate on what some of what has been happening over the last 2 years is doing to pricing and as a result of some of the policies that have been implemented for the last 2 years.

I myself am a cosponsor of what we are talking about today—to eliminate these junk plans—and I want to talk a little bit about

that. One of my colleagues on the other side said, let us talk about the facts—let us talk about what is happening.

You know, we received the story of Sam Bloechl from Chicago, and I want to share his story because I think it is important to highlight what is happening and what people are going through.

Now, Sam's story was brought to us by the Leukemia and Lymphoma Foundation. Sam unknowingly enrolled in a junk plan after he was deceptively steered into it by a broker.

Now, Sam had been experiencing back pain and he was completely transparent about this when he talked to the broker about his condition. Sam writes in a letter to the committee that he thought it would be smart to talk to a broker about upgrading his coverage so he could have better healthcare access for any future medical care.

Now, the broker assured Sam that the junk plan was the right insurance plan for him, given his back pain. After enrolling in the junk plan, Sam was diagnosed with an aggressive form of blood cancer—non-Hodgkin's lymphoma.

After undergoing 6 months of chemotherapy and radiation, his insurance company informed him that they were not going to pay for the treatment, leaving him with \$800,000 in medical bills.

The insurance company also refused to pay for a bone marrow transplant, treatment necessary to allow Sam to achieve lasting remission. Now, Sam writes in his letter that the insurance company claimed that cancer was a preexisting condition because he had previously visited a chiropractor for his back pain.

Sam was left with almost a million dollars in medical bills and no insurance—and no health insurance for the treatment that he needed in order to stay alive.

Now, while fighting cancer, Sam is also trying to figure out how to avoid bankruptcy. Sam is only 32 years old and a business owner. He writes that instead of planning for his future with his fiancé and building his business, he is left up at night wondering how to stay afloat.

So I want to start by entering Sam's letter to the committee into the record now. And I also—Madam Chairwoman, can I enter that into—thank you very much.

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

Ms. Keith, can you discuss how insurance companies are able to essentially defraud patients like Sam?

Ms. KEITH. Certainly. So it sounds like Sam was a victim of something called postclaims underwriting, which is something we have been discussing where his back pain, which he disclosed, was used as a reason to deny coverage for his cancer treatment and care, leaving him on the hook for all these bills.

I think other ways that short-term plans have exposed consumers to high out-of-pocket costs like this is through their refusal to cover preexisting conditions, the benefit gaps.

But even when you think you fully understand the product and you disclose your back pain and you think you know what you are getting, to be surprised that your cancer treatment wouldn't be covered I think is something that is very troubling for patients and consumers—the stories that we are hearing all across the country.

Ms. BARRAGÁN. Right.

Commissioner Altman, could you describe the impact of the Trump administration's decision to expand the junk plans on patients who may be in a similar situation to Sam?

Ms. ALTMAN. Yes, and thank you for sharing that story. I think that story is so indicative of many of the pieces we have talked about today, from limited benefits to deceptive marketing practices which are, for the record, illegal, to postclaims underwriting and, frankly, also to the fact that something like this can happen to anyone, and that is why every person needs comprehensive health insurance to cover things like unexpected cancer diagnoses, and the story is also one that demonstrates the short-term plans are not that.

Ms. BARRAGÁN. Well, thank you. I know. Sam writes that somebody shouldn't have to worry about filing for bankruptcy or getting stuck with \$800,000 in medical bills. I agree. I think that is why we are having the hearing today. I also think that is why having legislation to protect individuals like Sam and reverse the administration's attacks on Americans with preexisting conditions is important.

And with that, I yield back.

Ms. ESHOO. I thank the gentlewoman.

I am now pleased to recognize the ranking member of the subcommittee, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Thank you for the recognition. Thanks to our witnesses for being here. I know it has been a long morning and now afternoon, but I appreciate your input into this important subject.

Ms. Turner, let me ask you—probably 2 years ago, I guess in March of 2017, the Health Affairs published the article on the invisible high-risk pools that the State of Maine had used to rescue its insurance industry after their attempt at community rating guaranteed issue got them into so much difficulty in the individual market. The invisible risk pool was a way to sort of reconstitute that market. Would you qualify those as junk plans?

Ms. TURNER. I think that the risk pools actually provide the social safety net so that, if somebody does wind up in a situation like Janet that I describe in Colorado who had insurance but when she was diagnosed with hepatitis C, the high-risk pool in the State was there to provide her care and, ultimately, pay for her \$600,000 liver transplant. So there are other options available than the ACA, and we have seen those in the past, and Maine is another example.

Mr. BURGESS. Great. Thank you.

Madam Chairwoman, just before we finish up, I am going to have another—a couple of unanimous consent requests so that I don't get gavelled out. I just would like to make that information available to you.

Now, Ms. Turner, staying with you, one of the issues I brought up in my opening statement was the issue of global budgeting. Can you speak to how a global budget system would impact patients and the healthcare system at large?

Ms. TURNER. Whoever controls the money is going to control the choices, and whoever is controlling that global budget, whether it is a regional health administrator, whether it is a Federal bureaucracy, whether it is a hospital system, is going to control the choices for that patient and they are going to allocate the money in a way

that I am sure they will believe is going to be the fairest way possible, but it always winds up they wind up with shortages, they wind up with waiting lines.

We have seen in California—I am sorry, in Canada—that hospitals have to close in December because they have run out of money. So I think that it significantly diminishes individual patient choice, and it often leads to rationing of care.

Mr. BURGESS. While we are on the subject of Canada, it is my understanding that Canada is opposed to the system in the United States where, if a bill is submitted by CMS it is paid. In Canada, there is a fixed budget and, once that budget is exhausted, the bills are held until the next year. So a fundamental difference in the approach.

One of the things that has concerned me for some is that you do see that there is an effort to create a single-payer, Government-run system, and you see this not just in the United States.

I mean, this has been something that has been ubiquitous across the world. Why is that? Why does a country want to control something that inherently should be an individual issue?

Ms. TURNER. Now, I have thought about this for many years, and I do believe that there is a sense of fairness—that if everybody is in the same system that everybody will be treated the same.

But that is not the way that it works in any country that has some form of a Government-centralized healthcare system. The affluent people always find a way to buy out of it, and people who have fewer means always wind up with their care rationed and limited.

Mr. BURGESS. So does it concern you, some of the statements we have heard about pushing to that type of system, particularly those that say we are going to void any private insurance? The large group market would disappear of necessity under a single-payer system in this country.

Ms. TURNER. With 173 million people in the employer health insurance market that value their coverage, I think that would be very problematic. When you have 60 million people on Medicaid that value that coverage and that would see it compromised if we had another 200 and what would be 70 million people on that program.

So I think that there—the system as it is has evolved over decades, and I think it is important to build on that system and figure out how do we help these 15 million people who are in the individual market who are the most exposed to the high premiums and the high cost, the high deductibles, and the possibility of losing their coverage.

Mr. BURGESS. I do know when I ran my medical practice, obviously, I was in the small group market when I bought insurance for my employees. I would have welcomed the ability to go into an association health plan.

If county medical societies across the country had put together a group health insurance model, that would have been welcome news for me and those patients would have been protected from preexisting conditions, unlike others in the individual market.

So thank you so much for your time today, and I will yield back.

Ms. ESHOO. Thank you, Dr. Burgess.

Let us see. It is now my pleasure to recognize the gentleman from California, Mr. Cárdenas.

Mr. CÁRDENAS. Thank you very much, Madam Chair and Ranking Member, for putting this very important hearing together in full view of the public, and I want to thank the witnesses for being here as well—the ones I agree with and the ones I disagree with. Thank you so much for providing your perspective.

Since the passage of the Affordable Care Act in 2010, more than 20 million Americans have gained meaningful access to insurance coverage. Before Donald Trump became President, the uninsured in this country fell from 18 percent to 11 percent, the biggest jump in any period of time in the country's history.

Yet, basically, since day one the Trump administration has actively undermined the law and attacked Americans' healthcare. The administration cut the advertising and enrollment budget from \$100 million to \$10 million. This has had a very real consequence, and I have heard stories from my own district where constituents mistakenly believed that the healthcare exchanges ended with the Presidency of President Obama.

The administration's sabotage efforts have resulted in the highest uninsured rate in 4 years. According to a Kaiser Family Foundation study, over 80 percent of uninsured adults were not aware of the deadline to enroll in coverage in 2017. Again, it was this Trump administration that reduced the enrollment administration's advertising budget from \$100 million to \$10 million.

Another survey by the Commonwealth Fund said that 41 percent of uninsured adults are still unaware of the ACA marketplaces or that subsidies are available to help them pay for coverage.

The Trump administration is strangling healthcare for millions of people and undermining the law of the land.

Ms. Keith, I understand that uninsured Americans are less likely to be aware of the deadlines or availability of affordable coverage. Is that a correct statement of today?

Ms. KEITH. That is correct, yes.

Mr. CÁRDENAS. OK.

Also, Ms. Keith, can you briefly describe how gutting funding for outreach and enrollment impacts new enrollments?

Ms. KEITH. Certainly. New enrollees tend to be younger and healthier. As you can imagine, patients who are older and have health conditions are very motivated to enroll in coverage.

It is really younger and healthier consumers who aren't aware and need to better understand the marketplace options available to them. What we have seen is since 2016 new enrollment through healthcare.gov is down by about 50 percent.

We need younger and healthier consumers to help keep the risk pools stable and help keep premiums down. I believe I mentioned earlier Covered California attributes its marketing in 2015 and 2016 to a reduction in 6 to 8 percent in premiums. So advertising can pay off in terms of sort of bringing in younger and healthier people who need coverage for themselves but also help the risk pool.

Mr. CÁRDENAS. Now, Ms. Keith, can you describe how what you just described—younger, healthier patients not enrolling—how that affects other Americans' ability to get comprehensive healthcare?

Ms. KEITH. Sure. By not having younger and healthier folks in or having fewer and fewer new enrollees, there is a possibility that premiums will increase.

Mr. CÁRDENAS. OK.

Ms. Altman, what is the level of awareness among consumers in Pennsylvania, for example, about the ACA and their healthcare options in the ACA marketplaces?

Ms. ALTMAN. I would say that my experience in speaking to Pennsylvanians is very reflective of the study that Ms. Keith mentioned. In particular, there seems to be a significant lack of awareness about the financial support available under the Affordable Care Act.

Many consumers come to enrollment events and think there is no way they will be able to afford the coverage, only to find out that it is all more affordable than they ever thought it could be.

Mr. CÁRDENAS. Thank you. And also, Ms. Turner, you mentioned something that, as a former business owner, on the face of it I would probably agree with but I don't agree with in this case about how we are trying to provide comprehensive healthcare to as many Americans as possible, and I quote, "individual patient choice."

When I was a little boy, my parents had an individual patient choice, and they chose to go without insurance coverage because it was too far out of reach for my family's single-income, first-grade-education immigrant father who was a gardener.

He couldn't be a CEO—didn't aspire to be, or what have you. But he provided food on the table for 13 people every single day, and I am so proud of him and my mother for doing what they could with what little they had.

Also, my parents' individual choice was to not participate in preventative medicine practices like going to see a doctor because even that was too expensive for us to do as a low-income family.

My parents' individual patient choice was to look at us and pray for us when we got a bad fever or something and then, now and again, once in a while, say it is time to go—time to take us to the emergency room.

Not to our regular care doctor, not to a place where we could actually be preventative in these measures, but the dangerous choice of waiting to the last minute to decide, "I think my child is in very serious danger. Now it is time to go to see a doctor." That is individual choice that the Affordable Care Act, as flawed as it is, has been trying to overcome, and it was able to overcome that for tens of millions of people that before were like my family when I was growing up.

Thank you very much, Madam Chair. I yield back.

Ms. ESHOO. I thank the gentleman. You just saw and heard passion on display.

Now, we have two Members that have been waiting very, very patiently. They are members of the full committee. Ms. Schakowsky is also a chair of a subcommittee, and the rules of the committee allow for Members that are not part of this subcommittee to come and to participate, but they have to come last.

So thank you to the gentlewoman from Illinois and for her great service on this subcommittee in previous Congresses. I recognize her for 5 minutes of questioning.

Ms. SCHAKOWSKY. I thank you, Chairman Eshoo, for allowing me to waive onto the subcommittee, a subcommittee I served on for 16 years, and I am happy to be here today.

I just wanted to point out that the State of Illinois passed legislation preventing these short-term—we call them junk plans, because there was a robust debate about those.

And while we saw 7 percent lower enrollment, I think it could have been even higher had—that we could have done better had the—I call it—I do call it sabotage of limiting the navigators.

Ms. Turner said that only 1 percent of the navigators had anything to do with it. Has the public program that was essentially defunded been helpful, and would we have had more enrollment had we had the dollars to advertise the programs?

Both of you, actually.

Ms. KEITH. Absolutely, and I think when we talk about navigators, who we are really talking about is community-based organizations, United Ways, legal aid societies, American Cancer Society, organizations like that who are sort of bedrock institutions in the community.

Although some of that data I think has been disputed on navigators, I will say under the statute navigator enrollment is only one of the five things that navigators are supposed to work on. Their real goal is to help folks with limited English proficiency, lower-income folks.

They have a lot of other things they are doing that aren't just enrollment. So I think having those navigators there is really helping families with complex conditions, families who need a little bit of extra help to get enrolled.

And then to your question, I tend to agree—if we had outreach and marketing funding you would—the marketplaces sort of remain stable even with these cuts, but at least one study has showed that we should have 2.3 million more new enrollees at a minimum. So the marketplace should be much bigger than it is.

Ms. ALTMAN. Just speaking for Pennsylvania, I can say that the navigator organizations in Pennsylvania are incredibly committed and incredibly effective in reaching people and helping the most challenged individuals through their healthcare questions and issues and enrolling people both in the marketplace and in Medicaid as well, particularly with the expansion, and especially in reaching groups of people who are not going to be reached otherwise—those who have specific healthcare needs.

One of our navigator organizations focuses on individuals with mental health conditions, focusing on groups for whom English is not their primary language. We have other navigator organizations focused on certain communities in that category. And so they do fill a very unique void.

Ms. SCHAKOWSKY. Let me interrupt. I have little time left. I wanted to refer to a bill, H.R. 1143, that Representative Eshoo sponsors. But I wonder if either of you are knowledgeable about the Georgetown University Health Policy Institute findings about really what has happened when brokers are telling people about these plans and how they concluded that insurance brokers selling these plans engaged in deceptive marketing practices.

Ms. KEITH. Thank you for that question. This was a study done by my colleagues on the really aggressive marketing and outreach we've seen in short-term plans. By and large, there are a lot of ads funded going towards marketing of these short-term plans.

Brokers—we found instances where brokers were very aggressive by phone—you have a lot of robocalls—brokers who would refuse—really wanted someone to purchase while they were on the phone and refused to provide written information at all. You are seeing plan—or website, web brokers saying that they sell ACA plans and short-term plans but then only allowing enrollment in short-term plans. I worry—

Ms. SCHAKOWSKY. And did some of those people think they were getting a comprehensive ACA plan?

Ms. KEITH. I am sure that is true. It is very confusing.

The other thing I was going to add is that we have seen steering. So even when patients might be eligible for subsidies or consumers might be eligible for subsidies through the marketplace, being directed to a short-term plan when they might qualify for a much cheaper, more comprehensive policy.

Ms. ALTMAN. I will just add very quickly that my department has had to revoke the insurance licenses of a number of agents and brokers who have done exactly what you said and lied to consumers and told them these plans are things that they are not, and it is falling to States to do what we can to be vigilant in a very active marketplace with a lot of marketing that is very questionable.

Ms. SCHAKOWSKY. Let me just say choice is a good thing. It needs to be informed choice. People really need to know what is going on, and these plans—I am happy that they were outlawed in the State of Illinois.

I yield back. Thank you very much for letting me be here.

Ms. ESHOO. Thank you for your patience and your attendance.

I now would like to recognize another member of the full committee—not of the subcommittee but always welcome here and a new member to the full committee, the gentleman from Florida, Mr. Soto. You are recognized for 5 minutes.

We are going to vote pretty soon, too.

Mr. SOTO. Thank you. Yes, I will be efficient. Thank you, Chairwoman Eshoo.

So sabotage of the ACA—allow me to count the ways. Let me just go through the top five as I see it: first, eliminating cost-sharing subsidies, that raised rates; second, cutting enrollment period in half; third, cutting marketing dollars in half or more; fourth, eliminating high-risk corridors, hurting competition; and fifth, eliminating individual mandates.

One that we still need to talk about is, there was an attempt to eliminate preexisting conditions in the Trumpcare bill that did not pass, thank God, but if we didn't stop them, we would have seen even that sabotaged.

I think all parties can agree this was a big issue in the last election and that Americans want us to get to work on bipartisan solutions on it. I come from the State of Florida, home to the largest Federal exchange in the Nation—1.7 million Floridians are on the ACA exchanges, up 50,000 from last year.

So, first, I would like to get a potential consensus here from the witnesses. Yes or no: Did eliminating the cost-sharing by the Trump administration and the last Congress raise rates altogether?

Yes or no, and we'll start with Ms. Keith.

Ms. KEITH. Yes, it did.

Mr. SOTO. Ms. Altman?

Ms. ALTMAN. Absolutely.

Mr. SOTO. Ms. Turner?

Ms. TURNER. It was not—funding was not included in the original law, and this Congress was trying to provide the funding in context of larger reforms.

Mr. SOTO. So I will take that as a no. OK.

And then, for my second and final question: Why would a State like Florida still have an increase in ACA enrollment even with these five clear sabotages of the ACA opinions?

We will start with Ms. Keith.

Ms. KEITH. One response is that there is still continued demand for the type of coverage that the ACA provides for comprehensive, affordable, quality coverage. At the same time, you still have subsidies available for most folks who enroll through the marketplace, and that has been, I think, the enduring stability of these programs.

Mr. SOTO. Ms. Altman?

Ms. ALTMAN. Just reiterating, I think that demonstrates the value proposition that the comprehensive coverage along with the financial assistance available on the marketplace provides to millions of Americans.

Mr. SOTO. And Ms. Turner?

Ms. TURNER. Maybe sort of ending on a bipartisan note, there is such broad agreement that we need to help people to purchase coverage who are shut out of the market for whatever reason and make it more affordable. I hope to work with you in doing that.

Mr. SOTO. Just to conclude, you know, Florida is a giant State, third largest in the union, and a lot of our constituents don't have access to the foundational plans of this Nation—employer-based plans—that so many Americans are on, particularly because they may work in the service industry or the agriculture industry, which is why the ACA continues, despite all the sabotages, to be a smashing success in my State, because this is really the only option people have.

So from Florida's perspective, we cannot let this fail, and despite attempts to make it fail it has still thrived for us to still be the largest Federal exchange in the Nation.

So I look forward to hearing from all of you on that in the future and work with the committee, and thank Chair Eshoo for the opportunity.

And with that, I yield back.

Ms. ESHOO. You are always welcome here. I would—I think that this is—we have concluded the questioning of both the guests of the subcommittee and all the Members.

I want to thank the witnesses again. I think that each one of you did an outstanding job. I don't necessarily agree with you, Ms. Turner, but you worked hard to answer the questions, and I certainly appreciate that.

Ms. TURNER. Thank you, Chairman.

Ms. ESHOO. I also want to thank the authors of the legislation. They are not here now, but I think to say this for the record that they have worked hard on these bills, and I want to thank Congresswomen Castor, Kuster, and Blunt Rochester.

