

HEALTHCARE LIFELINE: THE AFFORDABLE CARE ACT AND THE COVID-19 PANDEMIC

VIRTUAL HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTEENTH CONGRESS SECOND SESSION

WEDNESDAY, SEPTEMBER 23, 2020

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HEALTH CARE LIFELINE: THE AFFORDABLE CARE ACT AND THE COVID-19 PANDEMIC

WEDNESDAY, SEPTEMBER 23, 2020

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

The subcommittee met, pursuant to call, at 10:00 a.m., via Cisco Webex online video conferencing, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

Members present: Representatives Eshoo, Engel, Butterfield, Matsui, Castor, Sarbanes, Luján, Schrader, Kennedy, Cárdenas, Welch, Ruiz, Dingell, Kuster, Kelly, Barragán, Blunt Rochester, 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, O'Halleran, and Rodgers.

Staff present: Jeffrey C. Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Perry Hamilton, Deputy Chief Clerk; Saha Khaterzai, Professional Staff Member; Una Lee, Chief Health Counsel; Aisling McDonough, Policy Coordinator; Meghan Mullon, Policy Analyst; Joe Orlando, Policy Analyst; Kaitlyn Peel, Digital Director; Tim Robinson, Chief Counsel; Chloe Rodriguez, Deputy Chief Clerk; Rick Van Buren, Health Counsel; Nolan Ahern, Minority Professional Staff, Health; Mike Bloomquist, Minority Staff Director; William Clutterbuck, Minority Staff Assistant; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; Clare Paoletta, Minority Policy Analyst, Health; and Brannon Rains, Minority Policy Analyst.

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

And due to COVID-19, today's hearing is being held, obviously, remotely. All Members and witnesses will be participating via video conferencing.

As part of our hearing, the microphones will be set on mute to eliminate background noise. So members and witnesses, please unmute your microphone each time you wish to speak so that we don't have to go through, can you hear me, am I—I see lips moving but no sound.

Documents for the record, will be sent to—or should be sent to Meghan Mullon at the email address we have provided to the staff, and all documents will be entered into the record at the conclusion of the hearing.

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

We begin our hearing today on a really very somber note. This week, our country passed the tragic milestone of losing 200,000 of our fellow Americans to COVID. And last Friday, America lost its most consequential jurist of our time, Justice Ruth Bader Ginsburg, to pancreatic cancer. These painful losses are why we are having this hearing today.

Millions of Americans are struggling. They are sick, many are hungry, so many are jobless. Yet on November 10, the Trump administration, along with Republican attorneys general, will argue before the Supreme Court that it should strike down the entirety of the Affordable Care Act. If successful—and they may be—21 million Americans will lose healthcare immediately.

Protections for the 133 million Americans with preexisting conditions, such as asthma, diabetes, and the lasting health conditions caused by COVID, which has infected 7 million Americans to date, will be gone. Young adults will lose their ability to stay on their parents' health insurance until the age of 26. Approximately 109 Americans will face lifetime limits on their coverage, keeping them from being able to afford care for expensive illnesses like cancer, hemophilia, and mental health conditions.

The title of today's hearing calls the Affordable Care Act a lifeline. This is the first recession where Americans who lose their job-based health coverage have the lifeline of affordable coverage because of the ACA. A recent study by the Kaiser Family Foundation found that for workers who filed unemployment claims during the pandemic, more than 20 million may be eligible for the ACA's Medicaid or marketplace coverage.

Some States, including my home State of California, have embraced the Affordable Care Act's lifeline and offered special enrollment periods. As we will hear from Peter Lee, the CEO of Covered California, the State offered a special enrollment period during the pandemic. Between March 20 and August 31, nearly 290,000 Californians signed up for coverage through the enrollment period.

I would like to enter into the record the letter I received from AFSCME Council 57 that said, quote: California's decision to have a special enrollment period for the ACA has been a game changer in the lives of those who have lost their healthcare coverage when they lost their jobs during the pandemic or have been impacted by the wildfires. Sadly, the Trump administration has not offered a special enrollment period, keeping Americans from the ACA's lifeline.

The American Medical Association wrote in a friend-of-the-court briefing that striking down the Affordable Care Act, quote, at a time when the system is struggling to respond to a pandemic, would be a self-inflicted wound that could take decades to heal, unquote.

I ask my Republican colleagues to avoid these self-inflicted wounds, end your decade-long fight to repeal and weaken the Af-

fordable Care Act. Join us in passing the HEROES Act to shore up Medicaid coverage for nearly 73.5 million Americans across our country and help save the jobs and health coverage of firefighters, of police officers, teachers, hospital workers, and other essential workers across our country.

I thank everyone, and I look forward to—we all look forward to welcoming and hearing from our witnesses.

[The prepared statement of Mr. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

We begin our hearing today on a somber note. Earlier this week our country passed the tragic milestone of losing 200,000 of our fellow Americans to COVID-19, and last Friday, America lost the greatest jurist of our time, Justice Ruth Bader Ginsburg to pancreatic cancer.

These painful losses are why we're having this hearing today. Millions of Americans are struggling, sick, hungry, and jobless, yet on November 10th the Trump Administration along with Republican Attorneys General will argue before the Supreme Court that it should strike down the entirety of the Affordable Care Act.

If successful, and they may be, 21 million Americans will lose health coverage immediately.

Protections for the 133 million Americans with preexisting health conditions such as asthma, diabetes, and the lasting health conditions caused by COVID-19 which has infected 7 million Americans to date, will be gone.

Two million young adults will lose their ability to stay on their parent's health insurance until the age of 26. Approximately 109 million Americans will face lifetime limits on their coverage, keeping them from being able to afford care for expensive illnesses like cancer, hemophilia, and mental health conditions.

The title of today's hearing calls the Affordable Care Act a "lifeline." This is the first recession where Americans who lose their job-based health coverage have the lifeline of affordable coverage because of the ACA. A recent study by the Kaiser Family Foundation found that for the workers who filed unemployment claims during the pandemic, more than 20 million may be eligible for the ACA's Medicaid or Marketplace coverage.