And I also would like to ask for unanimous consent to place into the record the following: the letter of endorsement from the AARP for all of the bills that were discussed today, a letter of endorsement from the American Academy of Physicians, the testimony for the record from Sam Bloechl, a letter of endorsement from the Federation of American Hospitals—that is an endorsement of the legislation that was discussed today—the same from the American Medical Association on the four bills, the letter from the American Lung Association in support of H.R. 987, letter from the American Lung Association in support of H.R. 1010, statement from the American Lung Association in support of legislation repealing 1332, statement from the American Heart Association in support of H.R. 1010, statement from the American Heart Association in support of H.R. 986, statement for the record from the Association for Community Affiliated Plans, a statement for the record from America's Health Insurance Plans, a letter from 23 health partners and patient advocacy groups to the Trump administration expressing strong concerns with the Section 1332 waiver guidance, a letter from 23—I am almost done—23 health partners and patient advocacy groups to the Trump administration expressing strong concerns with the short-term limited duration insurance final rule, a letter from the American Hospital Association, and a statement of support from Families USA.

Not hearing any opposition, these items will be placed in the record.

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

And I would like to recognize Dr. Burgess for his request for items to be placed in the record.

Mr. BURGESS. So, Madam Chair, I have a unanimous consent request to place into the record a statement for the record submitted by the Coalition to Protect and Promote Association Health Plans.

I also would like to submit for the record an article from the Washington Post, "The Health 202: Association health plans expanded under President Trump look promising so far," and I appreciate your offer to have a hearing on association health plans.

We have heard some discussion about lifetime limits, and I would point out that even under Medicare there are sometimes what are called therapy caps. Therapy caps were repealed for physical therapy and occupational therapy last year in the bipartisan Budget Act of 2018.

But I would just like to submit for the record the members of the committee who voted against that and therefore voted against repeal of therapy caps in the bipartisan Budget Act, and I thank you for the consideration.

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

I will yield back.

Ms. ESHOO. I thank the gentleman.

We don't often enough say "thank you" to the staff to the committee, and so on behalf of all of the members of the subcommittee

I want to thank both the majority staff and the minority staff for the work that they do to help prepare us, to bring the witnesses forward, to draw up some of the talking points and the answers to questions that may be asked, and it is sincere thanks from all of the members of the subcommittee.

So with that, I think we will make it over to the floor and maybe even be there, Dr. Burgess, before the bells ring.

Thank you again to the witnesses, the time that you have given to us, and, you know, your commitment to these issues by dedicating your lives to them. It is in no small measure, I think, a gift to the country.

Mr. BURGESS. So do we have five legislative days to submit questions for the record?

Ms. ESHOO. We do, and we have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared and, of course, we trust and I ask that the witnesses respond promptly to any questions that you may receive, and we have already placed what we wish to place into the record.

So at this time, the subcommittee is adjourned.

[Whereupon, at 1:28 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

.....
 (Original Signature of Member)

116TH CONGRESS
 1ST SESSION

H. R. 1010

To provide that the rule entitled "Short-Term, Limited Duration Insurance" shall have no force or effect.

IN THE HOUSE OF REPRESENTATIVES

Ms. CASTOR of Florida introduced the following bill, which was referred to the Committee on _____

A BILL

To provide that the rule entitled "Short-Term, Limited Duration Insurance" shall have no force or effect.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT-TERM LIMITED DURATION INSURANCE**

4 **RULE PROHIBITION.**

5 The Secretary of Health and Human Services, the
 6 Secretary of the Treasury, and the Secretary of Labor
 7 may not take any action to implement, enforce, or other-
 8 wise give effect to the rule entitled "Short-Term, Limited
 9 Duration Insurance" (83 Fed. Reg. 38212 (August 3,

- 1 2018)), and the Secretaries may not promulgate any sub-
- 2 stantially similar rule.

.....
(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 986

To provide that certain guidance related to waivers for State innovation under the Patient Protection and Affordable Care Act shall have no force or effect.

IN THE HOUSE OF REPRESENTATIVES

Ms. KUSTER of New Hampshire introduced the following bill; which was referred to the Committee on

A BILL

To provide that certain guidance related to waivers for State innovation under the Patient Protection and Affordable Care Act shall have no force or effect.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Protecting Americans
5 with Preexisting Conditions Act of 2019”.

1 **SEC. 2. PROVIDING THAT CERTAIN GUIDANCE RELATED TO**
2 **WAIVERS FOR STATE INNOVATION UNDER**
3 **THE PATIENT PROTECTION AND AFFORD-**
4 **ABLE CARE ACT SHALL HAVE NO FORCE OR**
5 **EFFECT.**

6 Beginning April 1, 2019, the Secretary of Health and
7 Human Services and the Secretary of the Treasury may
8 not take any action to implement, enforce, or otherwise
9 give effect to the guidance entitled “State Relief and Em-
10 powerment Waivers” (83 Fed. Reg. 53575 (October 24,
11 2018)), and the Secretaries may not promulgate any sub-
12 stantially similar guidance or rule.

.....
(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 987

To amend the Patient Protection and Affordable Care Act to provide for Federal Exchange outreach and educational activities.

IN THE HOUSE OF REPRESENTATIVES

Ms. BLUNT ROCHESTER (for herself and [see ATTACHED LIST of cosponsors]) introduced the following bill; which was referred to the Committee on

A BILL

To amend the Patient Protection and Affordable Care Act to provide for Federal Exchange outreach and educational activities.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Marketing and Out-
5 reach Restoration to Empower Health Education Act of
6 2019” or the “MORE Health Education Act”.

1 **SEC. 2. FEDERAL EXCHANGE OUTREACH AND EDU-**
2 **CATIONAL ACTIVITIES.**

3 Section 1321(c) of the Patient Protection and Afford-
4 able Care Act (42 U.S.C. 18041(c)) is amended by adding
5 at the end the following new paragraph:

6 “(3) OUTREACH AND EDUCATIONAL ACTIVI-
7 TIES.—

8 “(A) IN GENERAL.—In the case of an Ex-
9 change established or operated by the Secretary
10 within a State pursuant to this subsection, the
11 Secretary shall carry out outreach and edu-
12 cational activities for purposes of informing po-
13 tential enrollees in qualified health plans offered
14 through the Exchange of the availability of cov-
15 erage under such plans and financial assistance
16 for coverage under such plans. Such outreach
17 and educational activities shall be provided in a
18 manner that is culturally and linguistically ap-
19 propriate to the needs of the populations being
20 served by the Exchange (including hard-to-
21 reach populations, such as racial and sexual mi-
22 norities, limited English proficient populations,
23 and young adults).

24 “(B) LIMITATION ON USE OF FUNDS.—No
25 funds appropriated under this paragraph shall

1 be used for expenditures for promoting non-
2 ACA compliant health insurance coverage.

3 “(C) NON-ACA COMPLIANT HEALTH IN-
4 SURANCE COVERAGE.—For purposes of this
5 subparagraph (B):

6 “(i) The term ‘non-ACA compliant
7 health insurance coverage’ means health
8 insurance coverage, or a group health plan,
9 that is not a qualified health plan.

10 “(ii) Such term includes the following:

11 “(I) An association health plan.

12 “(II) Short-term limited duration
13 insurance.

14 “(D) FUNDING.—Out of any funds in the
15 Treasury not otherwise appropriated, there are
16 hereby appropriated for fiscal year 2020 and
17 each subsequent fiscal year, \$100,000,000 to
18 carry out this paragraph. Funds appropriated
19 under this subparagraph shall remain available
20 until expended.”.

21 **SEC. 3. DETERMINATION OF BUDGETARY EFFECTS.**

22 The budgetary effects of this Act, for the purpose of
23 complying with the Statutory Pay-As-You-Go Act of 2010,
24 shall be determined by reference to the latest statement
25 titled “Budgetary Effects of PAYGO Legislation” for this

G:\P\16\HACA\ECDO\OUTREACH-ED_01.XML

4

1 Act, submitted for printing in the Congressional Record
2 by the Chairman of the House Budget Committee, pro-
3 vided that such statement has been submitted prior to the
4 vote on passage.

.....
 (Original Signature of Member)

116TH CONGRESS
 1ST SESSION

H. R. _____

To amend title XXVII of the Public Health Service Act to require a health insurance issuer offering short-term limited duration insurance to include a standardized disclosure and certain information with respect to coverage exclusions and premium variations in marketing, application, and enrollment materials distributed in connection with such insurance and prohibiting the sale of such insurance during certain periods.

IN THE HOUSE OF REPRESENTATIVES

Ms. ESTROO introduced the following bill; which was referred to the Committee on _____

A BILL

To amend title XXVII of the Public Health Service Act to require a health insurance issuer offering short-term limited duration insurance to include a standardized disclosure and certain information with respect to coverage exclusions and premium variations in marketing, application, and enrollment materials distributed in connection with such insurance and prohibiting the sale of such insurance during certain periods.

I Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Educating Consumers
3 on the Risks of Short-Term Plans Act of 2019”.

4 **SEC. 2. REQUIRING A HEALTH INSURANCE ISSUER OFFER-**
5 **ING SHORT-TERM LIMITED DURATION INSUR-**
6 **ANCE TO INCLUDE A STANDARDIZED DISCLO-**
7 **SURE AND CERTAIN INFORMATION WITH RE-**
8 **SPECT TO COVERAGE EXCLUSIONS AND PRE-**
9 **MIUM VARIATIONS IN MARKETING, APPLICA-**
10 **TION, AND ENROLLMENT MATERIALS DIS-**
11 **TRIBUTED IN CONNECTION WITH SUCH IN-**
12 **SURANCE AND PROHIBITING THE SALE OF**
13 **SUCH INSURANCE DURING CERTAIN PERI-**
14 **ODS.**

15 (a) IN GENERAL.—Subpart II of part A of title
16 XXVII of the Public Health Service Act (42 U.S.C.
17 300gg–11 et seq.) is amended by adding at the end the
18 following new section:

19 **“SEC. 2730. INFORMATION REQUIRED TO BE INCLUDED IN**
20 **MARKETING, APPLICATION, AND ENROLL-**
21 **MENT MATERIALS DISTRIBUTED IN CONNEC-**
22 **TION WITH SHORT-TERM LIMITED DURATION**
23 **INSURANCE; LIMITATION ON ENROLLMENT**
24 **PERIOD.**

25 **“(a) PROVISION OF INFORMATION.—**

1 “(1) IN GENERAL.—A health insurance issuer
2 offering short-term limited duration insurance shall
3 include in any marketing, application, or enrollment
4 materials distributed by such issuer in connection
5 with such insurance, in a prominent location set
6 apart from other information—

7 “(A) the standardized disclosure estab-
8 lished by the Secretary under paragraph (2);
9 and

10 “(B) a list of all medical conditions, in-
11 cluding both physical and mental health condi-
12 tions—

13 “(i) which may result in an individual
14 being denied the ability to enroll under
15 such insurance;

16 “(ii) for which such issuer may apply
17 a preexisting condition exclusion (as de-
18 fined in section 2704(b)(1)) with respect to
19 an enrollee under such insurance;

20 “(iii) which may result in an increase
21 in premium amounts for such an enrollee
22 compared to what such amounts would
23 have otherwise been for such enrollee ab-
24 sent such condition; or

1 “(iv) for which such issuer may termi-
2 nate coverage under such insurance with
3 respect to such an enrollee.

4 “(2) ESTABLISHMENT OF DISCLOSURE.—For
5 purposes of paragraph (1)(A), the Secretary shall es-
6 tablish a standardized disclosure with respect to
7 short-term limited duration insurance offered by a
8 health insurance issuer that includes the following
9 information:

10 “(A) A notification that such insurance
11 may not cover preexisting conditions of an en-
12 rollee, including past physical or mental health
13 conditions, regardless of whether such enrollee
14 was aware of such conditions or had sought
15 treatment for such conditions on or before the
16 date of enrollment in such insurance.

17 “(B) A notification that such issuer may
18 rescind coverage under such insurance if an en-
19 rollee seeks treatment for such a preexisting
20 condition, regardless of whether such enrollee
21 was aware of such condition or had sought
22 treatment for such condition on or before the
23 date of enrollment in such insurance.

24 “(C) A notification that such insurance
25 provides limited benefits compared to individual

1 health insurance coverage and does not include
2 all benefits required to be covered under the
3 Patient Protection and Affordable Care Act (in-
4 cluding the essential health benefits package (as
5 defined in section 1302(a) of such Act)) or
6 under this title.

7 “(D) A notification that coverage under
8 such insurance is temporary and may not cover
9 the costs of an enrollee for most hospital or
10 other medical items and services, including both
11 physical and mental health items and services.

12 “(E) A notification that an individual
13 should carefully review the benefits provided
14 under such insurance before enrolling in such
15 insurance.

16 “(F) A notification informing individuals
17 of the opportunity to purchase comprehensive
18 individual health insurance coverage through
19 Exchanges established under the Patient Pro-
20 tection and Affordable Care Act that provides
21 coverage for preexisting conditions without pre-
22 mium increases for such conditions and for
23 which such individuals may be eligible for finan-
24 cial assistance. Such notification shall include

1 information on how such individuals may access
2 such Exchanges.

3 “(b) LIMITATION ON ENROLLMENT PERIOD.—A
4 health insurance issuer offering short-term limited dura-
5 tion insurance may not enroll any individual in such insur-
6 ance during any annual open enrollment period applicable
7 to such individual with respect to an Exchange.”.

8 (b) CONFORMING AMENDMENTS.—

9 (1) ENFORCEMENT.—Section 2723 of the Pub-
10 lic Health Service Act (42 U.S.C. 300gg-22) is
11 amended—

12 (A) in subsection (a)—

13 (i) in paragraph (1), by inserting “, or
14 short-term limited duration insurance in
15 the State,” after “group market”; and

16 (ii) in paragraph (2), by inserting
17 “(or, in the case of such a failure with re-
18 spect to section 2730, in connection with
19 short-term limited duration insurance)”
20 after “individual health insurance cov-
21 erage”; and

22 (B) in subsection (b)(1)(B), by inserting “,
23 short-term limited duration insurance,” after
24 “individual health insurance coverage”.

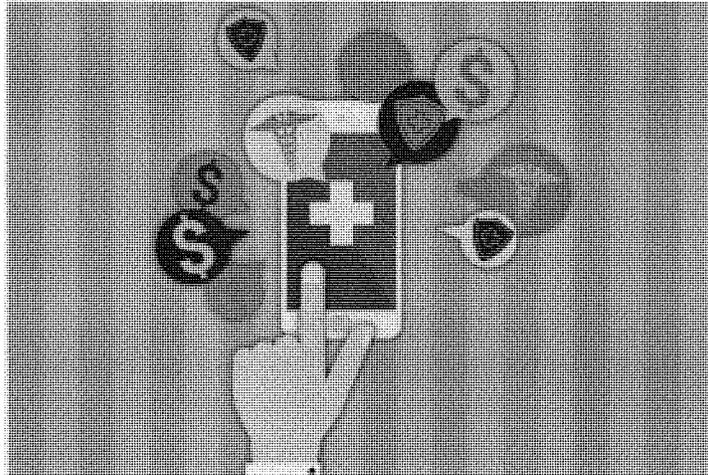
1 (2) PREEMPTION.—Section 2724(a)(1) of such
2 Act (42 U.S.C. 300gg-23(a)(1)) is amended by in-
3 serting “or short-term limited duration insurance”
4 after “group health insurance coverage”.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall apply with respect to marketing, applica-
7 tion, and enrollment materials distributed in connection
8 with short-term limited duration insurance on or after
9 September 1, 2019.



Ads For Short-Term Plans Lacking ACA Protections Swamped Consumers' Online Searches

By **Steven Findlay** • JANUARY 31, 2019



(Caitlin Hillyard/KHN illustration; Getty Images)

Consumers shopping for insurance online last fall — using search terms such as “Obamacare plans,” “ACA enroll” and “cheap health insurance” — were most often directed to websites that promote individual health plans that didn’t meet consumer protections of the Affordable Care Act, according to a new study.

They also failed to get adequate information about those plans’ limitations, according to the analysis by researchers at Georgetown University’s Center on Health Insurance Reforms.

The study, provided to Kaiser Health News, detailed online marketing practices in

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"It was disturbing, but not unexpected, to find such a high proportion of misleading ads and come-ons," said Sabrina Corlette, the lead author. "That raises the risk that consumers could be duped into buying health insurance that they think offers comprehensive and secure coverage, but does not."

The study focused primarily on the marketing of short-term plans, which don't have to meet most ACA provisions, such as the requirement to cover preexisting conditions. The researchers found that regardless of the search term used, companies promoting or selling only these kinds of plans dominated the results.

Insurance regulators from each of the states told Corlette's team that tracking the marketing and sales of short-term plans is challenging, as is educating consumers about the risks of limited coverage.

Michael Conway, Colorado's interim insurance commissioner, told Kaiser Health News in an interview that he has a "high level of concern" that the marketing tactics the study found could have drawn unsuspecting consumers into selections that do not meet their needs.

"We are on alert for complaints," Conway said. "If we have to strengthen our regulations on marketing, we will."

Eric Cioppa, Maine's insurance superintendent, said in an interview that his office has no evidence that consumers unknowingly purchased short-term plans based on misleading online marketing.

"We'll respond accordingly and aggressively if we find that took place," Cioppa said.

But Corlette said the findings provide early evidence that after regulatory changes by the Trump administration, some insurers are aggressively marketing short-term plans as a replacement for traditional health insurance, without fully informing consumers of the limits of the skimpier coverage.

That could warrant stronger f **Stay informed.** x

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The study, funded by the Robert Wood Johnson Foundation, looked at online marketing in Colorado, Florida, Idaho, Maine, Minnesota, Missouri, Texas and Virginia. Those states were selected to reflect diverse geography and regulatory approaches, according to the researchers. Of the eight, Colorado and Minnesota require short-term plans to adhere to a shorter contract duration than required by federal law.

Changes In Short-Term Plan Rules

The ACA bars insurers from denying coverage to people who have health problems or charging them higher premiums. The law also mandates a minimum set of health benefits and requires plans to cap enrollees' out-of-pocket expenses.

By comparison, short-term plans can deny coverage to applicants who have a preexisting condition and often exclude or limit coverage of maternity care, mental health treatment and prescription drugs.

As a result, short-term plans cost significantly less — typically about half to a third of an ACA plan if the deductible is the same. They are sold outside the ACA exchanges. And people who buy them don't qualify for the government's premium subsidies.

These plans are not new. They predate the ACA and allow people to buy coverage between jobs, for example.

The Obama administration put a 90-day limit on such coverage in 2017 because of concerns that the less expensive plans would attract younger and healthier people. Losing such customers could undermine the stability of the ACA marketplaces because they would be left with older and sicker enrollees.

Beginning this year, however, the Trump administration lengthened the potential duration of short-term plans to 364 days and allowed customers to renew the plans.

Seema Verma, the administrator of the Centers for Medicare & Medicaid Services that oversees the ACA insurance coverage that can be "a lifeli

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"These plans are different, and consumers do need to know what they are purchasing, which is why we now require more robust warnings about the limits of these plans than before," she said. "Fundamentally, we believe in giving consumers more options and leaving it up to them to decide what is right for them and their families."

The study evaluated online ads in the weeks just before and during the latest open enrollment for ACA coverage, which in most states began Nov. 1 and ended Dec. 15. The researchers analyzed 256 search results and 65 websites and interviewed state regulators in all eight states.

They found that Google searches were most often topped by paid "lead-generating" websites. Such sites don't sell insurance but ask shoppers for contact and demographic information. Insurers and brokers can buy that information and contact prospective customers. Or, call centers affiliated with the lead-generating sites phone consumers and direct them to a seller.

The researchers also created a profile of a 29-year-old consumer seeking insurance who was in good health and with an income of \$20,000 so she was eligible for premium subsidies for ACA-compliant coverage. They entered this consumer's information into several lead-generating websites and fielded six phone pitches from brokers selling short-term and other non-ACA plans.

Among their findings:

- During ACA open enrollment, only 19 percent of the searches using the common search terms yielded sites offering solely ACA-compliant plans. Before open enrollment, the return was less than 1 percent.
- Lead-generating sites promoting short-term plans or other non-ACA compliant insurance products were the most common search result in every state, representing more than half of all search results before and during open enrollment.
- The six brokers who encouraged the purchase of coverage over the phone provided minimal plan information. Most refused to provide written materials or discontinued the call when asked for more information. **Stay informed.**
- State officials lack full information about the insurance market. Sign up for our free daily news email. **Subscribe now**

Most said they plan to start monitoring the insurers' practices more closely this year.

'Necessary Niche'

An estimated 600,000 to 750,000 people bought short-term plans in 2017. The Trump administration projected last year that about 200,000 ACA customers would switch to this coverage in 2019 due to its rule change. A second government forecast predicted that the new policy would boost short-term coverage enrollment to about 2 million people by 2022.

Insurers who specialize in short-term plans vigorously defend them.

"This is a small and necessary niche in the [individual insurance] marketplace," said Jeff Smedsrud, CEO of Pivot Health, based in Scottsdale, Ariz., and one of the firms whose website the study analyzed. "If people need temporary coverage, we are there for them. We don't want people who qualify for a government subsidy to buy our short-term plans. They should get coverage under the ACA."

Shaun Greene, head of business operations at AgileHealthInsurance.com, said short-term plans offer a more affordable option to people who don't qualify for a government subsidy under the ACA.

But Matthew Fiedler, a health insurance specialist at the Brookings Institution who was not affiliated with the study, said the longer-duration short-term plans may befuddle some customers. The study, he said, "strongly suggests that some consumers are going to be confused and end up with plans that cover less than they expected."

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February 13, 2019

The Honorable Anna Eshoo
 Chair
 House Committee on Energy and
 Commerce
 House Health Subcommittee
 2125 Rayburn House Office Building
 Washington, DC 20515

The Honorable Michael Burgess
 Ranking Member
 House Committee on Energy and
 Commerce
 House Health Subcommittee
 2125 Rayburn House Office Building
 Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

AARP is pleased to endorse H.R. 986, H.R. 987, H.R. 1010, and H.R. 1143. All four of these bills would restore and enforce the core consumer protections of the Affordable Care Act (ACA) and we applaud the Subcommittee on Health for holding a hearing to highlight the adverse impacts recent changes implemented by the Administration have had on health insurance for all Americans, especially those age 50-64.

The Affordable Care Act (ACA) addressed key obstacles in availability of health coverage, particularly for Americans age 50-64. Prior to the ACA, health insurance coverage was out-of-reach for many of these Americans not yet eligible for Medicare. Many paid more for less coverage than they do today and most states permitted insurers to charge older Americans five times or more than those who are younger for the same coverage. In many instances, due to a pre-existing condition, coverage was not only unaffordable but also unavailable. The ACA's elimination of pre-existing condition exclusions and its limit on age-rating of 3:1 - combined with the law's coverage subsidies - are critical to ensuring that pre-Medicare eligible Americans can get and afford quality coverage.

Over the past two years, the Administration has issued rules and guidance that put at risk the critical consumer protections enshrined in the ACA. The most debilitating of these actions to these protections are the STLD plan rule and revised Section 1332 waiver guidance. AARP is extremely concerned that the revised Section 1332 guidance not only allows for the sale of non-compliant, non-consumer protected health insurance plans, but it also allows for these plans to be eligible for advanced premium tax credits (subsidies to purchase coverage). Additionally, we have repeatedly raised concern

Alabama | Alaska | Arizona | Arkansas | California | Colorado | Connecticut | Delaware | District of Columbia | Florida | Georgia | Hawaii | Idaho | Illinois | Indiana | Iowa | Kansas | Kentucky | Louisiana | Maine | Maryland | Massachusetts | Michigan | Minnesota | Mississippi | Missouri | Montana | Nebraska | Nevada | New Hampshire | New Jersey | New Mexico | New York | North Carolina | North Dakota | Ohio | Oklahoma | Oregon | Pennsylvania | Puerto Rico | Rhode Island | South Carolina | South Dakota | Tennessee | Texas | Utah | Vermont | Virgin Islands | Virginia | Washington | West Virginia | Wisconsin | Wyoming

about the expansion of – and lack of consumer protections for – STLD plans in the individual health insurance market. While in some cases these plans may offer lower premiums, the lack of ACA-compliant consumer protections will undermine the use and value of these policies when someone faces a health emergency.

The revised 1332 guidance and STLD plan rule is particularly impactful to Americans age 50-64. For older Americans, a critical aspect of these consumer protections is the prohibition on denying coverage or charging higher rates for preexisting conditions and the prohibition on charging older Americans more than 3 times the rate of the youngest Americans. The 3:1 age rating provision is crucial in protecting older Americans from paying an “age tax;” essentially having to pay exorbitant rates for health insurance coverage simply because of their age. Prior to enactment of the ACA, health insurance carriers were allowed to charge rates that were often five or ten times higher, effectively rendering health insurance unaffordable to older Americans seeking coverage in the individual market. STLDs are not subject to this prohibition on age rating, allowing for insurers to go well beyond the 3:1 limit when pricing these plans for older Americans.

STLD plans can also charge higher premiums or flat out deny coverage for an individual with a preexisting condition. At least 40 percent of Americans between the ages of 50-64 have what could be characterized by an insurance carrier as a preexisting condition¹. As people age, they tend to develop more health problems, including chronic conditions like congestive heart failure, rheumatoid arthritis, and kidney disease. Because STLDs allow for discrimination in coverage or pricing based on a preexisting condition, older Americans are particularly vulnerable to coverage denial in these plans.

While effectively excluding many older Americans from access to these plans, they also draw a younger, healthier population from the individual health insurance marketplace. Not only are these participants at risk for the many conditions and services not covered by these non-complaint plans – such as prescription drugs and mental health – but the segmented market means that those remaining in the ACA marketplace will experience higher premiums.

Beyond the lack of consumer protections for these non-complaint plans, we have also expressed our concerns about inadequate guidance for marketing these plans, especially to older Americans. The rule’s notice language is insufficient and is likely to lead to more consumer confusion. The language requires an individual not just to read through hundreds of pages of insurance documentation, it would require an intimate knowledge of insurance products themselves to sufficiently understand the exclusions and potential consequences inherent in purchasing non-compliant plans as coverage. Regardless of the fate of the recent rules and guidance, clear disclosures must be required so that consumers can better identify and understand the implications of their decision.

The ACA has extended quality, affordable coverage to millions of older Americans. Congressional and Administrative efforts should be aimed at strengthening the ACA’s

¹ <https://www.aarp.org/content/dam/aarp/ppi/2017-01/ACA-Protects-Millions-of-Older-Adults-with-Preexisting-Health-Conditions-PPI-AARP.pdf>

consumer protections across all health insurance marketplaces, not eroding them. These four bills and Subcommittee on Health hearing represent an important first step towards these goals and we look forward to working with Members from both sides of the aisle to advance this legislation. If you have any further questions, please feel free to contact me, or have your staff contact Brendan Rose on our Government Affairs staff at brose@aarp.org or 202-434-3770.

Sincerely,

A black rectangular redaction box covering the signature of Joyce A. Rogers.

Joyce A. Rogers
Senior Vice President
Government Affairs

cc: The Honorable Ann M. Kuster
The Honorable Lisa Blunt Rochester
The Honorable Kathy Castor



February 13, 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 support for three important bills under discussion today's hearing: *Strengthening our Health Care System: Legislation to Reserve ACA Sabotage and Ensure Pre-Existing Conditions Protections*.

Based on the organization's health care for all principles,¹ the AAFP is pleased to support the *Marketing and Outreach Restoration to Empower Health Education Act of 2019* (HR 987), *legislation to prohibit the expansion of short-term, limited duration insurance plans* (HR 1010), and the *Educating Consumers on the Risks of Short-Term Plans Act of 2019* (HR 1143).

The AAFP believes that all people regardless of social, economic or political status, race, religion, gender or sexual orientation should have access to primary medical care and other essential health care services. Care should be comprehensive, affordable, and include protections for those with financial hardships. 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.²

We are pleased to comment on these bills and look forward to working with you to advance comprehensive health care policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@afafp.org.

Sincerely,


 Michael L. Munger, MD, FAFAP
 Board Chair

Cc: Representatives Lisa Blunt Rochester and Kathy Castor

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¹ AAFP, Health Care For All (2014), available at <http://www.aafp.org/about/policies/all/health-care-for-all.html>

²¹ 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>

Testimony for the Record from Sam Bloechl (Chicago, IL)
U.S. House Energy & Commerce Committee
Health Subcommittee
Hearing on Strengthening Our Health Care System
February 13, 2019

Chairwoman Eshoo & Ranking Member Burgess,

My name is Sam Bloechl, and I live in Chicago, Illinois. I own a small landscape design business. In 2017, at 28 years old, I was diagnosed with Stage 4 non-Hodgkin lymphoma. As you can probably imagine, my diagnosis came as a shock to me, completely turning my life upside down. The endless tests, scans, appointments and treatments that followed were overwhelming and scary. But my diagnosis and battle with cancer is only half of the story. My biggest battle was the one I had with the insurance company that used loopholes in the rules to refuse to pay for my cancer care because they called it a pre-existing condition.

In 2016, I began experiencing some lower back pain that wouldn't go away. I had insurance coverage, but I thought it would be smart to talk to an insurance broker about upgrading my coverage for the next year, so that I could better cover any potential medical care I might need. During the conversation with the insurance broker, I was very upfront about my problem. I told her that I had been experiencing back pain for several weeks and had been to the chiropractor numerous times. I shared that the chiropractor had taken x-rays but that he had not made a diagnosis. I told the broker I was still experiencing pain and that I would most likely be going in for an MRI in January. She assured me that as long as there was no diagnosis made during my visits to the chiropractor, the plan she recommended was the right plan for me. In fact, even though I was prepared to pay higher premiums, she told me that I would be wasting my money to buy anything more expensive than the plan she recommended.

I wasn't prepared for what came next. What I thought was only back pain, turned out to be a cancer diagnosis that required immediate treatment. Non-Hodgkin's Lymphoma is an aggressive form of blood cancer, but it is treatable with an equally aggressive regimen. Roughly six months into chemo and radiation, I achieved remission. My doctors informed me that although my cancer is treatable, its aggressive nature makes it very likely to return. For my diagnosis, a bone marrow transplant was my best hope for long-term remission.

As I began preparing for my transplant, my insurance company told me that they would not pay for any of my treatment. It became clear to me pretty quickly that my cancer would be only half of my battle. The insurance company was refusing to pay for the rounds of chemo, radiation, imaging tests, and blood tests since I had been diagnosed in January. But they were also denying any payment for the bone marrow transplant I needed to achieve lasting remission. I couldn't believe it. They claimed that the cancer was a "pre-existing condition" because I had visited the chiropractor in 2016. Not only did this decision by my insurance company alter my recommended treatment regimen and delay my recovery, it meant that I had no insurance to cover the life-saving transplant I needed.

I appealed their decision, hoping that this was some kind of mistake. While I waited for them to review my case, I was forced to do nine additional rounds of maintenance chemo to maintain my temporary remission. After months for waiting for a decision and undergoing additional chemo, my appeal was

denied, leaving me with approximately \$800,000 in medical bills and again, no health insurance for the treatment and transplant I needed to stay alive.

As I learned later, the type of plan I was sold by the broker is called a “short term plan,” and these plans doesn’t have to follow the same rules as regular health insurance. Short term plans don’t have to cover treatments for pre-existing conditions, and they don’t have to cover basic treatments for cancer like prescription drugs. After spending countless hours on the phone—mostly on hold—working with several lawyers, relying on family and friends who made too many emotional and financial sacrifices to save my life, and experiencing an enormous amount of stress brainstorming how to stay alive, I was able to buy a new health insurance plan that would cover my transplant. Today, my cancer is in remission. My transplant, when I finally got it, went well. I’m not completely out of the woods, but I am very lucky to be as healthy as I am now.

Unfortunately, I can’t say the same about the financial disaster that has somehow, somehow, proven to be as challenging as the fight against cancer itself. In the time since my diagnosis, time that I should have spent focusing on my treatment, planning a future with my now-fiancé, and building my business, I have been kept up at night worrying about staying afloat, how to pay the next bill, and how to avoid bankruptcy.

Now that I have seen firsthand the danger of “short term plans,” I know just how important it is to put basic rules in place that protect patients when they need it most. Insurance is supposed to be there when something big happens: a cancer diagnosis, a heart attack, a car accident.

It’s unacceptable that people all across the country have to worry that their plan is filled with small print loopholes that let their insurer deny care when they need it. Someone with insurance shouldn’t have worry about that. They shouldn’t have to worry about getting a bill for \$800,000 in the middle of their cancer treatment. They shouldn’t have to worry about getting a letter from their insurer refusing to pay for a life-saving procedure because they say it’s for a pre-existing condition. They shouldn’t have to spend weeks fighting with their insurer while they are in the middle of a battle with cancer. They shouldn’t have to worry about bankruptcy while sitting in a chemo chair. They shouldn’t have to worry that a broker is selling them “junk insurance” because the broker gets a bigger commission for junk plans than for plans that have basic patient protections.

This all seems like common sense to me, but, unfortunately, I expect to hear many more stories like mine. That’s because federal rules protecting consumers from the loopholes in short term health plans have disappeared. The new rules allow these health plans—like the one I was sold—to continue discriminating against people with pre-existing conditions and exploiting loopholes to avoid paying for life-saving care when someone gets sick.

I am urging you today, on behalf of millions of people like me with a pre-existing condition, to prevent insurance companies from selling short term plans that advantage of the people you represent.

Thank you for the opportunity to tell my story.



Charles N. Kahn III
President and CEO

February 12, 2019

The Honorable Anna Eshoo
Chairwoman
Health Subcommittee
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Eshoo,

Thank you for holding the hearing, "Strengthening our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Condition Protections," and for your work to advance legislation that will preserve and strengthen the Patient Protection and Affordable Care Act (ACA). A great number of our patients, throughout the country, depend on the comprehensive coverage they purchase through the ACA's Marketplaces and we look forward to working with you to help sustain and improve that coverage.

We are supportive of the legislation (H.R. 986; H.R. 987; H.R. 1010; H.R. 1143) that the Subcommittee is considering as part of the hearing. The legislation seeks to address recently enacted policies that will make it harder for individuals to obtain meaningful health care coverage.

In public comments^{1,2}, the FAH expressed significant concern with these policies. Specifically, the FAH opposes the revisions to the implementing guidance to Section 1332 of the ACA as we believe the changes are not consistent with either the spirit or the meaning of the law and appear to be intended to encourage more enrollment in plans that do not cover a minimum set of essential benefits. We believe that this guidance, if acted on by states, will do great harm to the individual market, undermining its overall stability. As with our opposition to the revisions to the Section 1332 guidance, we have similar concerns with the recently finalized changes to the definition of short-term limited duration (STLD) plan. The new definition will put consumers at increased risk of inadequate and insufficient coverage and will likely harm the individual health insurance markets. These impacts would be particularly felt in states that do not restore reasonable limits on the duration of such coverage through state insurance regulation.

¹ https://fah.org/fah-ee2-uploads/website/documents/FAH_comment_letter_STLD_proposed_rule.pdf

² <https://fah.org/fah-ee2-uploads/website/documents/FAH.1332.Guidance.Comment.Letter.12.21.18.pdf>

We appreciate your work to highlight and act on these important matters. Millions of American patients have benefited greatly from the coverage they gained through implementation of the ACA. We look forward to working with you to support the ACA so these coverage gains can be sustained, expanded and improved.

Sincerely,



cc: The Honorable Frank Pallone, Chairman, House Committee on Energy & Commerce



JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

February 12, 2019

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
House Committee on Energy & Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael C. Burgess, MD
Ranking Member
Subcommittee on Health
House Committee on Energy & Commerce
U.S. House of Representatives
2322 A Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express the AMA's strong support for H.R. 986, H.R. 987, H.R. 1010, and H.R. 1143, which will be the focus of the Subcommittee on Health's legislative hearing on February 13th entitled, "Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections." The AMA believes that these bills would help ensure that the Affordable Care Act's (ACA) goals of increasing access to high quality insurance coverage and guaranteeing key consumer protections are maintained.

H.R. 1010, a bill "to provide that the rule entitled "Short-Term, Limited Duration Insurance" shall have no force or effect," would overturn the final short-term limited duration insurance (STLTDI) rule. The goal of the STLTDI final rule, issued on August 3, 2018 by U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL), and the U.S. Department of Treasury (Treasury), was to expand the availability of STLTDI plans. The final rule extends the maximum duration of STLTDI plans from three months to up to 12 months, and allows insurers to renew STLTDI plans further for up to 36 months. The AMA strongly opposed this rule, stating in our letter to the Departments that "The AMA shares the goals of the Departments to support state and federal efforts to increase health plan choices and make coverage affordable and comprehensive for individuals seeking health insurance in the individual and small group markets... Unfortunately, this proposed rule is antithetical to achieving these goals, as it would undercut crucial state and federal patient protections, disrupt and destabilize the individual health insurance markets, and result in substandard, inadequate health insurance coverage. Accordingly, we urge the Departments to withdraw the proposed rule."

The AMA objected to the rule in part because STLTDI plans are exempt from the ACA's consumer protection provisions and benefit standards, including the prohibition on pre-existing conditions exclusions, the guaranteed availability requirement, community rating (including gender and age rating protections), the prohibition on annual and lifetime coverage limits, and the annual out-of-pocket limits that protect consumers from large health care costs. Without the consumer protections required by the ACA, STLTDI is considerably less expensive than individual market insurance and hence is very attractive to healthy individuals who do not want or think they do not need comprehensive coverage. The final rule allows these skimpy, non-ACA-compliant plans to compete against ACA-compliant plans in a parallel market. The AMA is concerned by predictions from health policy experts that the expansion of STLTDI

The Honorable Anna Eshoo
The Honorable Michael C. Burgess, MD
February 12, 2019
Page 2

will undermine the individual insurance market and create an uneven playing field by luring away healthy consumers, thereby damaging the risk pool and driving up premiums for consumers left in the ACA-compliant market. The AMA believes that the expansion of STLDI plans will reverse progress that has been made in expanding meaningful coverage to millions of previously uninsured Americans.

H.R. 986, the “Protecting Americans with Preexisting Conditions Act of 2019,” would revoke the guidance on Section 1332 of the ACA entitled State Relief and Empowerment Waivers (2018 guidance) issued by the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Treasury on October 22, 2018. It also would prevent the CMS Administrator and Treasury Secretary from issuing any “substantially similar guidance or rule.” Section 1332 of the ACA established a new waiver supporting state innovation to enable states to experiment with and implement different models to provide health insurance coverage to their residents. While it allows some of the ACA’s private insurance and coverage provisions to be waived, states cannot waive key ACA protections, including the ban on preexisting condition exclusions, underwriting based on health status, and the ban on annual and lifetime limits. Section 1332 requires states to meet four statutory criteria or “guardrails” and show that a proposed waiver will provide comprehensive, affordable coverage to a comparable number of state residents as under the ACA, without increasing the federal deficit.