Some states, including my home state of California, have embraced the Affordable Care Act's lifeline and offered special enrollment periods. As we'll hear from Peter Lee, the CEO of Covered California, the state offered a special enrollment period during the pandemic. Between March 20th and August 31st nearly 290,000 Californians signed up for coverage through the enrollment period.

I'd like to enter into the record a letter I received from AFSCME Council 57 that said, "California's decision to have a special enrollment period for the ACA has been a game changer in the lives of those who have lost their healthcare coverage when they lost their jobs during the pandemic or have been impacted by the wild fires."

Sadly, the Trump Administration has not offered a special enrollment period, keeping Americans from the ACA's lifeline.

The American Medical Association wrote in a Friend of the Court Briefing that striking down the Affordable Care Act. "At a time when the system is struggling to respond to a pandemic. would be a self-inflicted wound that could take decades to heal."

I ask my Republican colleagues to avoid these self-inflicted wounds. End your decade-long fight to repeal and weaken the Affordable Care Act. Join us in passing the Heroes Act to shore up Medicaid coverage for nearly 73.5 million Americans across the country and help save the jobs and health coverage of firefighters, police, teachers, hospital workers, and other essential workers across the country.

Thank you and I look forward to hearing from our witnesses.

Ms. ESHOO. The Chair now recognizes Dr. Burgess, the ranking member of the Subcommittee on Health, for 5 minutes for his opening statement. And please remember to unmute.

Is Dr. Burgess with us?

If not, then I will recognize the ranking member of the full committee, Mr. Walden.

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

Mr. WALDEN. Well, thank you very much, Madam Chair. I assume you can hear me now. I will go ahead and start. I don't know where Dr. Burgess is, but I want to thank you for this hearing. It could give us a great opportunity to hear from the experts—and I hope we will—on how COVID-19's pandemic has affected healthcare coverage in this country.

And so we all need to have this discussion. We know Americans were promised, when the Affordable Care Act passed, a \$2,500 reduction in our insurance premiums, and lo and behold, that obviously never happened; in fact, just the opposite.

I remember all the stories when the ACA took over about people who were promised they could keep their health plan or their doctor, and neither of those things panned out well either. And meanwhile, we still have their—you know, a lot of folks who have no access to care, still in the 10 to 20 percent range in some places.

But I think even as troubling, if not more so, is the issues that have arisen around the edges. Chairman Pallone and I have worked a lot on this issue of surprise medical billing, something President Trump has been out front and leading on for most of the time in office. And we are very close it should become law, to stop this practice of surprise medical billing, where people think that—who have played by all the rules, think that they should be covered. And then as we heard in our hearings, turns out they get stuck with a bill for \$50,000 because somebody contracted out some facility within a hospital that their insurance said was covered, and they get stuck.

I am really troubled that we have not provided for continuous and robust funding for our community centers. It is a travesty that this Congress has not done that. As you know, Chairman Pallone and I, with our bill on surprise medical billing, could have funded that. And yet for whatever set of reasons, that hasn't happened either. And so our community health centers are left wondering, in the lurch, how long will they have their funding, how can they do their hiring, and they are hanging out there.

And so while we are having this hearing today and certainly will be informed thereby, I just sort of suspect that it will go down the lines of my friend's opening statement and perhaps trigger into some of the politics of healthcare as we are 45 days out from the election or whatever it is. And so it is unfortunate. We have worked together on a lot of issues, and there is certainly a lot we could do going forward.

It is unfortunate that we did not find common ground on the issues related to high cost of prescription drugs. But trading off innovation for—and cures, especially as we are seeing the fight on COVID, for the illusion that you are going to get cheaper prices just doesn't make sense.

And here we are, having worked together on 21st Century Cures legislation in the past and investing in our National Institutes of Health record amounts, looking forward to the various companies that have spent night and day trying to come up with a vaccine as they move through their trials. We have never needed innovation

more, not only in the vaccine world, but also in the world of therapies.

And finally I would just say, we need to work together to modernize the Strategic National Stockpile. There have been a lot of lessons learned at every phase as we have dealt with this unprecedented pandemic, a pandemic that, by the way, has killed millions across the world, hundreds of thousands. And it is not just in the U.S.

And so I think that Operation Warp Speed is something that we should be proud of, as the administration has moved at record pace to break down bureaucratic barriers while maintaining safety and efficacy of whatever pharmaceuticals become available, either treatments, which they are working on, therapies, as well as vaccines. These are twin needs for the American people and the healthcare of American people, and the administration has moved at record speed through this process to get these cures out to the public.

So I would close with this: I know the issue of preexisting conditions is something that is being raised, but let's not forget for those Republicans in 1996, as part of ERISA, put preexisting condition protection into law. I have multiple times this Congress, from day one, literally said, if we are going to have this litigation in the courts, shouldn't we come together as a Congress and reaffirm the preexisting conditions for American people, and that effort has been shot down every time by my friends on the other side of the aisle.

So there is a lot we can find common ground on, Americans expect us to do that, and I hope that after this hearing gets behind us, we could still work together this fall and get good things done.

And I yield back.

[The prepared statement of Mr. Walden follows:]

PREPARED STATEMENT OF HON. GREG WALDEN

Thank you, Madame Chairwoman. And welcome to our witnesses, thank you for being here today to offer your expertise.

Today's hearing could offer us a great opportunity to hear from experts about how the COVID-19 pandemic has affected healthcare coverage in this country. We could also discuss how, despite the Affordable Care Act still being the law of the land, the underlying costs of healthcare have continued to rise and are now being borne by patients who may have lost their employer-based care. Furthermore, we could also explore ways for the economy to safely reopen in coordination with public health efforts to ensure furloughed workers can come back to their jobs and regain the benefits they have bargained for and earned. I hope this hearing is an opportunity to discuss those worthy issues, which I believe should be of bipartisan interest.

I can't help but feel, however, that today's hearing is somewhat political in nature. That this topic will be used as an excuse to admonish the Trump Administration and celebrate the Affordable Care Act, to relitigate partisan debates of the past.