In the 2018 guidance, CMS and Treasury revised the agencies’ previous interpretation of the statutory requirements and significantly weakened the requirements that states must meet to receive waiver approval. Under the new guidance, the Administration indicated it would consider favorably state proposals promoting non-ACA compliant plans, including STLDI plans and Association Health Plans (AHPs), neither of which meet the ACA’s comprehensive benefit standards or include the ACA’s pre-existing condition protections. Moreover, the Administration indicated that states can use the 1332 process to take ACA subsidies that are now helping low- and moderate-income individuals afford ACA-compliant marketplace plans and use such subsidies to help individuals purchase STLDI plans and AHPs. The 2018 guidance allows states to simply demonstrate that a comparable number of residents will have access to comprehensive and affordable coverage, regardless of whether they actually enroll in that coverage. The AMA strenuously objected to these changes and urged the Departments to withdraw the guidance.

H.R. 987, the “Marketing and Outreach Restoration to Empower Health Education Act of 2019” or the “MORE Health Education Act,” would restore outreach and enrollment funding to assist consumers in signing up for health care. The Trump Administration decreased funding for the ACA’s 2018 Open Enrollment consumer outreach and enrollment educational activities from \$100 million to \$10 million, a 90 percent cut from the previous year, and continued to fund such activities at \$10 million during the 2019 Open Enrollment period. AMA policy strongly supports providing consumers with assistance in understanding their insurance options and the costs of coverage and in enrolling in the coverage that best meets their individual or family needs. We have watched with concern as the number of individuals enrolling in marketplace coverage has dropped over the past couple of years, and believe that H.R. 987 could help to reverse some of this decline by requiring HHS to conduct consumer outreach and enrollment educational activities for the ACA marketplaces, and prohibiting HHS from using funding—authorized at \$100 million per year—to promote plans such as STLDI and AHPs that do not provide comprehensive consumer protections.

The Honorable Anna Eshoo
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H.R. 1143, the "Educating Consumers on the Risks of Short-Term Plans Act of 2019," would require STLDI plans to disclose the risks of STLDI to prospective consumers, including disclosure that STLDI may not cover preexisting conditions, may not cover the costs of medical services, and that coverage may be rescinded if the individual seeks treatment for a preexisting condition. While the final rule requires that issuers of STLDI plans display prominently in consumer materials a notice explaining that the policy that they are purchasing is not required to comply with the ACA's federal market requirements, the language is very general and does not provide sufficient detail for consumers to understand the limitations of such policies. H.R. 1143 would remedy this defect by requiring in statute specific information regarding coverage exclusions and premium variations. Such language would allow consumers to understand more fully the limitations of STLDI plans that they may be considering.

The AMA applauds your leadership in holding a hearing on H.R. 1010, H.R. 986, H.R. 987, and H.R. 1143, and looks forward to working with you and your colleagues to advance these bills through the House of Representatives.

Sincerely,

A black rectangular redaction box covering the signature of James L. Madara, MD.

James L. Madara, MD

† AMERICAN LUNG ASSOCIATION.

February 12, 2019

The Honorable Lisa Blunt Rochester
U.S. House of Representatives
Washington, DC 20515

Dear Representative Blunt Rochester:

I am writing to express the American Lung Association's support for your legislation, HR 987, "the MORE Health Education Act." Your legislation will restore funding for outreach and enrollment for annual healthcare open enrollment – ensuring that consumers who need healthcare will hear about the opportunities for open enrollment.

In 2017, the Commonwealth Fund found that 40 percent of uninsured adults were not aware of healthcare.gov or the state marketplaces. Individuals with low incomes and racial and ethnic minorities were even more likely to be aware of their options.¹ These numbers highlight the great need for the outreach and enrollment funding provided in his legislation.

The Lung Association is deeply concerned about the growth of non-ACA compliant health insurance coverage, such as short-term limited-duration insurance plans. These plans are not required to cover the physicians, medications, and services that lung disease patients need. Without robust funding for outreach and educational activities to inform patients about the comprehensive coverage options available, patients with lung disease could mistakenly enroll in coverage that does not meet their medical needs and be left responsible for massive medical bills.

We applaud you for your commitment to ensuring that consumers learn about open enrollment and sign up for quality healthcare through healthcare.gov or a state portal. We look forward to working with you to ensure that your legislation becomes law.

Sincerely,


Deborah P. Brown
Chief Mission Officer

¹ Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty. Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017. The Commonwealth Fund. Accessed at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand>.

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Statement from the American Lung Association in Support of Legislation Repealing 1332 Guidance

The American Lung Association supports Representative Kuster's legislation that will prevent the implementation of the "State Relief and Empowerment Waivers" guidance. The American Lung Association strongly opposes this guidance, recognizing that it allows states to undermine quality and affordable healthcare for patients with lung disease.

The guidance allows states to take away critical protections for patients with pre-existing conditions, instead pushing them towards plans that provide inadequate coverage, such as short-term limited duration plans, which do not provide the coverage patients with chronic lung diseases need to manage their disease.

The American Lung Association urges Congress to pass this legislation that will repeal this misguided and dangerous guidance that serves to further erode protections for lung disease patients.

American Lung Association Opposes Short-Term Limited Duration Rule

The American Lung Association also opposes the Administration's short-term limited rule, released in August 2018. The American Lung Association recognizes that short-term plans will not offer sufficient healthcare coverage for those living with a lung disease such as asthma, lung cancer or COPD. Lung disease patients need access to treatment to be able to breathe. This is a reckless course of action that will negatively impact the health of patients around the country.



AHA/ASA Newsroom

Bill Would Reverse Administration Rule Allowing Short-Term Insurance Plans

American Heart Association Commends Introduction of H.R. 1010

February 08, 2019 | Categories: Advocacy News (/news?c=854)

Washington, D.C., February 8, 2019 – The American Heart Association issued the following statement regarding the release of H.R. 1010, a bill that would reverse a rule finalized by the White House last year that allowed short-term, limited-duration insurance plans to be sold alongside ACA-compliant health insurance plans:

"This legislation would reverse the administration's efforts to expand short-term, limited-duration insurance plans, which discriminate against individuals with pre-existing conditions, lack coverage for essential health benefits, increase deductibles and place harsh limitations on benefits.

"Patients with short-term plans run the risk of accumulating excessive medical bills or even forgoing critical care because of cost.

"We opposed this rule before it was finalized by the White House and are grateful that lawmakers, including Rep. Kathy Castor (FL), are working hard to protect patients from short-term plans. We urge lawmakers to support this legislation and put an immediate stop to the short-term rule."

###

The American Heart Association is a leading force for a world of longer, healthier lives. With nearly a century of lifesaving work, the Dallas-based association is dedicated to ensuring equitable health for all. We are a trustworthy source empowering people to improve their heart health, brain health and well-being. We collaborate with numerous organizations and millions of volunteers to fund innovative research, advocate for stronger public health policies, and share lifesaving resources and information. Connect with us on heart.org (<http://www.heart.org/HEARTORG>), Facebook (<http://facebook.com/AmericanHeart>), Twitter (http://twitter.com/American_Heart) or by calling 1-800-AHA-USA1.

For media inquiries please contact:

Suniti Sarah Bal -- 202-787-9292; suniti_bal@heart.org

For public inquiries please contact:

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heart.org (<https://www.heart.org/en>) and [strokeassociation.org](http://www.strokeassociation.org) (<http://www.strokeassociation.org/STROKEORG/>)

AHA/ASA Newsroom

Bill Would Overturn Guidance Permitting States to Undermine ACA Patient Protections

February 06, 2019 | Categories: Advocacy News (/news?c=854)

Washington, D.C., February 6, 2019 – A House resolution introduced today would overturn guidance from the Centers for Medicare and Medicaid Services (CMS) that permits “state innovation waivers” under section 1332 of the Affordable Care Act.

The CMS guidance gives states the option to use taxpayer dollars to promote substandard plans that do not protect patients and consumers.

The American Heart Association released the following statement in response to H.R. 986, the “Protecting Americans with Pre-Existing Conditions Act”, introduced by Representative Ann Kuster (NH):

“The CMS guidance that this resolution seeks to overturn allows states to undermine critical protections for millions of Americans living with pre-existing conditions. Under the guidance issued in 2018, ‘state innovation waivers’ could allow for the sale of cheap, inadequate health insurance plans that can deny coverage for individuals with pre-existing conditions, charge them more for being sick or retroactively rescind coverage.

“This guidance opens the door for states to deny patients important protections that the Affordable Care Act provided for people with pre-existing conditions. We urge lawmakers to support this resolution and patient protections for their constituents.”

###

The American Heart Association is a leading force for a world of longer, healthier lives. With nearly a century of lifesaving work, the Dallas-based association is dedicated to ensuring equitable health for all. We are a trustworthy source empowering people to improve their heart health, brain health and well-being. We collaborate with numerous organizations and millions of volunteers to fund innovative research, advocate for stronger public health policies, and share lifesaving resources and information. Connect with us on heart.org (<http://www.heart.org/HEARTORG>), Facebook (<http://facebook.com/AmericanHeart>), Twitter (http://twitter.com/American_Heart) or by calling 1-800-AHA-USA1.

For media inquiries please contact:

Suniti Sarah Bal – 202-787-9292; suniti.bal@heart.org

For public inquiries please contact:

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[heart.org \(https://www.heart.org/en\)](https://www.heart.org/en) and [strokeassociation.org \(http://www.strokeassociation.org/STROKEORG/\)](http://www.strokeassociation.org)



1155 15th Street, N.W., Suite 600 | Washington, DC 20005
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 Ken Janda, Chairman | Margaret A. Murray, Chief Executive Officer

Statement by Margaret A. Murray, CEO, ACAP to the House Committee on Energy and Commerce

**Subcommittee on Health Hearing: *Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions and Protections*
 February 13, 2019**

Chairman Pallone, Chairwoman Eshoo, Ranking Member Walden, Ranking Member Burgess, and Members of the Committee:

ACAP is an association of 60 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), the Marketplaces, and Medicare Special Needs Plans for dually-eligible individuals, including over 765,000 Marketplace enrollees. Sixteen of ACAP’s SNHP members offer qualified health plans (QHPs) or basic health plans (BHPs) in the Marketplaces, including one that newly entered the Marketplace for 2019.

Since the passage of the Affordable Care Act (ACA), ACAP plans have advocated to reinforce each leg of the law’s foundational “three-legged stool”: affordable insurance options, a near-universal risk pool, and meaningful coverage. ACAP plans and many other issuers have embraced these ideals and offered coverage that provides high-value, affordable, and comprehensive care to consumers who had previously been subject to underwriting and other exclusionary practices. Without any one of these “legs,” the rest is not sustainable. We are concerned that Short-Term, Limited-Duration Insurance (STLDI) health plans threaten the balance of that stool. We appreciate the Committee’s attention to the issue in today’s hearing.

STLDI plans have been available for many years; however, their intended function has fundamentally changed. STLDI plans had historically been used to fill gaps in coverage for a short period of time. However, they lack comprehensive consumer protections such as pre-existing coverage requirements—not to mention they are permitted to underwrite coverage and even engage in post-claims underwriting and rescissions. Before the ACA, in practice there was effectively no difference between STLDI plans and pre-ACA individual market plans. As ACA coverage rolled out, however, and market protections such as guaranteed availability came into practice, brokers and issuers of STLDI plans began marketing them as alternatives to ACA coverage instead of as true “short-term” coverage. In response to this changing nature, the Obama Administration issued a regulation in 2016 restricting STLDI plans’ coverage terms to three months or less with renewals of no more than one year. In August of 2018, the Trump Administration changed course and issued a final rule that expands the coverage period for STLDI plans up to 12 months with coverage renewal up to 36 months. Although STLDI plans



may be an effective method of stop-gap coverage for consumers with coverage gaps due to changing employment or life situations, these new coverage duration limits permit them to effectively be sold as an alternative to ACA-compliant plans. Yet it should go without saying that much of the goal of the ACA was to curb the abuses like those that STLDI plans regularly engage in—post-claims underwriting, rescissions, and no guaranteed availability to name just a few.

Despite the similar 12-month duration, there are few similarities between STLDI and ACA-compliant coverage. While ACA-compliant plans must have a Medical Loss Ratio (MLR) of at least 80 percent—which requires 80 percent or more of earned premium dollars to be spent on medical care, as opposed to administrative costs and profits—many STLDI plans have an MLR of about 50 percent and moreover there are no MLR ratio requirements that STLDI plans must meet.¹ While ACA-compliant plans are required to cover Essential Health Benefits (including maternity care, prescription drugs, and mental health and substance use disorder treatment), STLDI plans are not mandated to do so. And, while ACA-compliant plans are prohibited from underwriting, imposing lifetime and annual limits, and excluding coverage for pre-existing conditions, STLDI plans do not have to follow the same rules.² Ultimately, for *any* consumer with significant health coverage needs, whether acute or chronic, STLDI plans do not provide meaningful coverage; for consumers with pre-existing conditions, it is safe to say that STLDI plans are wholly inadequate.

The distinctions between ACA-compliant coverage and STLDI plans are clear on paper, yet the marketing of STLDI plans can prove harmful to well-intentioned consumers. During Open Enrollment for 2019, the growing market for STLDI plans was on full display: a recent marketing scan conducted by the Georgetown University Center on Health Insurance Reforms (CHIR) found that in every state, over half of all results from websites that are designed to suggest appropriate health insurance products to consumers directed them to STLDI or other non-ACA compliant insurance products. In fact, during this year's Open Enrollment, less than 20 percent of CHIR's searches including phrases like "cheap health insurance" or "ACA enroll" returned sites offering solely ACA-compliant coverage.³ Or in many cases the STLDI plans themselves are guilty of misleading consumers. For example, one issuer recently introduced a product that does cover some pre-existing conditions—but with a maximum coverage limit for pre-existing condition claims of \$25,000—which is less than the average cost of a three-day

¹ Huth, Erik and Karcher, Jason. "The short-term/limited-duration insurance rule and the potential impact on health insurance markets." *Milliman*. August 2018. http://us.milliman.com/uploaded/files/insight/2018/The_STLDI_rule.pdf; National Association of Insurance Commissioners. "2017 Accident and Health Policy Experience Report." 2018. https://naic.org/prod_serv/AHP-IR-18.pdf

² Lucia, Kevin et al. "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market." *The Commonwealth Fund*. March 2018. https://www.commonwealthfund.org/sites/default/files/documents/_media_files_publications_fund_report_2018_mar_lucia_state_regulation_alternative_coverage_options_rev.pdf

³ Corlette, S. et al. "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and Regulatory Responses." *Georgetown University Health Policy Institute*. January 2019. <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>



hospital stay.⁴ Or, there is the case of Agile Health Insurance’s “Everest Prime STM” product, which features a marketing brochure with climbers summiting a mountain, yet the plan specifically excludes coverage for injuries related to mountain climbing.⁵ Or the regular practice by STLDI plans of considering pregnancy a pre-existing condition, even if the consumer was not yet aware of the pregnancy. Likewise, there are policies within the fine print that any conditions developed during the first 12 months of coverage (the coverage term) will be considered pre-existing conditions for any subsequent terms within the 3-year renewal period (and thus would no longer be covered).

These data and examples demonstrate that despite many consumers’ initiatives to purchase more comprehensive, ACA-compliant coverage, it may be difficult for them to know what they are purchasing and may effectively be duped into purchasing STLDI coverage when they need something more comprehensive. Or, a consumer may not fully understand the potential impact of purchasing an STLDI product, particularly consumers that don’t realize they have a pre-existing condition or what an STLDI plan might deem a pre-existing condition.

For example, a woman in Illinois went to the hospital with heavy vaginal bleeding resulting in a five-day hospital stay and a hysterectomy, only to be denied coverage under her short-term plan on the ground that her menstrual cycle constituted a pre-existing condition. Additionally, a man in Washington, D.C. also purchased a short-term plan with a stated maximum payout of \$750,000; when he sought coverage for a \$211,000 bill resulting from a hospitalization, he was paid only \$11,780, in part due to a denial of coverage based on his father’s medical history. While these may be particularly egregious examples, they demonstrate unscrupulous nature of STLDI plans, which generally engage in whatever practices necessary to avoid paying claims. One of the easiest ways to do so is to deem the claims as related to a pre-existing condition.

Finally, the proliferation of STLDI plans will have a deleterious impact on the risk pool and the stability of the health insurance Marketplaces. STLDI plans cost less money because they offer less coverage. These plans are expected to pull healthier and younger consumers out of the ACA-compliant individual risk pool, effectively segmenting risk in the individual market. The marketing research above further demonstrates that STLDI plans will not only be attractive but also readily available to consumers moving forward. To better understand the effect of STLDI plans on the individual market, ACAP commissioned the actuarial firm Wakely Consulting Group to model the impact of the Administration’s proposed rule.⁶ Wakely estimated that in 2019, adverse selection would decrease enrollment in the ACA-compliant individual market by between 400,000 and 790,000 enrollees. In addition, Wakely estimated that STLDI plans, in tandem with the repeal of the individual mandate, will contribute to a rise in premiums of up to 12.8 percent and a reduction in enrollment of up to 26.3 percent in the individual market over the

⁴ Palanker, Dania. Declaration of Dania Palanker in Support of Plaintiffs’ Motion for Preliminary Injunction, Association for Community Affiliated Plans et al v US Department of Treasury <https://www.communityplans.net/wp-content/uploads/2018/10/Declaration-of-Dania-Palanker.pdf>

⁵ *Modern Health Care*, May 7, 2018, p. 36

⁶ Cohen, M. et al. “Effect of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market.” *Wakely Consulting Group*, 2018. <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>



course of 4 to 5 years. For ACAP plans and others offering comprehensive QHP coverage that covers pre-existing conditions, they will essentially become high risk pools. This landscape is unsustainable; if ACA-compliant plans are forced to exit the Marketplaces, fewer affordable, comprehensive health insurance options will remain.

It is for these reasons that ACAP decided to file suit about this Administration's short-term, limited-duration insurance regulation. As noted above, the regulation effectively permits the exact type of plan the ACA was intending to outlaw to be sold in direct competition with ACA-compliant plans. We believe this is an inappropriate interpretation of the law. Regulations are intended to carry out law, however, in this case, the regulation is undermining the law and the ability of plans like ACAP's member plans to offer comprehensive, ACA-compliant coverage.

Conclusion

In conclusion, ACAP thanks you for the opportunity to provide feedback to the Committee and for your efforts to ensure protections for consumers with pre-existing conditions and other vulnerable populations. ACAP and its member plans are dedicated to serving Marketplace enrollees, including those with pre-existing conditions and we appreciate the Committee's attention to this important issue. We look forward to providing with additional feedback or guidance. Please contact Heather Foster, Vice President of Marketplace Policy (hfooster@communityplans.net or 202-204-7510) with any questions or for additional information.



**Statement on
“Strengthening Our Health Care System: Legislation to
Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections**

**Submitted to the
House Energy and Commerce Committee
Subcommittee on Health**

February 13, 2019

America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Every American deserves affordable, comprehensive coverage—regardless of their income, health status, or pre-existing conditions. This has been a core principle for health insurance providers and a constant commitment by our industry. Every day health insurance providers act on that commitment by working to improve coverage, affordability, and access to high-quality care. We strongly believe that by working together, we can ensure that America’s health care markets deliver strong patient protections, as well as robust competition and choice that lead to greater affordability.

Our statement for today’s hearing focuses on the following:

- Our commitment to ensuring that every American has access to affordable, comprehensive health coverage, including recommendations we have offered to improve affordability for individuals who buy coverage on their own, without support from an employer contribution

or if their income is too high to qualify for premium tax credit assistance;

- Our support for protecting Americans with pre-existing conditions; and
- Our comments on developments surrounding short-term plans, section 1332 state innovation waivers, and funding for outreach and education activities that encourage enrollment in health insurance coverage.