I want to be perfectly clear: Republicans support affordable healthcare for Americans. We also fully support protections for patients with pre-existing conditions. In fact, measures we've put on the House floor to affirm these protections have been denied four different times by Democrats. This issue is not up for debate. Holding a hearing that drudges up old arguments about the Affordable Care Act in an attempt to label Republicans as anti-patient is not only disingenuous, it is a waste of precious time.

In addition to supporting pre-existing conditions protections, we also want to address the cost of healthcare, an underlying problem that I hear from my constituents about on a regular basis. Americans were promised their premiums would go down by \$2500 a year if we passed the ACA but they did the opposite. Addressing

the cost of care is why I have worked in a bipartisan fashion with Chairman Pallone and Senators Alexander and Murray on the Lower Healthcare Costs Act, a bill that would bring much-needed transparency into our healthcare system and end the nefarious practice of surprise billing. These are the kinds of policies we should be discussing today, policies that put patients back in control of their healthcare and put dollars back in their pockets.

States, as the laboratories for democracy and public policy, are innovating to keep healthcare coverage accessible and affordable. My home state of Oregon, by working with both the Obama and Trump Administrations, has successfully applied for multiple waivers from CMS to invest in care and drive down the cost curve.

I'm also thrilled to have Director Cameron here from my neighboring state of Idaho. Director Cameron: I look forward to hearing about your partnership with providers to keep costs down for patients, especially during the COVID-19 pandemic.

As for the federal response to COVID-19, we have worked in a bipartisan fashion to provide trillions of dollars in relief to our communities. We have made testing and associated visits free to all patients regardless of their insurance status. We have poured funds into state Medicaid programs and set aside \$175 billion for medical providers to bring accessible testing and treatment to patients across the country. We have greatly expanded coverage of telehealth services and given patients more flexibility in how they spend their hard-earned dollars on healthcare expenses during the pandemic.

We do not believe, however, that the answer to every challenge is billions of dollars in increased federal spending. We have seen how one-size-fits-all approaches have affected the underlying cost of care, and we should be wary of the politicization of this crisis as a reason to massively expand federal programs. There are many types of coverage, including government programs, designed for times like this.

Dr. Holtz-Eakin: I look forward to your testimony on how we can target our response to directly address the challenges created by the economic downturn associated with this pandemic.

I want to close by urging my colleagues on both sides of the aisle to resist the temptation to engage in partisan politics; to be forward looking in our response to the COVID-19 pandemic; and to constructively engage our witnesses to tackle the legitimate public policy issues that have arisen during this crisis. If we simply retreat into our corners and use this hearing as an excuse to throw rocks at the other side, the American people will not benefit. I yield back.

Ms. ESHOO. Part 3 contained legislation. Cost of therapeutic drugs—Stockpile.

The Chair now recognizes the chairman of the full committee, Mr. Pallone. There is some terrible background noise.

Mr. WALDEN. Ma'am, I am having trouble hearing you. I would like to suspend this—

Ms. ESHOO. Would everyone mute so that we don't have that? It is really—thank you. Oh, there it goes again.

Frank, I think you are going to have to speak against this background noise.

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

Mr. PALLONE. Well, how is it now? Do you hear me well or not?

Ms. ESHOO. I can hear you, yes.

Mr. PALLONE. All right, let me try to—

Ms. ESHOO. It is still there. It is still there.

Mr. PALLONE. Thank you, Chairwoman Eshoo.

The COVID-19 pandemic has caused an unprecedented health and economic crisis. As many as 200,000 Americans have lost their lives, more than 6 million have been infected with the disease, of course, tens of millions have lost their jobs. And millions of American families are justifiably anxious and concerned about both their health and their financial security.

So as you know, the HEROES Act, which the House passed more than four months ago, would provide a lot of support and assistance to struggling families by expanding the healthcare safety net, increasing support to States to fund the Medicaid programs, and ensuring access to free treatment for COVID-19. But unfortunately, Senator McConnell and the Trump administration either do not understand the need for the Federal Government to take bold action, or worse, they prefer to willfully ignore and downplay the seriousness of the challenge before us.

So let me be clear, further delay in passing the HEROES Act or coming up with some kind of a consensus bill will cost us countless lives, lasting damage to our economy, and immeasurable financial hardship to millions of American families. And unfortunately, the Trump administration is not interested in working with Congress to address this crisis.

I know the President says he wants this or that, he wants a big bill, but hasn't really seriously sat down with the House leadership to come up with something that we can all agree on. Instead, the administration is actually seeking, in my opinion, to do further damage to our healthcare system and to the social safety net that millions of Americans have turned to during the crisis, and that is because the President continues to support this Republican lawsuit that is now before the Supreme Court to strike down the entire Affordable Care Act in the middle of this pandemic.

And now, the President and Senate Republicans are trying to jam a Supreme Court nominee through the Senate, just a month before the Presidential election, and I believe a big part of that is an attempt to seal the fate of the ACA and ensure its demise, because the hearing before the Supreme Court begins in November.

And I want to remind folks that what is at stake here, if the Trump administration succeeds and they do strike—and the Supreme Court does strike down the ACA. We would have 20 million Americans who would lose their healthcare coverage, protections for more than 133 million people with preexisting conditions would be eliminated, and everyone who has been infected with COVID-19 now has a preexisting condition and, in my opinion, could qualify as a preexisting condition. Also, tax credits for affordable health coverage would be gone, and young adults would no longer be able to stay on their parents' insurance until they turn 26. And of course, there is a lot, much more that would be repealed with the ACA, like the Indian Healthcare Improvement Act, and the list goes on.

But it doesn't have to be this way. Instead of attacking the ACA, the Trump administration could use it to help people in time of crisis. According to a Census Bureau survey, over 3 millions Americans have lost employer-sponsored coverage between April and July of this year. Yet the administration has refused to establish a broad special enrollment period to allow uninsured Americans to sign up for coverage through the ACA marketplace. And the Trump administration also refuses to invest in outreach and enrollment efforts to make Americans aware of their coverage options, and instead has imposed arbitrary barriers seemingly intended to deter enrollment.

In contrast, State-based marketplaces that have implemented broad emergency special enrollment periods have reported significant enrollment during the pandemic. People want to sign up.

Now, the Trump administration also continues to undermine Medicaid, even though it has been a lifeline for millions during the pandemic. According to one estimate, since February, Medicaid enrollment has increased by 6 million people. It is never a good time to be without health insurance, and it is especially dangerous during a pandemic.

A study by the University of Michigan found that even before the pandemic, Medicaid expansion had saved the lives of over 19,000 adults between the ages of 55 and 64. Medicaid is helping people keep healthcare coverage when they need it most.

So today's hearing is an opportunity to better understand the ACA's impact on the status of health coverage amidst the COVID-19 and what needs to be done to expand and improve access to quality—to quality affordable healthcare. And it is also an opportunity to reflect on what is at stake when the Supreme Court hears oral arguments in *Texas v. California* on November 11.

While the ACA has been a lifeline for millions during the pandemic, its future, once again, hangs in the balance of the Supreme Court, and I can't imagine, Madam Chair, that the stakes could be higher right now. So I look forward to the discussion. I think this hearing is very timely. And thank you again, Ms. Eshoo.

[The prepared statement of Chairman Pallone follows:]

PREPARED STATEMENT OF MR. PALLONE

The COVID-19 pandemic has caused an unprecedented health and economic crisis—200,000 Americans have lost their lives, more than six million have been infected with the disease and tens of millions have lost their jobs. Millions of American families are justifiably anxious and concerned about both their health and their financial security.

The Heroes Act, which the House passed more than four months ago, would provide more support and assistance to struggling families, by expanding the healthcare safety net, increasing support to states to fund their Medicaid programs, and ensuring access to free treatment for COVID-19. Unfortunately, Senator McConnell and the Trump Administration either do not understand the need for the Federal Government to take bold action, or worse, they prefer to willfully ignore and downplay the seriousness of the challenge we face. Let me be clear—further delay in passing the Heroes Act will cost us countless lives, lasting damage to our economy, and immeasurable financial hardship to millions of American families.

Unfortunately, the Trump Administration is not interested in working with Congress to address this crisis. Instead, the Administration is actually seeking to do further damage to our healthcare system and to the social safety net that millions of Americans have turned to during this crisis.

President Trump continues to support the Republican lawsuit that is now before the Supreme Court to strike down the entire Affordable Care Act (ACA) in the middle of a pandemic that has claimed the lives of more than 200,000 Americans. And now, the President and Senate Republicans are trying to jam a Supreme Court nominee through the Senate just a month before the Presidential election, in attempt to seal the fate of the ACA and ensure its demise.

I want to remind folks what is at stake here if the Trump Administration succeeds:

- 20 million Americans would lose their healthcare coverage;

- 1A protections for the more than 133 million people with pre-existing conditions would be eliminated and everyone who has been infected with COVID-19 now has a pre-existing condition;

- 1A tax credits for affordable health coverage would be gone;

- 1A young adults would no longer be able to stay on their parent's insurance until they turn 26; and much, much more.

It doesn't have to be this way. Instead of attacking the ACA, the Trump Administration could use it to help people in time of crisis. According to a Census Bureau survey, over three million Americans have lost employer-sponsored coverage between April and July of this year alone. Yet, the Administration has refused to establish a broad Special Enrollment Period to allow uninsured Americans to sign up for coverage through the ACA marketplaces.

The Administration also refuses to invest in outreach and enrollment efforts to make Americans aware of their coverage options, and instead, has imposed arbitrary barriers seemingly intended to deter enrollment. In contrast, state-based marketplaces that have implemented broad emergency Special Enrollment Periods have reported significant enrollment during the pandemic. The Administration also continues to undermine Medicaid, even though it has been a lifeline for millions during the pandemic. According to one estimate, since February, Medicaid enrollment has increased by 6 million people nationwide. There's never a good time to be without health insurance, and it's especially dangerous during a pandemic. A study by the University of Michigan found that even before the pandemic, Medicaid expansion had saved the lives of over 19,000 adults between the ages of 55 and 64. Medicaid is helping people keep healthcare coverage when they need it most.

Today's hearing is an opportunity to better understand the ACA's impact on the status of health coverage amidst COVID-19, and what needs to be done to expand and improve access to quality, affordable healthcare. It is also an opportunity to reflect on what's at stake when the Supreme Court hears oral arguments in *Texas v. California* on November 11. While the ACA has been a lifeline for millions during the pandemic, its future once again hangs in the balance with the Supreme Court. The stakes could not be higher.

I look forward to the discussion today and I yield back.

Ms. ESHOO. The gentleman yields back.

To Mr. Walden, do you want to—do you have an opening statement for Dr. Burgess? And if not, then we will proceed with introducing the witnesses.

Mr. WALDEN. Unless anybody else on our side wants the time? If not, I think we are prepared to go on to the hearing, Madam Chair.

Ms. ESHOO. OK. Thank you, Mr. Walden.

The gentleman yields back.

And the Chair will once again remind Members that pursuant to committee rules, all members' written opening statements will be made part of the record.

I now would like to welcome and introduce our witnesses for today.

The first, Dr. Benjamin Sommers, is the Huntley Quelch professor of health policy and economics at Harvard, its T.H. Chan School of Public Health. Welcome, and thank you, Dr. Sommers.

Mr. Douglas Holtz-Eakin is the president of the American Action Forum. Thank you for once again coming to our committee and being a witness. We appreciate it. You are always welcome.

Dr. Aviva Aron-Dine is the vice president for health policy at the Center on Budget and Policy Priorities. Welcome to you, and thank you.

Mr. Dean Cameron is the director of the Idaho Department of Insurance. Welcome to you, and on behalf of the subcommittee, we thank you.

And last but not least, Mr. Peter Lee, the executive director of Covered California. I have said it before, and I would like to say it again, that the Lee family in California are legendary. His grandfather founded the Palo Alto Medical Clinic. Everyone in that generation, from his grandfather and father and uncles and aunt, were all MDs.

So, Dr. Sommers, you are recognized for 5 minutes. And you can unmute so we can hear you. Welcome again, and thank you.