Ensuring Affordable, Comprehensive Health Coverage for All Americans

Health insurance providers are committed to providing high-quality, affordable coverage that improves the health and wellness of all Americans. Our members work every day to address the significant cost drivers of chronic disease and poor health, give consumers the power to choose the care and coverage that works best for them and their families, and improve patient care with innovative tools, treatments, and technology.

Approximately 180 million Americans rely on the protection and peace of mind provided by employer-provided coverage. Nearly 15 million Americans purchase their health coverage through the individual market—but high costs are a significant challenge for many who buy coverage on their own, without support from an employer contribution or if their income is too high to qualify for premium tax credit assistance.

To address this concern, AHIP released a report¹ in November 2018 outlining 12 recommendations that can be implemented, by federal and state policymakers, to make premiums more affordable for Americans who buy coverage on their own in the individual market.

The solutions in our report focus on helping hardworking Americans who fall into a gap—earning too much to qualify for financial support, but still struggling to pay their monthly premiums. Our recommendations are categorized into three areas: (1) addressing rising health care costs and drug prices; (2) offering premium savings to families making over 400 percent of the federal poverty level; and (3) increasing the number of consumers who buy coverage, which will balance the individual market risk pool to bring costs down for everyone.

¹ <https://www.ahip.org/12-solutions-to-lower-premiums-for-hardworking-americans-who-buy-their-own-coverage/>

Our specific recommendations, as explained in the report, would accomplish the following:

- Reduce surprise doctor bills;
- Increase competition in prescription drugs;
- Expand the use of telehealth;
- Create reinsurance programs;
- Provide savings to consumers who participate in wellness programs;
- Repeal the ACA health insurance tax;
- Provide tax parity for Americans who buy individual market coverage;
- Expand Health Savings Account (HSA) options;
- Curb inappropriate third-party premium payments;
- Increase flexibility for reference pricing;
- Create state premium discount programs; and
- Support marketing and outreach efforts to increase enrollment and strengthen the risk pool.

Americans With Pre-Existing Conditions Should Be Protected

The position of health insurance providers is clear: Every American deserves affordable, comprehensive coverage—regardless of their income, health status, or pre-existing conditions. No one should be denied or priced out of affordable coverage because of their health status.

Moreover, to make coverage more affordable for everyone, it is important to combine pre-existing condition protections with provisions that incentivize broad-based continuous coverage and a balanced risk pool. In a statement we submitted for the subcommittee's February 6 hearing, we highlighted four types of policies that address this goal: (1) continuous coverage requirements; (2) defined open enrollment and special enrollment periods; (3) premium assistance; and (4) a platform for consumers to shop for and compare coverage.

We are seriously concerned that current pre-existing condition protections, as well as policies that promote broad market participation, may be threatened by pending litigation. In February 2018, a lawsuit—*Texas v. United States*—was filed that challenges the constitutionality of the ACA. In December 2018, the United States District Court for the Northern District of Texas issued a broad ruling that would invalidate *all* of the Affordable Care Act—including provisions relating to the individual market (e.g., pre-existing condition protections), the employer market, Medicare Advantage, Medicare Part D, and Medicaid expansion.

AHIP has expressed concern that this ruling is misguided and wrong. This decision, if upheld, would deny coverage to more than 100 million Americans, including seniors, veterans, children, people with disabilities, hardworking Americans with low-incomes, young adults on their parents' plans until age 26, and millions of individuals with pre-existing conditions. Almost everyone, regardless of where they get their health coverage, would be affected by the chaos and pain this ruling would inflict on the American people.

Recent Regulatory and Administrative Actions

We understand that committee members have introduced legislation that would reverse regulations addressing short-term plans and section 1332 state innovation waivers, and restore funding for outreach activities that encourage enrollment in health insurance coverage.

Short-Term Plans

In August 2018, the Administration issued a final rule that expands short-term, limited duration insurance (STLDI) policies.

We agree that consumers deserve more choices, particularly those who do not qualify for federal subsidies and must pay the full premium on their own. However, we are concerned that consumers who rely on short-term plans for an extended time period will face high medical bills when they exceed their coverage limits or need care that is not covered. In addition, we believe it is essential for consumers to clearly understand what their plan does and does not cover. AHIP submitted detailed comments in April 2018 on the proposed version of this regulation.²

Section 1332 Waivers

In October 2018, the Administration issued updated guidance addressing section 1332 state innovation waivers, with the goal of giving states more flexibility to offer different coverage options.

² <https://www.ahip.org/wp-content/uploads/2018/04/AHIP-Comments-NPRM-on-STLDI-4-20-18FINAL.pdf>

In December 2018, AHIP submitted comments³ in which we generally expressed support for providing more flexibility for states, while also expressing appreciation for efforts by the Centers for Medicare & Medicaid Services (CMS) to streamline the approval of waiver applications to implement reinsurance programs. We support CMS' emphasis on promoting choice, competition, and multiple options for consumers. However, we oppose the use of pass-through funding for short-term, limited duration insurance plans or other alternative coverage options.

Other Stability Measures

We believe that providing federal funding for reinsurance programs would be an effective approach to stabilizing premiums in the individual health insurance market. Reinsurance is an effective, proven way to lower premiums. Building on our experience in the states, a federally funded reinsurance program would offset some of the costs of patients who have the most complex health conditions and need the most care. In the last three years, several states have adopted reinsurance arrangements through the use of 1332 waivers. Enacting measures like these can help significantly lower premiums for millions of individuals who rely on the individual market to access care, as long as they are adequately funded and designed to ensure that consumers in all states benefit. This approach also can reduce federal spending on premium tax credits.

Open Enrollment Outreach and Educational Activities

AHIP appreciates the committee's concerns about recent cuts in funding for outreach and education activities focusing on the annual open enrollment period for the ACA Exchanges.

We believe it is important for the federal government to devote adequate resources to marketing, outreach, and education before and during open enrollment to help consumers understand their coverage options and encourage broad participation. Marketing, outreach, and education activities are critical to ensure that all consumers are aware of the annual open enrollment period and enroll by the deadline. These activities help reduce the number of uninsured Americans. In addition, by encouraging continuous coverage and promoting enrollment of a broad mix of both healthy and less healthy individuals, these activities help to stabilize the risk pool and promote more affordable premiums.

³ https://www.ahip.org/wp-content/uploads/comment_letter_on_state_relief_and_empowerment_guidance.pdf

Conclusion

Affordable, comprehensive coverage for everyone requires effective insurance markets with broad-based participation, clear and consistent rules and regulations, and fair competition. The continuing litigation over the individual mandate should not jeopardize important patient protections. Health insurance providers are committed to ensuring that essential consumer protections are not at risk. By working together, we can cover pre-existing conditions, guarantee coverage, and lower premiums for everyone.



December 18, 2018

The Honorable Alex M. Azar II
 Secretary
 U.S. Department of Health and Human Services
 200 Independence Avenue, SE
 Washington, DC 20201

The Honorable Seema Verma
 Administrator
 Centers for Medicare & Medicaid Services
 P.O. Box 8016
 Baltimore, MD 21244-1850

The Honorable Steven T. Mnuchin
 Secretary
 U.S. Department of the Treasury
 1500 Pennsylvania Avenue, NW
 Washington, DC 20220

The Honorable David J. Kautter
 Assistant Secretary for Tax Policy
 U.S. Department of Treasury
 1500 Pennsylvania Avenue, NW
 Washington, DC 20220

Dear Secretary Azar, Secretary Mnuchin, Assistant Secretary Kautter and Administrator Verma:

The 23 undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on states' individual marketplaces to obtain their healthcare coverage. Together and separately, our non-profit, non-partisan organizations are dedicated to working on a bipartisan basis with the Administration, Members of Congress and state governments to protect the health and wellbeing of the patients and consumers we represent.

In March of 2017, our organizations agreed upon three overarching principles¹ as a guide for any efforts to help reform and improve the nation's healthcare system. These principles state that: (1) healthcare

should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit package.

Our organizations are deeply concerned about new guidance issued by the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services (HHS) and Department of Treasury (Treasury) regarding state waivers under Section 1332 of the Affordable Care Act (ACA). We are similarly concerned about the related Section 1332 State Relief and Empowerment Waiver Concepts Discussion Paper. In short, the policies that states could pursue under the new guidance would significantly undermine quality and affordable healthcare for patients with pre-existing conditions and clearly conflict with the statutory language that both authorizes these waivers and protects patients with pre-existing conditions. We filed comments urging CMS, HHS and Treasury to rescind this guidance, and we urge state leaders to refrain from using 1332 waivers, as envisioned by this new guidance, to undermine quality and affordable healthcare in their state.

Concerns with New Guidance

Section 1332 of the ACA outlines four clear guardrails that any waiver application must meet to be approved: coverage must be as affordable as it would be without the waiver; coverage must be as comprehensive as it would be without the waiver; a comparable number of people must be covered under the waiver as would be without it; and the waiver must not add to the federal deficit. Under the new guidance, HHS and Treasury will consider the number of people who have *access* to affordable, comprehensive coverage, rather than the number who *enroll* in this coverage. These agencies will also rely on a broad regulatory definition of insurance coverage that is not derived from the ACA.

This gross misinterpretation of the guardrails will have real consequences for patients, steering people into substandard coverage, such as short-term, limited-duration plans and association health plans, which often do not cover the full range of benefits and services that patients rely upon to manage their conditions. As a result, people who find themselves with substandard coverage would – in the event of a serious diagnosis – likely encounter massive medical bills. Further, policies that could be implemented under this new interpretation could fundamentally alter the risk pool for a state’s individual marketplace, making comprehensive coverage unaffordable for the patients who rely on it and jeopardizing the stability of the state’s marketplace. The resulting lack of access to care could have devastating short- and long-term consequences for the millions of patients we represent.

The ACA defines ten categories of Essential Health Benefits (EHBs), including hospitalization, preventive care, maternity and newborn care, emergency room services and prescription drugs. Access to the EHBs is critical for patients with pre-existing conditions. Under the new guidance, states will be able to design EHB benchmark plans that provide less generous coverage for individuals and yet still satisfy the coverage guardrail regarding comprehensiveness. Again, patients with serious and chronic conditions rely on coverage that includes EHBs to access the preventive services, medications, visits with primary care and specialist providers and other benefits and services that they need to manage their conditions. Allowing states to establish skimpier coverage requirements would seriously harm patients’ care and health outcomes.

The new guidance removes key language from previous guidance on 1332 waivers that protects vulnerable populations. The 2015 guidance recognized that the ACA prohibits states from using the Section 1332 waiver program in a manner that would harm vulnerable residents, including older

Americans, individuals with low incomes and those with serious health issues or who have a greater risk of developing serious health issues. It is deeply troubling that the new guidance purports to do away with this safeguard. Additionally, the new guidance does not include language from the 2015 guidance which stated that waiver applications would not be approved if they reduced the number of people with coverage that both provides an actuarial value equal to or greater than 60 percent and includes a maximum out-of-pocket limit compliant with the ACA. In effect, this omission invites waiver applications that would leave patients responsible for excessive cost-sharing and jeopardize their health and financial wellbeing.

Concerns with Waiver Concepts Paper

The Administration's waiver concepts discussion paper provides additional detail on proposals that, under the new guidance, could endanger patients with pre-existing conditions. For example, it invites states to make changes to the ACA's subsidy structure, which provides financial assistance to individuals with incomes between 100 and 400 percent of the federal poverty level (FPL). This means a state could change the current subsidy structure to, among other approaches, a fixed per-member-per-month contribution to a healthcare account based on age. If healthcare premiums were to increase, such an approach would provide no financial protection to patients (as the current subsidy structure does) and could drastically change the affordability of coverage for low-income populations. States could also use new flexibility to customize healthcare.gov to promote non-ACA-compliant plans like short-term, limited-duration and association health plans side-by-side with ACA-compliant plans, increasing confusion about the coverage provided and costs associated with different plans. Further, the discussion paper also invites states to apply for waivers to establish high risk pools, which have a long history of failing to provide adequate coverage for patients with serious and chronic conditions. Our organizations are deeply concerned about these changes and the risks they pose to the individuals we represent.

Additional Considerations for States

States that choose to pursue these policies will, as a direct result, not only jeopardize quality and affordable healthcare for patients and consumers in their states but also take on significant financial and administrative burdens. As the waiver concepts discussion paper outlines, making the technical changes necessary for many policies under this waiver will require significant time and cost.

There are also serious questions about the legality of this guidance. Any policy changes of this magnitude should go through a full rulemaking process, including a robust comment period.⁸ The guidance clearly defies many of the Section 1332 guardrails in ways that are inconsistent with the statute and congressional intent. Allowing a state to use a law that provides general authority to enforce the ACA in combination with a more specific executive branch action (a regulation or executive order) authorizing a waiver, rather than enacting a specific law authorizing the waiver, is at odds with the plain language of the ACA. States that rely on this guidance to pursue Section 1332 waivers are therefore exposing themselves to material litigation risk.

Our organizations represent millions of patients, individuals, caregivers and families who need access to quality and affordable healthcare coverage. In short, we are deeply concerned that the new guidance undermines the Section 1332 statutory language and its protections for patients with serious, acute and chronic conditions. We urge HHS and Treasury to immediately withdraw this guidance and urge state leaders to refrain from using these waivers, as envisioned by the new guidance, to undermine quality and affordable healthcare in their state. Again, we stand ready to work with you to protect the health and wellbeing of the patients and consumers we represent.

Sincerely,

Adult Congenital Heart Association
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Chronic Disease Coalition
Cystic Fibrosis Foundation
Epilepsy Foundation
Global Healthy Living Foundation
Hemophilia Federation of America
Immune Deficiency Foundation
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
Mended Little Hearts
Muscular Dystrophy Association
National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
WomenHeart: The National Coalition for Women with Heart Disease

CC: Governors and Insurance Commissioners

¹ American Heart Association website, "Healthcare reform principles." Available at: http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

² Christen Linke Young, Brookings Institution, "The Trump administration side-stepped rulemaking processes on the ACA's State Innovation Waivers—and it could make their new section 1332 guidance invalid." Available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/11/28/the-trump-administration-side-stepped-rulemaking-processes-on-the-acas-state-innovation-waivers-and-it-could-make-their-new-section-1332-guidance-invalid/>.



Advancing Health in America

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February 13, 2019

The Honorable Anna G. Eshoo
 Chairwoman
 Subcommittee on Health
 Committee on Energy and Commerce
 United States House of Representatives
 Washington, DC 20515

Dear Chairwoman Eshoo:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we thank you for holding this hearing on legislation to strengthen our health care system. We look forward to working with you and the rest of the Committee to address the important issues in the legislation being considered today (H.R. 986, H.R. 987, H.R. 1010 and H.R. 1143).

The AHA is committed to expanding affordable, high-quality health coverage. We have expressed our support for solutions to both lower the cost of coverage and provide greater choice among plans, including by supporting federal and state reinsurance programs, increasing outreach and enrollment assistance, and funding the cost-sharing reduction subsidies. These approaches retain vital consumer protections while supporting greater enrollment and reducing costs by better balancing the marketplace risk pools. In contrast, short-term, limited-duration insurance products could harm consumers by providing inadequate access to care and subjecting them to much higher out-of-pocket spending when illness or injury occurs.

While short-term, limited duration plans may be attractive to patients looking for lower premiums, there are serious drawbacks to using these types of plans as a primary source of coverage. These plans do not offer the level of protection that patients need over the long term because it is not possible to fully evaluate what one's health care needs will be in advance. Even well-informed patients who knowingly enroll in these limited plans anticipating very little need for care could find themselves diagnosed with a serious condition or in an accident, with no coverage to help them with their unexpected medical costs. H.R. 1010 and H.R. 1143 would take important steps to prevent the



The Honorable Anna G. Eshoo
February 13, 2019
Page 2 of 2

individual market from being weakened by short-term, limited duration products and ensure consumers are educated about the risks of such plans.

The AHA is committed to state flexibility, but we have expressed our concerns that the Administration's changes to Section 1332 waiver rules would permit waivers that depreciate the quality or affordability of coverage. We have urged the Administration to revise the 1332 waiver guidance to disallow the use of federal funds on inadequate insurance products. While we generally support flexibility, the changes to the "State Relief and Empowerment Waivers" go too far in allowing states to take actions that could result in weakened consumer protections and the destabilization of the individual health insurance market. We thank the Committee for considering H.R. 986 to protect patients from inadequate or unaffordable coverage.

Robust outreach, enrollment, and education to consumers about marketplace coverage options plays an important role in maintaining a balanced risk pool and keeping premiums affordable for consumers. The restoration of outreach and enrollment funds by H.R. 987 would help consumers better evaluate their coverage options and get and use the right coverage that meets their needs.

Thank you again for holding this hearing on legislation that would strengthen the individual market and ensure consumers have the information they need to make informed decisions about their insurance coverage.

Sincerely,


Thomas P. Nickels
Executive Vice President

Cc: The Honorable Frank Pallone
The Honorable Greg Walden
The Honorable Michael C. Burgess, M.D.
Members of the Subcommittee on Health of the Committee on Energy & Commerce

February 13, 2019

Statement on Hearing: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions

Washington, D.C. – Families USA Senior Director of Legislative Affairs Shawn Gremminger released the following statement regarding the introduction of four bills to protect and inform health care consumers

"We are thrilled to see members of Congress proposing legislation to benefit and protect America's health care consumers. With the introductions of bills H.R. 986, H.R. 987, H.R. 1010, and H.R. 1143, Rep. Ann M. Kuster (D-NH), Rep. Blunt Rochester (D-DE), Rep. Kathy Castor (D-FL), and Committee Chairwoman Eshoo (D-CA), respectively, are taking lead to strengthen the many gains afforded to America's families by the Affordable Care Act (ACA).

"In sum, the four bills represent a much needed effort to protect people with pre-existing conditions by reversing harmful Trump Administration policies which will flood the market with predatory junk insurance plans."

"We thank Representatives Kuster, Blunt Rochester, Castor, and Eshoo for standing to strengthen and protect the many gains afforded to America's families by the ACA, and to ensure consumers are educated about the many dangers of short-term plans. We also thank Committee Chairman Frank Pallone, Jr. (D-NJ) for making space for such an essential and timely conversation. We expect their collective action will signal to other lawmakers that Congress has an opportunity — and an obligation — to make health care better, more accessible, and more affordable for all Americans."

STATEMENT FOR THE RECORD

SUBMITTED TO THE

**House Committee on Energy & Commerce
Health Subcommittee**

**Hearing on “Strengthening Our Health Care System:
Legislation to Reverse ACA Sabotage and
Ensure Pre-Existing Conditions Protections”**

February 13, 2019

SUBMITTED BY THE

**The Coalition to Protect and Promote
Association Health Plans**

I. Overview

The Coalition to Protect and Promote Association Health Plans (the “Coalition”) is an *ad hoc* coalition comprised of 23 national and state member-based organizations. These organizations include: the American Bankers Association; American Composites Manufacturers Association; American Farm Bureau Federation; American Society of Association Executives; American Veterinary Medical Association; Associated Employers Benefit & Trust; Association of Web-Based Health Insurance Brokers; Financial Services Institute; Food Marketing Institute; Foundation for Government Accountability; Global Cold Chain Alliance; Indiana Credit Union League; International Franchise Association; International Sign Association; Land O’Lakes, Inc.; Manufacturer & Business Association; Michigan Dental Association; National Apartment Association; National Association of REALTORS®; NFIB; National Restaurant Association; National Marine Manufacturers Association; and the Transportation Intermediaries Association.

Several of our Coalition members currently sponsor an “association health plan” (or “AHP”) through which “group health plan” coverage is actively being provided to employees of their employer-members of these organizations. All of the Coalition’s member-organizations are interested in offering “group health plan” coverage through an AHP in accordance with the rules and requirements set forth in the United States Department of Labor’s (“DOL’s”) final regulations under Title I of the Employee Retirement Income Security Act (“ERISA”) (the “final AHP regulations”). The final AHP regulations establish additional criteria under ERISA section 3(5) for determining when employers may join together in a “bona fide group or association of employers” that will be treated as the “employer” sponsor of a “group health plan.”

The Coalition’s member-organizations represent over 1 million small employers and millions more who are employees of these employer-members or who are self-employed, the majority of whom would be eligible to obtain health coverage through an AHP sponsored by Coalition member-organizations in accordance with the final AHP regulations. Thousands of employees are already covered by AHPs sponsored by a number of our Coalition members in accordance with the DOL’s existing guidance that treat a “bona fide group or association of employers” as an “employer” as defined under ERISA section 3(5).

Without the rules and requirements set forth under the final AHP regulations, many Coalition members would be unable to provide quality and affordable health coverage to small employers and self-employed individuals who are currently struggling to afford health insurance offered in the existing “small group” and “individual” health insurance markets. More specifically, if all or a portion of the final AHP regulations are somehow invalidated through a court of law or through an act of Congress, thousands of employees and self-employed individuals who will be covered by an AHP established exclusively on account of the final AHP regulations – and who are currently enrolled in AHP coverage, effective January 1, 2019 – will *lose* their health coverage.

II. AHPs Are Not the Same As Short-Term Health Plans; AHPs Provide Comprehensive Coverage As Required Under the ACA, ERISA, HIPAA, COBRA, and State Law

It is important to emphasize that AHPs are *not* the same as short-term health plans. We believe it is paramount to make this distinction because ever since President Trump issued Executive Order 13813, the media and critics of the current Administration have inaccurately explained the rules applicable to AHPs. In short, the media and these critics have conflated AHPs and short-term health

plans, and they have described these health plans as being one-in-the-same. AHPs and short-term health plans are *vastly different*.

A. Short-Term Health Plans Are Exempt from the ACA; AHPs Are Subject to the ACA's Coverage Requirements

Under existing law, short-term health plans are *not* considered “health insurance” offered in the individual insurance market,¹ and therefore, short-term health plans are *not* subject to the Affordable Care Act’s (“ACA’s”) insurance and coverage requirements.² As a result, short-term health plans *can* deny a person coverage with a pre-existing condition (because the ACA’s pre-existing condition protections do *not* apply). Also, a short-term health plan *can* develop premiums based on a person’s health condition (because the prohibition against developing premiums based on health status does *not* apply). And, a short-term health plan *can* impose annual and lifetime limits on benefits and medical services covered under the plan (because the prohibition against imposing annual and lifetime limits does *not* apply).

On the other hand, AHPs – as a “group health plan”³ – *are* subject to the ACA’s coverage requirements.⁴ Again, this distinction is important to understand because a number of stakeholders have publicly stated that – similar to short-term health plans – AHPs (1) can deny a person coverage if they have a pre-existing condition, (2) can develop premiums based on a participant’s health condition, and (3) can impose annual and lifetime limits. These statements are *incorrect*.

According to the ACA, a fully-insured “large group” and self-insured AHP – as a “group health plan” – *must*:

- Eliminate all pre-existing condition exclusions for all plan participants.⁵
- Stop imposing annual and lifetime limits on the “essential health benefits” covered under the plan.⁶
- Provide coverage for certain preventive health services with no cost-sharing.⁷
- Cover “adult children” up to age 26.⁸
- Stop rescinding coverage absent fraud or misrepresentation.⁹
- Include new internal and external appeals processes (and provide notice).¹⁰

¹ Section 2791(b)(5) of the Public Health Service Act section (“PHSA”), providing that the term “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

² Section 1551 of the Affordable Care Act (“ACA”) incorporates the definitions under the PHSA – including PHSA section 2791(b)(5) – into the ACA’s insurance and coverage requirements.

³ Section 733(a)(1) of the Employee Income Retirement Security Act (“ERISA”) and PHSA section 2791(a)(1) provide that a “group health plan” is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents...directly, or through insurance, reimbursement, or otherwise.

⁴ ERISA section 715 incorporates by reference the ACA’s coverage requirements applicable to a “group health plan” into ERISA.

⁵ See PHSA section 2704.

⁶ See PHSA section 2711.

⁷ See PHSA section 2713.

⁸ See PHSA section 2714.

⁹ See PHSA section 2712.

¹⁰ See PHSA section 2719.

- Allow participants a choice of primary care physician/pediatrician/OB/GYN.¹¹
- Provide direct access to emergency services.¹²
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.¹³
- Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014.¹⁴
- Eliminate waiting periods that exceed 90 days.¹⁵
- Cover the cost of clinical trial participation.¹⁶
- Provide participants with a summary of benefits and coverage.¹⁷
- Provide annual reports describing the plan's quality-of-care provisions.¹⁸

B. Consumer Protections Under ERISA, HIPAA, and COBRA Apply to AHPs

Under ERISA, there are specific notice and disclosure requirements that a fully-insured "large group" and self-insured AHP must comply with.¹⁹ In addition, ERISA's fiduciary responsibilities apply,²⁰ requiring the AHP and its employer members to act in the best interest of the plan participants. AHP plan participants also have a private right of action to sue the AHP if there is wrong-doing,²¹ and there are detailed procedures for filing health status.²²

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,²³ and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant's health condition.²⁴

C. The Proposed AHP Regulations Do Not Change the Requirements Under ERISA, HIPAA, COBRA, and the ACA

Importantly, the proposed AHP regulations do *nothing* to change the requirements under ERISA, HIPAA, COBRA and the ACA that otherwise apply to a "group health plan." As a result, it is important to once again emphasize that AHPs are *not* short-term health plans free from the above described Federal law requirements. Rather, AHPs are required to provide a comprehensive level of coverage with adequate consumer protections that both Democrats and Republicans in Congress have enacted into law over the past decades, *including protections for individuals with a pre-existing condition.*

¹¹ *Id.*

¹² See PHSa section 2719A.

¹³ See PHSa section 2705.

¹⁴ See PHSa section 2707(b).

¹⁵ See PHSa section 2708.

¹⁶ See PHSa section 2709.

¹⁷ See PHSa section 2715.

¹⁸ See PHSa section 2717.

¹⁹ ERISA, Title I, Subtitle B Part 1.

²⁰ ERISA, Title I, Subtitle B Part 4.

²¹ ERISA section 502.

²² ERISA section 503.

²³ ERISA, Title I, Subtitle B Part 7.

²⁴ ERISA section 702.

D. State Benefit Mandates Apply to Fully-Insured “Large Group” AHPs

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured “large group” AHP will be subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured “large group” plans in most States are as good as the ACA’s Federal “essential health benefits” (“EHB”) requirement. Even in States where their benefit mandates do not cover all of the ten (10) medical services that make up the Federal EHB standard,²⁵ the drafters of the ACA observed that most if not all fully-insured “large group” plans comply with the Federal EHBs, which led Congress to exempt fully-insured “large group plans” from the EHB requirement entirely.

E. State MEWA Statutes Apply to Self-Insured AHPs

In the case of a self-insured AHP, this arrangement is by definition a “multiple employer welfare arrangement” (“MEWA”).²⁶ In the case of a self-insured MEWA, Congress specifically amended ERISA’s preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.²⁷ Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs. States that have yet to enact a State MEWA statute are not prohibited from doing so in the future. In addition, States with existing State MEWA statutes are free to amend those statutes to impose specific coverage, rating, and/or solvency requirements on self-insured AHPs.

III. The AHP Regulations Will Not Return the Health Care Markets to a “Pre-ACA World”

Critics of AHPs have argued that these arrangements will somehow return the country to a “pre-ACA world,” particularly to a world where people with pre-existing conditions will be unprotected by Federal law. As discussed above, *every* AHP is a “group health plan” under the law, and therefore, subject to the consumer protections under ERISA, HIPAA, COBRA, and State law. More importantly, as a “group health plan,” AHPs are subject to the ACA’s “coverage requirements,” which, among other things, requires an AHP to offer coverage to a person with a pre-existing condition (i.e., a person with a pre-existing condition *cannot* be denied coverage under an AHP).

IV. AHPs Are the Same as Large Employer Plans; Newly Created AHPs Are Offering Comprehensive Coverage

The final AHP regulations give small businesses an opportunity to stand on the same footing as large employers with respect to the provision of employee health benefits. Large employers

²⁵ According to the ACA, individual and small group health plans must cover a list of ten (10) medical services that make up the “Federal EHB standard:” ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. [ACA section 1302(b)].

²⁶ See ERISA section 3(40).

²⁷ ERISA section 514(b)(6)(A)(ii).

voluntarily offer health benefits to their employees to attract and retain talented workers, and to keep their employees healthy and productive. Large employers have historically offered comprehensive benefits because the labor market traditionally demands such quality health coverage.

Small employers – just like large employers – want to attract and retain talented workers and to keep their employees healthy and productive. As a result, small employers – just like large employers – *want* to offer comprehensive health coverage. However, because they lack the resources and bargaining power of large employers, the majority of small employers are unable to offer comprehensive coverage at an affordable price. This is where AHPs can play such an important and socially-beneficial role. By obtaining health coverage through an AHP – which effectively will be treated as a health plan sponsored by a large employer – small employers will be able to compete with large employers and offer comprehensive benefits at affordable prices.

The type of “groups or association of employers” interested in sponsoring an AHP are member-based organizations. These organizations *want* to offer AHP coverage – which again, is effectively a large employer plan – to their employer-members, not only to help their employer-members attract and retain talented workers, but as a member benefit to attract new members and retain their current members. An offer of less comprehensive, sub-standard health coverage will actually be detrimental to these organizations (i.e., their current members will leave the organization and they will be unable to attract any new employer-members).

This is not just theory, but practice. For example, Land O’Lakes, Inc. – a member of our Coalition and a member-based cooperative-owned company – has successfully enrolled 2,000 self-employed farmers and employees of employer members of a Land O’Lakes Cooperative in a self-insured AHP established in accordance with the final AHP regulations. Coverage is effective January 1, 2019. It should be noted that Land O’Lakes, Inc. is able to offer self-insured AHP coverage to their self-employed farmers *only* because of the existence of the final AHP regulations. And it should be further noted that if all or a portion of the final AHP regulations are somehow invalidated through a court of law or through an act of Congress, these self-employed farmers will *lose* their health coverage.

Importantly, the Land O’Lakes AHP offers its members eight (8) different plan designs. While the Land O’Lakes AHP is *not* required to cover the ACA’s “essential health benefits” (“EHBs”), *all* of the Land O’Lakes AHP plans *voluntarily* cover the ten (10) statutory EHB categories, along with all of the services that fall into the EHB categories that are medically necessary. The health coverage Land O’Lakes offers to its farmer and employee-members is therefore “comprehensive,” and also superior in price (e.g., 15% to 25% more affordable than “individual market” rates in Nebraska, and 10% more affordable than “individual market” rates in Minnesota). The National Restaurant Association – another Coalition member and a member-based organization – is likewise offering comprehensive health coverage through its 120 plan designs, which also *voluntarily* cover all of the ACA’s EHB categories.

V. A Regulatory Framework Has Been Put In Place Over Time to Combat Fraud and Abuse; Our Coalition Pledges to Work With the NAIC and Congress to Fight Against Fraud and Abuse

It is important to point out that an AHP can take the form of either a fully-insured or a self-insured arrangement. This is a crucial distinction when it comes to the issue of fraud and abuse. For example, fully-insured AHPs are under-written by insurance companies, which are themselves subject

to significant State regulation. In addition, States impose specific requirements on agents and brokers who sell insurance, imposing significant penalties on agents/brokers that engage in the fraudulent sale of insurance products. As result, there have been very few cases of fraud and abuse in fully-insured AHPs. And based on the current regulatory environment, it is unlikely that any fraud will occur in the context of fully-insured AHPs in the future.

While self-insured AHPs have in the past been more vulnerable to fraud and abuse, this history prompted Congress to act. Before 1983, self-insured AHPs resisted efforts at State regulation by arguing that such State regulation was pre-empted by ERISA. However – as stated above – Congress amended ERISA to give States the exclusive authority to regulate self-insured AHPs in any manner the State may choose.

Therefore, since 1983, the States have been free to regulate self-insured AHPs as they see fit, and they have exercised that authority through the enactment of State multiple employer welfare arrangement (“MEWA”) laws. Currently, a number of States – including California, Illinois, and Wisconsin – flatly prohibit the establishment of any new self-insured AHPs. Other States – such as Indiana, Michigan, Nebraska, and Ohio – have enacted MEWA laws that set forth comprehensive certification and approval processes that an organization seeking to operate a self-insured AHP in the respective State must satisfy. Any such certification/approval must come directly from the State’s Insurance Commissioner, and any such certification/approval will only be provided by the Commissioner if all of the State’s MEWA law requirements are satisfied.

More extensive oversight has also come at the Federal level through the enactment of the ACA. Specifically, Congress expanded and strengthened the DOL’s authority over MEWAs – and thus over AHPs – through a multi-pronged approach to eliminate MEWA/AHP abuses. These new requirements include improvements in reporting, together with stronger enforcement tools, and expanded required registration with the DOL prior to operating in a State. This additional information enhances the State and Federal governments’ joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor the authority to issue a cease and desist order when a MEWA/AHP engages in fraudulent or other abusive conduct, and to issue a summary seizure order when a MEWA/AHP is in a financially hazardous condition.

This detailed State and Federal regulatory framework – which was not in place at all prior to 1983, and which has been built up over the years – provides safeguards that will largely prevent fraud and abuse, and, where such misconduct does occur, will significantly mitigate its effects. The Coalition has also pledged to the National Association of Insurance Commissioners (“NAIC”) that we are ready, willing, and able to work with the State Insurance Commissioners to build on the current regulatory framework. In addition, the Coalition seeks to work with members of Congress to provide additional funding for the DOL’s enforcement activities – as established under the ACA – as well as to fund State enforcement efforts.

VI. AHPs Will Not Segment the Markets

Critics of AHPs argue that these arrangements will somehow destabilize the “individual” and “small group” markets. Our Coalition believes that these claims are over-stated. For example, critics have overlooked the fact that AHPs are offering comprehensive coverage at a lower cost relative to the “individual” and “small group” market plans (as described above). In our experience, employees and individuals shop for health insurance based on price, as well as the comprehensiveness of the health

coverage. The health status of a particular employee or individual also drives their behavior. In cases where an employee or individual is healthy, they will most likely gravitate toward health coverage with a lower cost. If, however, an employee or individual is less healthy (and thus a “high-medical utilizer”), they are more likely to seek out comprehensive coverage, although price remains an important factor as well.

Critics, therefore, are wrong when they predict that AHPs will draw *only* healthy people out of the ACA markets. Because AHP coverage is proving to be as comprehensive as – if not more comprehensive than – existing “small group” or “individual” market coverage, while still being offered at a more affordable price, both healthy people *and* less healthy/high-medical utilizers are going to be attracted to AHP coverage. Thus, due to the fact that less healthy/high-medical utilizers will exit the “small group” or “individual” markets to enroll in an AHP (because such plans will offer comprehensive benefits at a lower cost), the expanded availability of AHP coverage will actually *benefit* the “small group” and “individual” markets from a health risk perspective, drawing less healthy/high-medical utilizers out of the current risk pool. At the very least, this beneficial effect should offset any “destabilizing” effect that will result when healthy employees and “working owners” also leave the “small group” and “individual” markets for superior AHP coverage.

In addition, predictions of market destabilization are not just speculative, but also incomplete because they fail to account for the numbers of small employers – as well as “working owners” in the “unsubsidized” individual market – who are currently *not* covered by any form of health insurance. If the employees of these small employers – along with these “working owners” – choose to enroll in an AHP, the current ACA’s “small group” or “individual” markets will *not* be affected because these insured “lives” were never in those markets (and in their risk pools) in the first place.

This is not a theoretical consideration. Since the enactment of the ACA in 2010, health coverage offered by small employers with fewer than 50 employees has declined by over 20%.²⁸ Only about 50% of small employers with fewer than 50 employees actually offer health coverage, as compared to 97% of large employers with 50 to 199 employees.²⁹ Importantly, 47% of small employers with fewer than 50 employees identify the high cost of health insurance as the primary reason for not offering coverage.³⁰

A similar phenomenon exists in the “unsubsidized” individual market. Since 2015, about 3 million individuals have exited the ACA’s “individual” market.³¹ This amounts to a loss of about 17% of the “individual” market from its peak.³² It is reasonable to infer that many, if not most, of these individuals exited the “individual” market due to significant premium increases following the enactment of the ACA. It is also reasonable to infer that many of these individuals will be attracted to an AHP that offers comprehensive coverage, additional flexibility, and lower prices. As a result, it is reasonable to conclude that these “lives” are currently *not* a part of the ACA’s “individual” market, which therefore cannot be affected by their migration from uninsured status to an AHP.³³

²⁸ See Employer Health Benefits: 2018 Annual Survey (Kaiser Family Foundation 2018).

²⁹ *Id.*

³⁰ *Id.*

³¹ See Semanskee, Cox, and Levitt, *Data Note: Changes in Enrollment in the Individual Health Insurance Market* (Kaiser Family Foundation, July 2018) at p.1.

³² *Id.*

³³ In 2013, the Obama Administration announced what is referred to as its “transitional policy,” which authorized States to allow insurance companies to continue to sell non-ACA-compliant health plans to small employers and individuals. This “transitional policy” has been extended multiple times, most recently through December 31, 2019. Although this market has

VII. Conclusion

It is important to emphasize that one of the main reasons why employers offer health coverage to their employees – even through an AHP – is to attract and retain talent. A strong argument can be made that to remain competitive among their peers, small employers – especially those offering health coverage through an AHP – are going to make sure that their plan offers a comprehensive level of health coverage so they can attract and retain talented workers.

Most of the AHPs that have started offering coverage as of January 1, 2019 voluntarily cover all of the EHBs. In some cases, all of the plan designs offered by the AHP cover all ten (10) EHBs. In other cases, an AHP will offer multiple plan designs, some of which do not cover all ten (10) EHBs, while other plan designs cover all ten (10) EHBs. This approach provides flexibility for plan participants, while ensuring that *all* plan participants have access to EHB-plans.

There has been very little fraud in the case of fully-insured AHPs in the past. Why? Because States heavily regulate insurance carriers under-writing AHP health coverage. In addition, States impose specific requirements on agents and brokers who sell insurance, imposing significant penalties on agents/brokers that engage in the fraudulent sale of insurance products. Based on the current regulatory environment, it is unlikely that any fraud will occur in the context of fully-insured AHPs. In the case of self-insured AHPs, States and the DOL have the necessary tools to combat fraud, and existing law now acts as a deterrent against fraudulent behavior in the self-insured AHP context.

Economics 101 tells us that less healthy groups and less healthy individuals will be attracted to AHPs to the same extent healthy groups and individuals will be attracted to AHPs. Why? Because AHPs will offer comprehensive coverage at a lower cost. AHPs can offer the same level of coverage as a “small group” or “individual” market plan at a lower cost because of (1) lower administrative costs in the “large group” and self-insured markets, (2) no “risk adjustment,” which results in defensive pricing, and (3) the flexibility to provide benefit offerings like tele-health or value-based insurance designs. If less healthy groups and individuals exit the “small group” and “individual” markets, this will benefit the existing markets. At a minimum, less healthy groups and individuals exiting the markets will offset the effects of healthy people exiting the markets, thus negating the adverse effects that critics claim.

been shrinking, a good number of small employers – as well as individuals – are still enrolled in these non-ACA-compliant plans. Because these non-ACA-compliant plans are subject to different rules than ACA-compliant “small group” and “individual” market plans, these “lives” are in a separate risk pool and not a part of the existing “small group” and “individual” market risk pools. If the small employers and individuals that currently get coverage under these non-ACA-compliant “transitional” plans are attracted to an AHP, their enrollment in the AHP will likewise have zero impact on the ACA’s reformed “small group” and “individual” markets.