STATEMENTS OF BENJAMIN D. SOMMERS, M.D., PH.D., HUNTLEY QUELCH PROFESSOR OF HEALTH CARE ECONOMICS, PROFESSOR OF HEALTH POLICY & ECONOMICS/PROFESSOR OF MEDICINE, HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH/BRIGHAM & WOMEN'S HOSPITAL; DR. DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM; AVIVA ARON-DINE, PH.D., VICE PRESIDENT FOR HEALTH POLICY CENTER ON BUDGET AND POLICY PRIORITIES; DEAN CAMERON, DIRECTOR, IDAHO DEPARTMENT OF INSURANCE; AND PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA

STATEMENT OF BENJAMIN D. SOMMERS, M.D., Ph.D.

Dr. SOMMERS. Chairwoman Eshoo, Ranking Member Burgess, and other distinguished members, thank you for having me here today to discuss this important topic. I am a professor at the Harvard School of Public Health, a health economist, and a physician, and I would like to make three main points in my testimony today.

The Affordable Care Act produced the largest drop in the uninsured rate in the U.S. since the creation of Medicare and Medicaid more than 50 years ago, with far-ranging benefits to public health. Twenty million people gained health insurance, and nearly a decade of research has shown that the law has produced significant benefits to families of improved affordability and financial security, improved access to primary care, prescription medications, and care for chronic conditions, and downstream improvements in health status across a range of conditions, including surgical diseases like appendicitis, heart disease, cancer, kidney disease, and overall survival. The research is now showing that the ACA has literally been a life-saver.

The second point is that even with the Affordable Care Act, there are still nearly 30 million people in the United States without health insurance before the pandemic. And this number has been rising since 2016. This erosion of coverage has happened during a period of low unemployment, and though the ACA has narrowed disparities, coverage rates are still lowest among low-income families and communities of color.

The recent growth in the uninsured rate has happened due to a combination of factors where the administration has taken policy steps to actively undercut the law. These policies include shortening open enrollment periods, cutting funding for advertising and outreach, repeated efforts to repeal the law, which surveys showed left up to a quarter of the public confused as to whether the law was still in effect, as well as defunding important aspects of the law, including cost-sharing reductions for low-income families.

Finally, the administration has allowed, and in some cases encouraged, States to implement policies that make it harder for people to enroll and to maintain their health insurance. The reason this latter point matters is because the uninsured is not a stable population where everyone in it has been uninsured for years and years. Many people move in and out of coverage over time. This is

often called churning, and this particularly happens when enrollment in public programs and staying in public programs is made difficult.

One prominent recent example encouraged by the administration was work requirements in Medicaid. In research that we recently published, we found that work requirements in the State of Arkansas, the first State to implement them, led to 18,000 people being disenrolled from Medicaid, even though our study found that more than 95 percent of the target population should have been eligible for coverage but got caught up in red tape and complications with the new policy. Rather than helping people get enrolled, these policies are roadblocks.

All told, roughly half of the 30 million uninsured Americans, before the pandemic, were already eligible for either Medicaid or marketplace subsidies. Doing better outreach, eliminating red tape, and helping people keep their coverage over time are key policies to reduce this number.

The third point is that the COVID pandemic threatens to leave millions more without health insurance, but the ACA is a critical safety net for many who are losing their jobs. Prior to the Affordable Care Act, when U.S. workers lost their coverage through work, roughly one in four no longer had that insurance by the end of the year.

But when we went back and analyzed this data after the implementation of the ACA, what we found was that job loss did not lead to a significant risk of being becoming uninsured. While people did lose their employer coverage, large increases in Medicaid and marketplace coverage more than offset that loss.

And more broadly, our research shows that the Affordable Care Act produced its largest coverage gains among blue collar workers, those in agriculture, transportation, construction, and service jobs, many of whom are essential workers during the pandemic but are also at high risk for losing their jobs during the economic downturn.

Finally, on a personal note, I am a primary care doctor, and I work in a community health center in Boston. I was there yesterday afternoon seeing patients. Many of my patients are essential workers, stocking grocery store shelves, cleaning subway stations, delivering packages, cooking at restaurants, and caring for sick patients in nursing homes and hospitals. The community I work in has been hit very hard by COVID.

Even in the best of times, the difference between having health insurance and not having it can mean financial security or financial ruin. It can mean life or death. And in a pandemic, health insurance means being confident that you can get seen, get tested, and get treated if you get sick.

To conclude, there is a simple question for the members of the committee here today to face. Do we make it easy or hard for people to get coverage and stay enrolled? During a pandemic, as a primary care doctor and as a public health professor, the community answer is incredibly clear. We have to be doing everything we can to get people access to health insurance and healthcare.

I appreciate the opportunity to be here today and to participate in this critical conversation.

[The prepared statement of Dr. Sommers follows:]



Department of Health Policy and Management

Benjamin D. Sommers, M.D., Ph.D.
Huntley Quelch Professor of Health Care Economics

Professor of Medicine
Harvard Medical School
Brigham and Women's Hospital

September 23, 2020

My name is Benjamin Sommers, and I am the Huntley Quelch Professor of Health Care Economics at the Harvard T.H. Chan School of Public Health, and a Professor of Medicine at Harvard Medical School. I am a health economist and primary care physician, and my areas of focus are health insurance, affordability of care, Medicaid, and health care disparities. I would like to thank Chairwoman Eshoo, Ranking Member Burgess, and the distinguished members of the committee for inviting me here today to discuss the role of the Affordable Care Act in responding to the COVID-19 pandemic to protect health insurance coverage in the U.S. My testimony draws largely on a series of academic studies conducted by my colleagues and me since the passage of the Affordable Care Act in 2010.