The Health 202: Association health plans expanded under Trump look promising so far

By Paige Winfield Cunningham

THE PROGNOSIS

A crop of new health insurance plans enabled under regulations from the Trump administration appears more consumer-friendly and less like “junk” insurance than Democrats originally charged.

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

President Trump billed the new rules as one of several ways to provide consumers with cheaper coverage options than they could find in the Obamacare marketplaces, prompting complaints by Democrats that he was undermining consumer protections laid out in the Affordable Care Act. There’s indeed plenty of evidence the administration is trying to weaken the ACA, including the Justice Department’s refusal to defend it in court.

But when it comes to these new association health plans, they appear — at least so far — to offer benefits comparable to most workplace plans and haven’t tried to discriminate against patients with preexisting conditions, according to an analysis released today by Kev Coleman, a former analyst at the insurance information website HealthPocket.

“We’re not seeing skinny plans,” said Coleman, who founded a website last year with information on association health plans. “We’re seeing the regular doctor care, we’re seeing emergency room care, we’re seeing mental health coverage.”

The farm cooperative Land O’Lakes, which is expanding its association plan to farmers in Nebraska and Minnesota, has said its premiums will cost 25 percent to 35 percent less than plans sold on Nebraska’s ACA marketplace. Every category of essential health benefits — which are required for marketplace plans — is covered, according to an analysis by Modern Healthcare.

Several business associations in Nevada have started offering association health plans to member companies. Enrollees in the plan offered by the Reno-Sparks Chamber of Commerce have cited lower deductibles and out-of-pocket costs.

Two of Michigan's largest business associations are partnering to offer members association plans managed by BlueCross BlueShield of Michigan, some of which will cover essential health benefits and offer different premium and deductible levels.

According to Coleman, who analyzed 28 association health plans operating under the new rules, a majority of the new association plans are being launched by regional chambers of commerce, four out of five are being managed by a third-party insurance company, and half the plans offer tax-free savings account options.

The idea behind expanding association health plans was to make more widely available the type of coverage often offered to employees of big companies. Small businesses have typically struggled to provide affordable coverage for workers, given the small size of their risk pools.

The new regulations allow small businesses, associations and self-employed individuals — including those operating in different industries — to band together to buy health coverage by pooling all of their employees together. The health consulting firm Avalere has estimated 3.2 million people could eventually be covered by such plans, which have to comply with the same rules governing large employer plans.

The association plans don't have to cover the essential health benefits required of plans purchased by individuals in the ACA marketplaces — something Democrats have been quick to note. Analysts have also warned that they'll cause marketplace premiums to increase by as much as 3.5 percent, by drawing healthy people away from Obamacare plans and into association coverage.

But what's sometimes been lost in heated, politicized exchanges is that the Labor Department did ban these plans from discriminating against patients with preexisting conditions. That perhaps reflects a growing realization among Republicans that opposing these popular protections is a political loser.

Democrats' claims that association plans constitute "junk" insurance aren't necessarily true. That's because the plans are subject to the same requirements currently in place for large employer plans, including requirements to fully cover preventive care and bans on limiting annual and lifetime benefits.

Republicans strove to highlight association health plans in a contentious Capitol Hill hearing Tuesday. Ways and Means Democrats spent their time bashing GOP lawmakers for trying so long and hard to knock down the ACA and its protections for people with preexisting conditions.

For their single witness, Republicans brought in Rob Robertson, chief administrator of the Nebraska Farm Bureau Federation. The organization for farmers and ranchers is offering an association health plan it says will cost 25 percent less than plans currently offered in the state's individual market and will cover a broad range of benefits including prescription drugs, emergency room visits and prenatal and maternity care.

The plan won't discriminate against people with preexisting conditions, Robertson said. **That's now a point of emphasis for Republicans, who spent last year's midterm elections on the defensive as Democrats accused them of abandoning people with serious medical conditions and drawing attention to a GOP-led state lawsuit against the ACA that could dismantle those protections.**

"I say to my colleagues on the other side of the aisle, take 'yes' for an answer," Rep. Tom Reed (R-N.Y.) said. "We agree with you. This reform is good; this reform will stay as the law of the land."

But even if association health plans ultimately prove successful — and it's too early to say for sure — Republicans face a harsh reality on health-care policy. After years of slamming the ACA but failing to come up with a viable alternative, they're now stuck in a defensive posture as energized Democrats leveraged the issue to their favor in 2018 and seek to do the same in 2020.

"They get that preexisting conditions must be protected," Rep. Tom Suozzi (D-N.Y.) said sarcastically in remarks aimed at his colleagues on the other end of the dais. "They hear the message — it only took years; it only took hundreds of millions of dollars of campaign commercials."

AHH, OOF and OUCH

AHH: House Budget Committee Chairman John Yarmuth (D-Ky.) said the party will begin holding hearings in the spring on expanding Medicare -- the latest signal that Democratic lawmakers want to move forward with discussing a national health-care program.

In an interview with Reuters's Yasmeen Abutaleb and Susan Cornwell, Yarmuth said a "majority" in the party wants to "do something, some kind of Medicare expansion. I've had a number of major corporate CEOs say to me we need to go to Medicare for All." Yarmuth cited a goal of getting some kind of legislation passed by the end of next year and told Reuters it may be practical to pass a bill allowing people to join Medicare as early as age 50 or 55.

1/6/2018 The Health 202 Association health plans expanded under Trump took a step closer to the White House Post
 The Health 202 wrote last week about the many varied Medicare-for-All-style plans Democrats have proposed so far.

OOO: FDA inspectors found a Mylan manufacturing plant in West Virginia may have recorded that drugs passed tests even when they fell short of U.S. standards, during an inspection in November 2016, Bloomberg News's Anna Edney wrote in this first in a series of four investigative pieces.

"The inspectors also found bins full of shredded documents, including quality-control records, in parts of the factory where every piece of paper is supposed to be saved," Anna writes. "A warning letter, the FDA's strongest rebuke, was drafted. It would mean the agency could refuse to consider any Mylan application for a new drug made at that plant until the company fixed things."

But the FDA never sent Mylan a warning letter. By July 2017, agency leaders had decided to leave the issue in Mylan's hands.

"[FDA Commissioner Scott] Gottlieb's actions on generic approvals have drawn praise from both parties in Congress," Anna reports. "But with Democrats having taken control of the House, members who oversee the FDA say they plan to examine a crucial public-health question posed by his efforts: **Is the fast-tracking of those approvals coming at the expense of oversight that's supposed to ensure that drugs already on the market are safe and effective?**"

A decline in inspections and a relaxing of penalties have raised quality concerns, Anna reports. While FDA increased its generic drug approvals 94 percent in fiscal year 2018, surveillance inspections done globally by the FDA—meant to ensure existing drug-making plants meet U.S. standards— have fallen, she writes.

OUCH: Planned Parenthood's new president Leana Wen is ready for a fight against the Trump administration, which is expected to soon announce a final Title X family-planning funding plan, our Post-colleague Ariana Eunjung Cha reports.

The proposed plan announced in May would prohibit federal money from going to clinics that provide abortion services or referrals. The network of women's health and abortion clinics serves about 41 percent of Title X patients, receiving about \$60 million from the program, Ariana writes.

In an interview with The Post, Wen said changes in the proposal "would compromise our ethical obligations," comparing abortion services to insulin for diabetics. "I want people to think about what if this were any other aspect of medical care. Imagine if the Trump administration prevented people with diabetes from talking to their doctors about insulin," she said, adding: "Whatever decisions are coming up have nothing to do with medicine and everything to do with politics."

Wen pledged to try to get the expected new ruled delayed, get lawmakers to reverse the changes or take the issue to court. She also noted the program serves mostly disadvantaged and minority women. "They are trying

to prevent people who already have the greatest barrier" from care, Wen said.

HEALTH ON THE HILL

— Members of the Senate Finance Committee debated skyrocketing prescription drug prices in a hearing yesterday, vowing to summon pharmaceutical executives before them in the future. **Committee Chairman Chuck Grassley (R-Iowa) and ranking Democrat Ron Wyden (Ore.) noted in opening statements they invited several pharmaceutical executives to testify before the panel, but all but two declined.**

"The companies that declined said they would be very happy to have discussions in private but not in public," Grassley said. "That is not what I mean when I talk about transparency."

"That ought to tell you something," Wyden said about the companies' refusal. "Even the Big Tobacco companies were willing to come to Congress and testify, and they made a product that kills people. They all lied to me, but at least they showed up...The drugmakers are going to have to show up as well."

— Discussion during the hearing largely revolved around ideas that have been floated before, such as a potential change to the rebate structure, restructuring the 340B federal drug discount program (which requires drug companies to give discounts to hospitals serving low-income people) and allowing Medicare Part D to negotiate directly with drug companies -- one proposal that Grassley has said he doesn't want to pursue.

Wyden said reforms are needed to Medicare Part D. "Why isn't Medicare negotiating?" Wyden asked. "Private Part D plans negotiate with drugmakers ... I don't see how Part D, as structured today, is going to protect the senior and the taxpayer."

— **When asked by Grassley to name one way to lower drug costs, former CBO Director Doug Holtz-Eakin suggested changing the 340B drug program, which has grown far beyond its original scope.** "The first thing to do is stop having policies that push up drug prices and one that comes to mind is the 340 B program," he said. "It was a well-intentioned program that was intended to provide drugs at lower costs to needy patients. But it's not well-targeted on those patients right now, it's leading to higher drug costs, and I would encourage the committee to take a close look at reforming the 340B program."

But Sen. Debbie Stabenow (D-Mich.) challenged Holtz-Eakin's remarks, saying she wanted to "disagree that 340B is the primary reason for higher prices. There's a whole lot of other reasons and that is not the primary reason."

— **There was also discussion around drug rebates, which the Department of Health and Human Services has targeted as a cause of high drug list prices.** Peter Bach, director of the Memorial Sloan Kettering Center for Health Policy and Outcomes, explained the current rebate structure allows higher list

prices for drugs and higher rebates that “push more than the fair share to the patients that take expensive drugs,” adding that those patients pay “more than the negotiated price.”

When Sen. John Cornyn (R-Tex.) asked why an anti-kickback rule essentially barring rebates exists under the Social Security Act but not for prescription drugs, there was laughter in the room when Holtz-Eakin said he “can’t explain that and won’t pretend to.”

“It’s not a transparent arrangement, and it does produce upward pressure on drug prices and the negotiation between the [pharmacy benefit managers] and pharma in terms of the net cost,” Cornyn said.

— When Sen. Kamala Harris advocated at a CNN town hall this week for doing away with private health insurance to make way for Medicare-for-All, she stepped into an area of specifics that made her vulnerable to criticism.

Harris’s suggestion that the United States should “move on” from private health insurance, “drew attention to the fact that the Medicare-for-all plans backed by 16 senators — including five potential candidates for the Democratic nomination — would in effect remove private health insurance from the estimated 251 million Americans who use it, broadly disrupting the industry and the way Americans experience the medical system,” our Post colleague Annie Linskey reports.

There was a swift response from Republicans as well as from Howard Schultz, the billionaire coffee tycoon considering an independent presidential run. “That’s not American,” the former Starbucks chief executive, said on CBS News. “What’s next? What industry are we going to abolish next? The coffee industry?”

Annie compares the remarks in part to President Barack Obama, who was criticized for saying about the ACA before it was implemented: “If you like your health-care plan, you’ll be able to keep your health-care plan.”

“On the campaign trail, candidates often hear complaints from voters frustrated by rising drug prices, staggering and widely inconsistent medical bills, skyrocketing deductibles, unaffordable premiums, and difficult-to-conquer bureaucracies, creating pressure to offer a sweeping overhaul plan,” Annie writes. **“But the candidates’ slogans inevitably prove difficult to implement. And often it’s not exactly clear what those slogans meant to begin with.”**

She adds experience suggests voters, “despite their complaints about the health system, often react negatively to proposals for sweeping change, possibly because of uncertainty about what would follow.”

AGENCY ALERT

— On the same day lawmakers were talking drug pricing on Capitol Hill, Health and Human Services Secretary Alex Azar called for pharmaceutical companies to bring down the cost of

3/6/2018 The Health 990: Association health plans expanded under Trump look promising so far. The Washington Post
medications, criticizing the companies that “once again announced large price increases” at the beginning of the year.

Azar noted that a goal for the Trump administration is to bring down list prices altogether. “Drug companies defend themselves by pointing out that these annual increases are on the ‘list price’ of drugs,” he writes in a Stat op-ed. “List prices are typically reduced by additional payments to middlemen such as pharmacy benefit managers and health insurers ... But Americans know better, because increases in list prices hit their pocketbooks.”

Azar explicitly writes that “the definition of success for Americans and for President Trump will be lower list prices — not flat net prices or smaller and fewer list price increases.” The inclusion suggests the administration is pushing back on pharmaceutical companies that have so far simply stalled price hikes, wrote Rachel Sachs, an associate professor of law at Washington University School of Law in St. Louis:

3/6/2019

Final Vote Results for Roll Call 69

FINAL VOTE RESULTS FOR ROLL CALL 69(Republicans in roman; Democrats in *italic*; Independents underlined)**H R 1892** RECORDED VOTE 9-Feb-2018 5:32 AM**QUESTION:** On Motion to Concur in the Senate Amdt to the House Amdt to the Senate Amdt**BILL TITLE:** The Bipartisan Budget Act of 2018

	AYES	NOES	PRES	<u>NY</u>
REPUBLICAN	167	67		4
DEMOCRATIC	73	119		1
INDEPENDENT				
TOTALS	240	186		5

--- AYES 240 ---

Abraham	Gibbs	<i>Murphy (FL)</i>
Aderholt	<i>Gonzalez (TX)</i>	<i>Nolan</i>
Allen	Goodlatte	Nunes
Amodei	<i>Gottheimer</i>	<i>O'Halleran</i>
Arrington	Gowdy	<i>O'Rourke</i>
Babin	Granger	Olson
Bacon	Graves (GA)	Palazzo
Banks (IN)	Graves (MO)	<i>Pascarell</i>
Barletta	<i>Green, Al</i>	Paulsen
Barr	<i>Green, Gene</i>	Pittenger
<i>Beatty</i>	Grothman	Poe (TX)
<i>Bera</i>	Guthrie	Poliquin
Bergman	<i>Hanabusa</i>	Reichert
Bilirakis	Handel	<i>Rice (NY)</i>
<i>Bishop (GA)</i>	Harper	Roby
Bishop (MI)	Hartzler	Roe (TN)
Bishop (UT)	<i>Heck</i>	Rogers (AL)
Blackburn	Higgins (LA)	Rogers (KY)
<i>Blunt Rochester</i>	<i>Higgins (NY)</i>	Rooney, Francis
Bost	Hill	Rooney, Thomas J.
Brady (TX)	<i>Himes</i>	<i>Rosen</i>
Brooks (IN)	<i>Huffman</i>	Roskam
Buchanan	Huizenga	Ross
Bueshon	Hultgren	Royce (CA)
Burgess	Hunter	<i>Ruiz</i>
<i>Bustos</i>	Hurd	<i>Ruppersberger</i>
<i>Butterfield</i>	Issa	Russell
Byrne	<i>Jackson Lee</i>	Rutherford
Calvert	Jenkins (KS)	<i>Ryan (OH)</i>
<i>Carbajal</i>	Jenkins (WV)	Ryan (WI)
Carter (GA)	Johnson (OH)	Scalise
Carter (TX)	<i>Johnson, E. B.</i>	<i>Schneider</i>
<i>Cartwright</i>	Johnson, Sam	<i>Scott (VA)</i>
<i>Castor (FL)</i>	Joyce (OH)	Scott, Austin

<http://clerk.house.gov/evs/2018/roll069.xml>

1/4

Cheney	<i>Kaptur</i>	<i>Scott, David</i>
Coffman	Katko	Sessions
<i>Cohen</i>	<i>Keating</i>	<i>Sewell (AL)</i>
Cole	Kelly (MS)	<i>Shea-Porter</i>
Collins (GA)	Kelly (PA)	Shimkus
Collins (NY)	<i>Kilmer</i>	Shuster
Comstock	King (NY)	Simpson
Conaway	Kinzinger	<i>Sinema</i>
<i>Connolly</i>	Knight	<i>Slaughter</i>
Cook	<i>Kuster (NH)</i>	Smith (NJ)
<i>Costa</i>	Kustoff (TN)	Smith (TX)
Costello (PA)	LaHood	<i>Soto</i>
<i>Courtney</i>	LaMalfa	Stefanik
Cramer	Lamborn	Stewart
Crawford	Lance	Stivers
<i>Crist</i>	<i>Langevin</i>	Taylor
<i>Cuellar</i>	<i>Larsen (WA)</i>	Tenney
Culberson	<i>Larsen (CT)</i>	<i>Thompson (CA)</i>
Curbelo (FL)	Latta	<i>Thompson (MS)</i>
Davis, Rodney	<i>Lawrence</i>	Thompson (PA)
<i>DeLauro</i>	<i>Lawson (FL)</i>	Thornberry
<i>DelBene</i>	LoBiondo	Tipton
Denham	<i>Loebsack</i>	<i>Tonko</i>
Dent	Loudermilk	Trott
DeSantis	Love	<i>Tsongas</i>
DesJarlais	Lucas	Turner
<i>Deutch</i>	Luetkemeyer	Upton
Diaz-Balart	<i>Lynch</i>	Valadao
Donovan	MacArthur	<i>Vela</i>
<i>Doyle, Michael F.</i>	Marchant	<i>Visclosky</i>
Duffy	Marino	Wagner
Dunn	Marshall	Walberg
Estes (KS)	Mast	Walden
<i>Esty (CT)</i>	McCarthy	Walorski
<i>Evans</i>	McCaul	Walters, Mimi
Farenthold	<i>McCollum</i>	Weber (TX)
Faso	McHenry	<i>Welch</i>
Ferguson	McKinley	Wenstrup
Fitzpatrick	McMorris Rodgers	Williams
Fleischmann	<i>McNerney</i>	Wilson (SC)
Flores	McSally	Wittman
Fortenberry	Meehan	Womack
Frelinghuysen	Messer	Woodall
<i>Fudge</i>	Mitchell	<i>Yarmuth</i>
Gallagher	Moolenaar	Young (AK)
<i>Garamendi</i>	Mullin	Young (IA)

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<i>Adams</i>	Gosar	<i>Panetta</i>
<i>Aguilar</i>	Graves (LA)	<i>Payne</i>
Amash	Griffith	Pearce
<i>Barragán</i>	<i>Grijalva</i>	<i>Pelosi</i>

Barton	<i>Gutiérrez</i>	<i>Perlmutter</i>
Bass	Harris	Perry
Beyer	<i>Hastings</i>	<i>Peters</i>
Biggs	Hensarling	<i>Peterson</i>
<i>Blumenauer</i>	Herrera Beutler	<i>Pingree</i>
<i>Bonamici</i>	Hice, Jody B.	<i>Pocan</i>
<i>Boyle, Brendan F.</i>	Holding	<i>Polis</i>
<i>Brady (PA)</i>	Hollingsworth	Posey
Brat	<i>Hoyer</i>	<i>Price (NC)</i>
Brooks (AL)	Hudson	<i>Quigley</i>
<i>Brown (MD)</i>	<i>Jayapal</i>	<i>Raskin</i>
<i>Brownley (CA)</i>	<i>Jeffries</i>	Ratcliffe
Buck	<i>Johnson (GA)</i>	Reed
Budd	Johnson (LA)	Renacci
<i>Capuano</i>	Jordan	Rice (SC)
<i>Cárdenas</i>	<i>Kelly (IL)</i>	<i>Richmond</i>
<i>Carson (IN)</i>	<i>Kennedy</i>	Rohrabacher
<i>Castro (TX)</i>	<i>Khanna</i>	Rokita
Chabot	<i>Kihuen</i>	Ros-Lehtinen
<i>Chu, Judy</i>	<i>Kildee</i>	Rothfus
<i>Cicilline</i>	<i>Kind</i>	Rouzer
<i>Clark (MA)</i>	King (IA)	<i>Roybal-Allard</i>
<i>Clarke (NY)</i>	<i>Krishnamoorthi</i>	<i>Rush</i>
Clay	Labrador	<i>Sánchez</i>
<i>Cleaver</i>	<i>Lee</i>	Sanford
<i>Clyburn</i>	<i>Levin</i>	<i>Sarbanes</i>
Comer	<i>Lewis (GA)</i>	<i>Schakowsky</i>
<i>Cooper</i>	Lewis (MN)	<i>Schiff</i>
<i>Correa</i>	<i>Lieu, Ted</i>	<i>Schrader</i>
<i>Crowley</i>	<i>Lipinski</i>	Schweikert
Curtis	<i>Lofgren</i>	Sensenbrenner
Davidson	Long	Serrano
<i>Davis (CA)</i>	<i>Lowenthal</i>	<i>Sherman</i>
<i>Davis, Danny</i>	Lowey	<i>Sires</i>
<i>DeFazio</i>	<i>Lujan Grisham, M.</i>	Smith (MO)
<i>DeGette</i>	<i>Luján, Ben Ray</i>	Smith (NE)
<i>Delaney</i>	<i>Maloney, Carolyn B.</i>	<i>Smith (WA)</i>
<i>Demings</i>	<i>Maloney, Sean</i>	Smucker
<i>DeSaulnier</i>	Massie	<i>Speier</i>
<i>Dingell</i>	<i>Matsui</i>	<i>Suozi</i>
<i>Doggett</i>	McClintock	<i>Swalwell (CA)</i>
Duncan (SC)	<i>McEachin</i>	<i>Takano</i>
Duncan (TN)	<i>McGovern</i>	<i>Titus</i>
<i>Ellison</i>	Meadows	<i>Torres</i>
Emmer	<i>Meeks</i>	<i>Vargas</i>
<i>Engel</i>	<i>Meng</i>	<i>Veasey</i>
<i>Eshoo</i>	Mooney (WV)	<i>Vélázquez</i>
<i>Espallat</i>	<i>Moore</i>	Walker
<i>Foster</i>	<i>Moulton</i>	<i>Waltz</i>
Fox	<i>Nadler</i>	<i>Wasserman Schultz</i>
<i>Frankel (FL)</i>	<i>Napolitano</i>	<i>Waters, Maxine</i>
<i>Gabbard</i>	<i>Neal</i>	<i>Watson Coleman</i>
Gaetz	Newhouse	Webster (FL)
<i>Gallego</i>	Noem	Westerman

3/6/2019

Final Vote Results for Roll Call 69

Garrett	Norcross	Wilson (FL)
Gianforte	Norman	Yoder
Gohmert	Pallone	Yoho
Gomez	Palmer	Zeldin

--- NOT VOTING 5 ---

Black	Bridenstine	Jones
Blum	Cummings	

Ms. Katie Keith

Subcommittee on Health
Hearing on
“Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and
Ensure Pre-Existing Conditions Protections”
February 13, 2019

Additional Questions for the Record
Ms. Katie Keith, JD, MPH, Associate Research Professor and Adjunct Professor of Law,
Georgetown University

The Honorable Debbie Dingell (D-MI)

1. You noted that a recent analysis from the Kaiser Family Foundation showed that no short-term plans covered maternity care in 2018. How will the Trump Administration’s decision to expand short-term plans affect pregnant women in the individual market?

Answer: First, the Trump administration’s decision to expand short-term plans is contributing to higher premiums for consumers, including pregnant women, in the individual market. The burden of higher premiums falls primarily on middle-income families and individuals who are not eligible for subsidies under the Affordable Care Act.

Second, while the Trump administration has asserted that short-term plans provide additional choices in the market, these plans are not an option for pregnant women. These plans are medically underwritten and would likely treat being pregnant as a pre-existing medical condition. Because of this, short-term plan insurers can, and likely do, refuse to offer a policy to a pregnant woman or charge her much higher premiums, making the policy unaffordable.

Finally, short-term plans present a particular risk for women who enroll in this type of coverage and then become pregnant. As you note in your question, these plans typically do not cover maternity care. Thus, enrollees who become pregnant are exposed to significant health and financial risks by having to pay for maternity care on their own or forgoing care that they and their family need.

I am especially concerned about what this might mean for young women. Data from Young Invincibles shows that 83 percent of first-time mothers are between the ages of 18 and 34.¹ Short-term plans are marketed to younger, healthier people—often through

¹ Erin Hemlin, *What's Happened to Millennials Since the ACA? Unprecedented Coverage and Improved Access to Benefits*, Young Invincibles (Apr. 2017), available at: <http://younginvincibles.org/wp->

Ms. Katie Keith

aggressive and misleading marketing tactics, as discussed in my written testimony. Young women may enroll in a short-term policy and become pregnant only to find out that the policy will not cover maternity care or other critical services that they may need.

2. The Trump Administration's Section 1332 waiver guidance will let states choose to allow insurance plans that do not follow the ACA's consumer protections as long as at least one ACA compliant plan is offered. Some have tried to argue that this guidance would maintain protections for people with pre-existing conditions because at least one ACA plan would be available. Can you describe how this decision will actually impact people with pre-existing conditions in the individual market?

Answer: The impact of the Section 1332 waiver guidance will depend on the proposals that states develop in response to the Trump administration's guidance. To date, no state has yet applied for a waiver under the Trump administration's relaxed interpretations.

The guidance is, however, concerning because it encourages states to propose waivers that would undermine access to coverage and care for people with pre-existing medical conditions in the individual market. The new guidance encourages states to define "coverage" to include plans that allow for medical underwriting and do not cover pre-existing conditions. As a result, states could allow increased enrollment in short-term plans or other non-comprehensive sources of coverage. The guidance suggests that states could potentially receive federal funding to subsidize these plans, which discriminate against those with pre-existing conditions. The new guidance would also allow for state waivers that increase the number of people with less comprehensive coverage or higher out-of-pocket costs. This would be especially burdensome to those with pre-existing conditions who need regular care.

Overall, the guidance encourages states to consider waivers for less comprehensive coverage that would not meet the needs of those with pre-existing conditions. Because these types of proposals are inconsistent with the text of Section 1332 and the Affordable Care Act, I expect that approval of a waiver that fails to meet the statutory requirements of Section 1332 would face a swift legal challenge.

The Honorable Kathy Castor (D-FL)

1. Please identify the insurance companies that are offering short-term, limited duration plans and in which states they are offering them.

Answer: There is currently no source of comprehensive data on the insurance companies that are offering short-term, limited duration plans and in which states they are offering them. Even state insurance departments have little information about the status of their

Ms. Katie Keith

current short-term plan markets.² To help address this gap, the National Association of Insurance Commissioners (NAIC) is pursuing a data call on the sale of short-term, limited duration insurance coverage. It is not clear when this data call will be finalized or whether (and the degree to which) the results will be made available to the public.

Although comprehensive data does not exist, I am aware of a number of insurance companies offering this type of coverage, typically in multiple states. These include Golden Rule Insurance Company, National General Accident and Health, and Health Insurance Innovations, Inc. Additional data is available from a study by colleagues at Georgetown University's Center on Health Insurance Reforms that identified insurance companies that are eligible to sell short-term, limited duration plans in 17 states (although not all may be actively doing so at this time).³ Finally, an annual report from the NAIC, released in 2018, identifies the 30 largest companies that offered short-term coverage in 2017.⁴

² Emily Curran et al., "Do States Know the Status of Their Short-Term Health Plan Markets?" *Commonwealth Fund Blog* (Aug. 2018), available at: <https://www.commonwealthfund.org/blog/2018/do-states-know-short-term-health-plan-markets>.

³ Emily Curran et al., "Do States Know the Status of Their Short-Term Health Plan Markets?" *Commonwealth Fund Blog* (Aug. 2018), available at: <https://www.commonwealthfund.org/blog/2018/do-states-know-short-term-health-plan-markets>.

⁴ National Association of Insurance Commissioners, *2017 Accident and Health Policy Experience Report*, at 83 (2018), available at: https://www.naic.org/prod_serv/AHP-LR-18.pdf.

April 24, 2019

The Honorable Debbie Dingell
U.S. House of Representatives
116 Cannon House Office Building
Washington, DC 20515

The Honorable Debbie Dingell:

Thank you for your time and attention during my testimony before the House Energy and Commerce's Subcommittee on Health's hearing entitled "Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections" concerning short-term limited duration insurance (STLDI).

Following my testimony, you asked:

You noted that the Administration's decision to cut outreach and enrollment efforts by 90 percent has made it difficult to reach and inform consumers. Can you describe the efforts you would be making if this funding was restored?

I appreciate you highlighting the importance of adequately funding outreach and enrollment efforts. At its fundamental essence, outreach and enrollment is critical to the long-term viability of the health insurance market, because outreach encourages enrollment. As more people are enrolled in health insurance coverage, the size of the risk pool increases, and therefore the more expensive risks are spread across a larger population. Additionally, increasing enrollment means that more people have health insurance coverage and are consequently protected from being subject to overwhelming medical debt if they need significant medical care. Finally, health insurance coverage allows individuals to more readily access health care services, which can allow for a more proactive approach to avoiding catastrophic and costly medical conditions which consequently lowers the overall costs of the health care system.

To facilitate increased enrollment in the health insurance market, outreach and enrollment initiatives use a two-prong approach. First, outreach efforts focus on educating consumers about the importance of enrolling in health insurance at the right time, in the health insurance product most suitable for the consumer's needs. Outreach campaigns highlight the criticality of open enrollment periods, while also providing educational opportunities for individuals regarding the nuances of shopping for and selecting an appropriate health insurance plan – for example, adequate provider networks, drug formulary coverage, and anticipated out-of-pocket costs.

Second, enrollment efforts focus on securing successful enrollment for consumers in the most appropriate coverage for them. For example, enrollment assistance generally allows a consumer to explore whether their income allows them to secure health care coverage through a government program, or whether financial assistance is available within the individual market. Enrollment efforts also focus on ensuring the consumer's enrollment is effectuated, rather than having the application process stalled for various reasons.

As the federal government currently runs Pennsylvania's health insurance exchange, we have relied on the federal government to conduct outreach and enrollment efforts in the Commonwealth. As the federal government ceased conducting such activities, outreach and enrollment efforts have fallen to the state to coordinate and fund. We have conducted successful outreach and enrollment campaigns operating on a very limited budget, using funds that have had to unfortunately be reallocated from other purposes. If outreach and enrollment funding were restored, the funding would be given to the federal government as the entity responsible for running Pennsylvania's exchange.

Our expectation is that if this funding were to be restored, the federal government would use those funds to once again implement a rigorous and multi-faceted approach to outreach and consumer assistance for the health insurance exchange, including broad marketing and advertising, as well as targeted and on-the-ground efforts through a robust navigator program and other strategies.

Based on the most recent American Community Survey data, Pennsylvania's uninsured rate is at an all-time low. Overall, our goal is to ensure that we continue to increase coverage and move that number in the right direction, not the wrong one. We view outreach and enrollment efforts as a critical piece of ensuring that happens. If these funds were restored and used effectively, they would be used to support Pennsylvanians through the enrollment process, ensure they are aware of the timelines, options, and financial assistance, and, ultimately, increase coverage.

Thank you for the opportunity to respond to your question. We look forward to working with you on the many issues involving health insurance coverage and are pleased that you have an interest in these matters.

Sincerely,

Jessica K. Altman
Commissioner

cc: Hon. Frank Pallone, Jr., Chairman
Committee on Energy and Commerce

Hon. Greg Walden, Ranking Member
Committee on Energy and Commerce

Hon. Anna G. Eshoo, Chairwoman
Subcommittee on Health

Hon. Michael C. Burgess, Ranking Member
Subcommittee on Health

April 24, 2019

The Honorable Kathy Castor
U.S. House of Representatives
2052 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kathy Castor:

Thank you for your time and attention during my testimony before the House Energy and Commerce's Subcommittee on Health's hearing entitled "Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections" concerning short-term limited duration insurance (STLDI).

Following my testimony, you asked:

Please identify the insurance companies that are offering short-term, limited duration plans and in which states they are offering them.

Thank you for your interest in the sales of STLDI. As I mentioned in my testimony, I have committed my Department to doing all that it can to make sure that STLDI is accurately and appropriately represented to Pennsylvanians, but remain concerned by the volume of untoward practices in the market. For that reason, we are working to better understand the proliferation of STLDI in the Commonwealth and are asking questions of our market similar to the question you raised to me.

As Pennsylvania's insurance commissioner, I am not in a position to provide national information on companies offering STLDI, nor in which states those companies are selling. I would be happy to provide additional information on STLDI in Pennsylvania specifically, if that information is of interest. However, the National Association of Insurance Commissioners (NAIC), which is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories, is working to coordinate with regulators like myself from across the country to better understand the overall STLDI market.

Specifically, the NAIC's Market Analysis Working Group will be issuing a survey on STLDI later this year. The data call will survey short-term plans' sale, coverage and marketing tactics, and how those things vary from state to state. The NAIC intends to share the non-proprietary information with Congress and the Administration. The findings will be helpful to regulators and legislators when attempting to glean how and where STLDI products are sold, and I believe will be the most helpful resource to respond to your question. With your permission, I will plan to coordinate with the NAIC to follow up with you following the compilation of the NAIC's survey to provide a more substantive response to your question.

Thank you for the opportunity to respond to your question. I look forward to working with you on the many issues involving health insurance coverage and are pleased that you have an interest in these matters.

Sincerely,

Jessica K. Altman
Commissioner

cc: Hon. Frank Pallone, Jr., Chairman
Committee on Energy and Commerce

Hon. Greg Walden, Ranking Member
Committee on Energy and Commerce

Hon. Anna G. Eshoo, Chairwoman
Subcommittee on Health

Hon. Michael C. Burgess, Ranking Member
Subcommittee on Health



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

April 25, 2019

Hon. Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone:

Thank you for inviting me to testify before the Subcommittee on Health on February 13 about "Strengthening Our Health Care System."

Please see attached for my reply to the written follow-up question from Rep. Kathy Castor about short-term limited duration plans and which states are offering them.

I hope to continue to work with the committee on legislation to strengthen our health care system and provide more choices of more affordable health coverage and care.

Sincerely,

Grace-Marie Turner
President

cc: Hon. Greg Welden, Ranking Member, Committee on Energy and Commerce
Hon. Anna G. Ishoo, Chairwoman, Subcommittee on Health
Hon. Michael C. Burgess, M.D., Ranking Member, Subcommittee on Health

Q. Please identify the insurance companies that are offering short-term limited duration plans and in which states they are offering them.

A. The following table lists, by state, the insurers that reported short-term limited-duration policies in effect as of December 31, 2018.

State	Parent Company	Subsidiary
AR	CATHOLIC HLTH INITIATIVES GRP	QCA HLTH PLAN INC
AR	ARKANSAS BCBS GRP	USABLE MUT INS CO
DE	GENEVE HOLDINGS INC GRP	INDEPENDENCE AMER INS CO
ID	BLUE CROSS OF ID GRP	BLUE CROSS OF ID HLTH SERV INC
IL	CARLE HOLDING CO GRP	HEALTH ALLIANCE MEDICAL PLANS
IL	WARRIOR INVICTUS HOLDING CO GRP	UNITED SECURITY HLTH & CAS INS CO
IN	UNITEDHEALTH GRP	GOLDEN RULE INS CO
MI	JACKSON NATL GRP	JACKSON NATL LIFE INS CO
MI	SPECTRUM HLTH GRP	PRIORITY HLTH INS CO
MO	BCBS OF KC GRP	BCBS OF KC
NC	AMTRUST NGH GRP	INTEGON NATL INS CO
NY	GENEVE HOLDINGS INC GRP	STANDARD SECURITY LIFE INS CO OF NY
OH	MEDICAL MUT OF OH GRP	MEDICAL MUT OF OH
OH	MUNICH RE GRP	AMERICAN MODERN HOME INS CO
OR	CAMBIA HEALTH SOLUTIONS INC	LIFEMAP ASSUR CO
SC	BCBS OF SC GRP	COMPANION LIFE INS CO
TX	NEW ERA LIFE GRP	PHILADELPHIA AMER LIFE INS CO
TX	AMTRUST NGH GRP	NATIONAL HLTH INS CO
UT	IHC INC GRP	SELECTHEALTH BENEFIT ASSUR CO INC
UT	STANDARD LIFE & CAS INS CO	STANDARD LIFE & CAS INS CO
WI	SOUTHERN GUAR INS CO	SOUTHERN GUAR INS CO

The total number of STLD policies reported by insurers as in-force was 57,595, with an aggregate enrollment of 86,618 covered lives.

About the data: This information was compiled by Heritage Senior Fellow Ed Haislmaier using data from the National Association of Insurance Commissioners (NAIC) "Accident And Health Policy Experience Report" for 2018. Insurers file that report annually with state regulators. The table uses abbreviations assigned by the NAIC. Note that it is not possible to identify from this source instances of states 1) where an insurer has policies in-force but has stopped writing new policies, or; 2) where an insurer has started offering the coverage but did not yet have policies in-force as of the reporting date.

The Foundation for Government Accountability also closely follows short-term limited-duration plans. Senior fellow Josh Archambault reports that the plans are available in 42 states, based upon the most recent data available from

healthinsurance.org.

https://www.healthinsurance.org/assets/img/landing_pages/stm_pdf/state-by-state-short-term-health-insurance.pdf

He provided a list of some companies that sell short-term plans, but it is not exhaustive and they are not in all states. (For example, one company is in 26 states, and one is in 40 states.)

- Companion Life
- Everest Reinsurance Company
- LifeShield National Insurance Company
- National General Accident and Health
- Standard Life & Accident Insurance Company
- UnitedHealth
- IHC Group

Some BlueCross BlueShield state plans are selling in the market as well but don't sell under the name BCBS or Anthem.

Value of Bridge Plans: During the hearing, many members of the committee called STLD plans “junk insurance” because these policies are not required to cover all of the benefits mandated by the Affordable Care Act. But these bridge plans can be a lifeline for people who are otherwise shut out of the market for insurance or need coverage when they are between jobs, starting new companies, retiring early, or otherwise can't afford traditional coverage.

One example: A single dad with two boys had to drop his ACA exchange policy because he lost his subsidy eligibility and couldn't afford to pay the high premiums. He wanted to protect his family and bought a short-term limited-duration plan. Tragically, one of his sons was diagnosed with leukemia some months after he bought the policy. The insurer paid \$170,000 for the boy to get the care he needed. His dad was extremely grateful this option was available to him. FGA polling shows the strong support for giving people the option of bridge plans, and a recent does as well.

<https://www.youtube.com/watch?v=2QB-QUxuR-A>

I appreciate your follow-question and am happy to provide additional information.