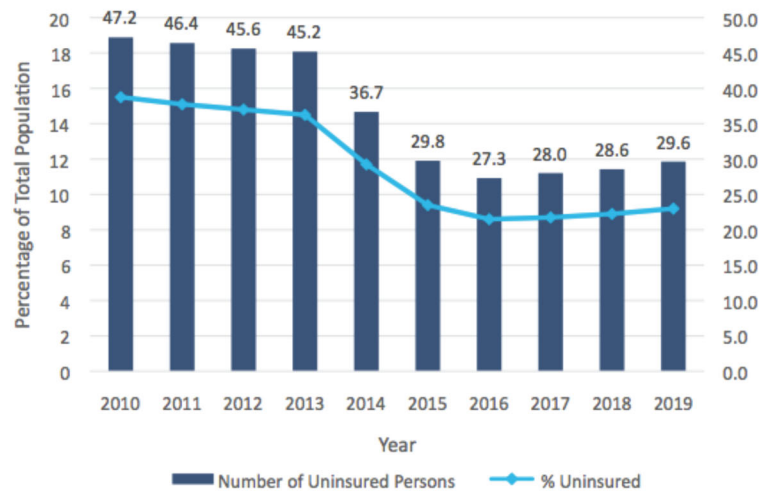
In order to examine the challenges currently facing the nation in terms of health insurance, it is important to understand the composition of the uninsured population in the U.S. prior to this year's public health and economic crisis; the changes in coverage brought about by the Affordable Care Act over the past decade; and what we know so far about how health insurance coverage has been affected since the pandemic hit the U.S. in March 2020.

The Uninsured Population in the U.S.

Last week, the Census Bureau released its estimates on the uninsured population in the U.S. from 2019, prior to the pandemic. Based on data from the American Community Survey, the number of U.S. residents without health insurance was 29.6 million, representing 9.2% of the population.¹ These numbers were fairly similar to the prior year (Figure 1), though they indicate a modest increase in the uninsured rate since 2016, when it was 8.6% (27.3 million people), which was the lowest level in U.S. history. Nonetheless, current rates reflect a dramatic reduction in the uninsured population since 2010, before the implementation of the Affordable Care Act, when there were nearly 50 million people without health insurance in the country.



Figure 1: Percentage and Number of Uninsured People in the U.S., 2010-2019



Notes: Statistics are from the American Community Survey, 2010-2019, for the full U.S. population (all ages). Figure created by Peggah Khorrami and Aditi Bhanja.

The risk of being without health insurance varies widely across groups. The highest risk age group for lacking coverage is non-elderly adults (19-64), with roughly 11% lacking insurance in 2019. In contrast, due to more generous Medicaid eligibility and the Children's Health Insurance Program, only 5% of children are uninsured, and only 1% of adults over age 65 are uninsured given near-universal coverage from Medicare. Other than age, one of the strongest predictors of lacking coverage is income, with 16% of those with incomes below the federal poverty level uninsured, 11% uninsured among those between 100% and 400% of poverty, and just 3% uninsured among those above 400% of poverty. The U.S. also has large disparities in coverage by race and ethnicity, with significantly higher uninsured rates among Blacks (9.6%), Latinos (16.7%), and Native Americans (19.6%)² than whites (5.2%) or Asian Americans (6.2%).¹

One important feature of the uninsured population is that it is not a static group of people who are all uninsured for long periods of time. Research over the past three decades has shown that people frequently move in and out of different types of coverage, and many experience multiple episodes over time without insurance.^{3,4} In addition, programs with income-based eligibility



rules like Medicaid and the ACA's Marketplace subsidies require re-verification of eligibility at least once annually, which produces frequent disruptions in coverage – often called “churning.”^{5,6} In addition, many pregnant women lose eligibility 3 months after delivery, since the income criteria for parental coverage are more restrictive than during pregnancy.⁷ Thus, increases in the uninsured rate can result from several different phenomena – the loss of private coverage due to job losses; decreased new enrollment in subsidized programs; and disenrollment from publicly-subsidized insurance due to eligibility changes, red tape, or lack of affordability.⁸

Role of the Affordable Care Act

The Affordable Care Act (ACA) implemented several large policy changes designed to expand health insurance to the uninsured population. First, in 2010, young adults under age 26 were allowed to remain on their parents' plans, which led to two to three million more young adults gaining insurance.⁹ Then, in 2014, private health insurance became available from the new health insurance Marketplaces (either federally-facilitated or state-based), with premium subsidies for those with incomes below 400% of the federal poverty level and major new consumer protections in the non-group insurance market. Also in 2014, Medicaid eligibility in participating states was expanded to non-elderly adults with incomes below 138% of the federal poverty level.

The result was a rapid decrease in the uninsured rate, discussed earlier and depicted in Figure 1. Roughly 20 million U.S. residents gained insurance between 2010 and 2016 from the provisions of the ACA.¹⁰ Research indicates that Medicaid accounted for about 60% of the law's coverage gains after 2014, evenly split between newly-eligible individuals and the “welcome mat” effect, in which previously-eligible but uninsured individuals signed up for Medicaid after the law's implementation. Marketplace subsidies accounted for roughly 40% of the law's coverage gains, and states running their own Marketplaces were nearly twice as effective at expanding coverage as states using the federal Marketplace. Evidence suggests that the individual mandate did not play a major role in boosting overall enrollment under the ACA.¹¹

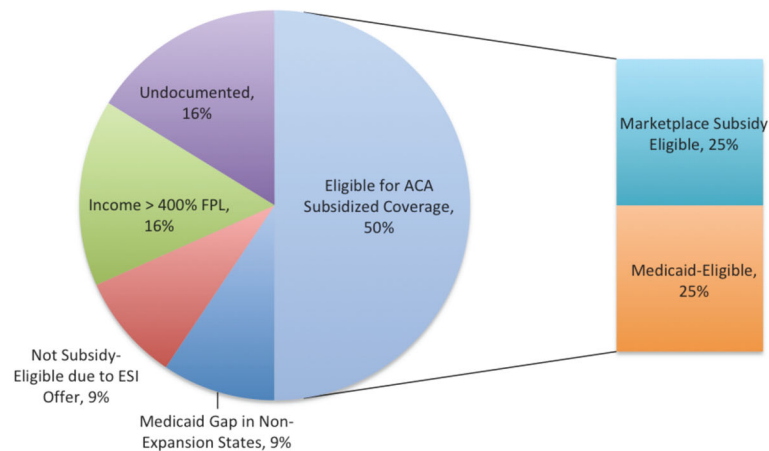
The large gains in coverage under the ACA have been studied in dozens of academic studies over the past decade to understand their downstream effects. The research literature shows that the ACA's coverage expansion led to improved affordability of medical care;¹² narrowed racial and ethnic disparities;¹³ better access to preventive care, prescription drugs and chronic disease management;¹⁴ enhanced well-being and self-reported health;¹⁵ and improved health outcomes including surgical conditions,¹⁶ heart disease,¹⁷ cancer,¹⁸ and overall survival.^{19,20}

Of the remaining 30 million uninsured individuals prior to the COVID pandemic in 2019, more than half were likely eligible for public or private coverage (Figure 2). An estimated 7.5 million were eligible for Medicaid but not enrolled. This was due to a variety of factors, including



difficulty navigating the application process, not being aware of the eligibility criteria, and difficulty completing the renewal process to maintain coverage. A similar 7.5 million were eligible for subsidized Marketplace coverage but were not enrolled, which surveys indicate was primarily due to affordability issues and lack of awareness.²¹ More than 2 million were low-income adults in the so-called Medicaid gap, living in non-expansion states with incomes too high to qualify for Medicaid but too low to receive Marketplace subsidies. The remainder of the pre-COVID uninsured were not eligible for subsidized coverage due to incomes above 400% of the poverty level, immigration status, or having an affordable employer offer of coverage.²²

Figure 2: The U.S. Uninsured Population By Estimated Program Eligibility, Pre-COVID



Notes: Figure reflects 2018 population estimates, adapted from Sommers 2020²² and Blumberg 2018.²³ ESI = Employer Sponsored Insurance.

*Put simply, a major driver of the uninsured rate in the U.S. in the post-ACA era is how easy or hard policies make it for eligible people to sign up and keep their coverage. The rise of the uninsured rate over the past 3 years coincides with policies under the current administration that shortened the open enrollment period, reduced outreach and advertising that informed consumers of their coverage options, created major uncertainty for insurers, and permitted states to enact new restrictions on Medicaid eligibility including work requirements.*²⁴⁻²⁶



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Finally, there are strong linkages between the ACA and health insurance for working families. The ACA plays a critical role in providing coverage options for those who work in industries unlikely to offer employer-sponsored insurance (ESI). Research shows that the ACA boosted coverage rates most dramatically for workers in blue collar fields such as agriculture, construction, and service jobs.²⁷ Furthermore, the ACA offers important coverage options to workers who have recently lost their jobs, a critical consideration relevant to the COVID pandemic. Prior to the ACA's implementation, when U.S. workers with ESI lost their jobs, roughly 1 in 4 no longer had that type of insurance by the end of the year. While some enrolled in Medicaid or a non-group private plan, the overall risk of becoming uninsured went up by roughly 5 percentage points after job loss (a roughly 14% relative increase). In contrast, in the post-ACA period of 2014-2016, after losing a job, workers did not experience any overall increase in the risk of being uninsured. While rates of ESI fell by a similar margin after job loss as in the pre-ACA years, large increases in Medicaid and Marketplace coverage more than offset that loss.²⁸ *In other words, the ACA provides a highly effective safety net for workers who lose their jobs.*

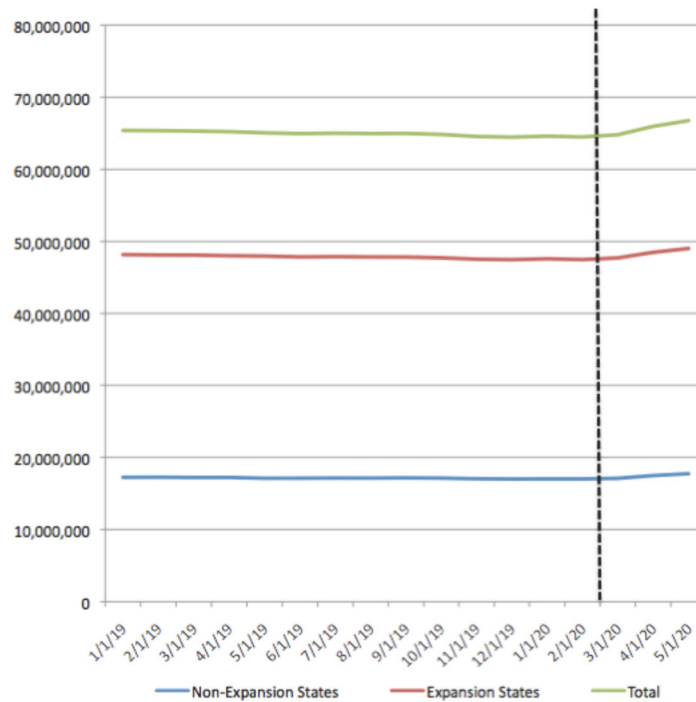
Coverage Changes and the COVID Pandemic

The COVID pandemic and associated economic downturn have led to a historically large and rapid rise in the unemployed rate in 2020, which threatens to leave millions of Americans without health insurance. Analysts have predicted that between 20 and 30 million people may lose their ESI during the crisis.²⁹ While it is too soon to know the long-term impact, preliminary data sources indicate a rise in the uninsured rate and a shift from employer coverage to Marketplace insurance and Medicaid – though smaller than some original estimates. A report analyzing a new survey launched in April 2020 by the Census Bureau found that 3.3 million adults lost their ESI between April and July, and 1.9 million became uninsured.³⁰ Notably this report was unable to compare these trends to the pre-COVID February baseline.

Enrollment statistics from the states and federal government show that the ACA is playing an important role in covering families who have lost their coverage from work. Data from the Centers for Medicare and Medicaid Services (CMS) collected from all 50 states show a sharp increase in Medicaid enrollment beginning in March of 2020 (Figure 3). Overall, enrollment increased by nearly 2.3 million from February until May, the most recent month with data for all 50 states. When splitting these trends out by state Medicaid expansion status, the totals were a 1.5 million increase in expansion states (from 47.5 million in February to 49.0 million in May, a 3.1% increase) and 700,000 in non-expansion states (from 17.0 million to 17.7 million, a 4.1% increase). It is likely that states that have not expanded Medicaid will see increasing numbers of people in the “Medicaid gap,” who are not eligible for any subsidized coverage.²⁹



Figure 3: Monthly Medicaid Enrollment Before and After Beginning of the COVID Crisis, By State Expansion Status



Notes: Dashed line indicates beginning of COVID-pandemic in the U.S., in March 2020. Data from Centers for Medicare and Medicaid Services, available at <https://data.medicare.gov/Enrollment/State-Medicaid-and-CHIP-Applications-Eligibility-D/n5ce-jxmc>

Meanwhile, private Marketplace coverage has also increased during this time, based on my team's unpublished analysis of federal and state enrollment reports for 2020. While Marketplace coverage is typically only available during designated open enrollment periods, the loss of another form of insurance allows individuals to sign up for a "special enrollment period" (SEP). In addition to these standard SEPs, most state-based marketplaces have enacted broader



enrollment periods to allow for more people to sign up for coverage since the pandemic began. The federal marketplace – *Healthcare.gov* – has not broadened its SEP criteria. Based on publicly-available data through mid-2020, 457,000 individuals have enrolled in fully state-based Marketplaces under Special Enrollment Periods across 12 states plus Washington DC. This represents a 15% increase compared to the 3.1 million people originally enrolled in these states’ Marketplace plans in 2020. Meanwhile, the 38 states using *Healthcare.gov* have enrolled 892,000 people via SEPs, up from 704,000 in 2019; even with this increase compared to last year, the federal SEP enrollment reflects only 11% of 8.3 million covered lives in the federal Marketplace, substantially below the state-based Marketplaces’ new enrollment.

Conclusion

Nearly a decade of research demonstrates that the Affordable Care Act has expanded insurance to 20 million people in the U.S., improving their financial security, access to care, and health. The COVID pandemic threatens to leave millions of Americans without health insurance due to widespread unemployment and lost income. The ACA can serve as a critical lifeline for those affected by the pandemic, particularly lower-income families, communities of color, and blue collar workers. Policymakers should maximize the law’s potential benefits by supporting aggressive outreach and assistance to help eligible people get enrolled and stay enrolled in coverage during this crisis and beyond.



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REFERENCES

1. Keisler-Starkey K, Bunch LN. Income, poverty, and health insurance coverage in the United States: 2019. Washington, DC: U.S. Census Bureau; 2020.
2. The Native American uninsured estimate is from the 2018 American Community Survey Public Use Microdata, since the Census Bureau's recently published report (endnote 1) does not include an estimate for this group.
3. Swartz K. Dynamics of people without health insurance. Don't let the numbers fool you. *Jama* 1994;271:64-6.
4. Short PF, Graefe DR. Battery-powered health insurance? Stability in coverage of the uninsured. *Health Aff (Millwood)* 2003;22:244-55.
5. Goldman AL, Sommers BD. Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act. *Health Aff (Millwood)* 2020;39:85-93.
6. Sommers BD, Gourevitch R, Maylone B, Blendon RJ, Epstein AM. Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many. *Health Aff (Millwood)* 2016;35:1816-24.
7. Daw JR, Hatfield LA, Swartz K, Sommers BD. Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth. *Health Aff (Millwood)* 2017;36:598-606.
8. Gordon SH, Sommers BD, Wilson IB, Galarraga O, Trivedi AN. Risk Factors for Early Disenrollment From Colorado's Affordable Care Act Marketplace. *Med Care* 2019;57:49-53.
9. Sommers BD, Schwartz K. 2.5 million young adults gain health insurance due to the Affordable Care Act. Washington, DC: Department of Health and Human Services; 2011.
10. Uheroi N, Finegold K, Gee E. Health Insurance Coverage and the Affordable Care Act, 2010-2016. Washington DC: U.S. Department of Health & Human Services; 2016.
11. Frean M, Gruber J, Sommers BD. Premium subsidies, the mandate, and Medicaid expansion: Coverage effects of the Affordable Care Act. *J Health Econ* 2017;53:72-86.
12. Collins SR, Rasmussen PW, Doty MM. Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period. New York, NY: The Commonwealth Fund; 2014.
13. Buchmueller TC, Levinson ZM, Levy HG, Wolfe BL. Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage. *Am J Public Health* 2016:e1-e6.
14. Sommers BD, Maylone B, Blendon RJ, Orav EJ, Epstein AM. Three-Year Impacts Of The Affordable Care Act: Improved Medical Care And Health Among Low-Income Adults. *Health Aff (Millwood)* 2017;36:1119-28.
15. Sommers BD, Gunja MZ, Finegold K, Musco T. Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act. *Jama* 2015;314:366-74.
16. Loehrer A, Chang DC, Scott JW, et al. The Affordable Care Act Medicaid expansion and changes in the care of surgical conditions. *JAMA Surgery* 2018;153:online e175568.



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T.H. CHAN

SCHOOL OF PUBLIC HEALTH

17. Khatana SAM, Bhatla A, Nathan AS, et al. Association of Medicaid Expansion With Cardiovascular Mortality. *JAMA cardiology* 2019.
18. Liu Y, Colditz GA, Kozower BD, et al. Association of Medicaid Expansion Under the Patient Protection and Affordable Care Act With Non–Small Cell Lung Cancer Survival. *JAMA oncology* 2020;6:1289-90.
19. Swaminathan S, Sommers BD, Thorsness R, Mehrotra R, Lee Y, Trivedi AN. Association of Medicaid Expansion With 1-Year Mortality Among Patients With End-Stage Renal Disease. *Jama* 2018;320:2242-50.
20. Goldin J, Lurie IZ, McCubbin J. Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach. Cambridge, MA: National Bureau of Economics Research; 2019.
21. Collins SR, Gunja MZ, Doty MM, Beutel S. To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not. New York: Commonwealth Fund; 2015.
22. Sommers BD. Health Insurance Coverage: What Comes After The ACA? *Health Aff (Millwood)* 2020;39:502-8.
23. Blumberg LJ, Holahan J, Karpman M, Elmendorf C. Characteristics of the Remaining Uninsured: An Update. Washington, DC: Urban Institute; 2018.
24. Sommers BD, Clark KL, Epstein AM. Early Changes in Health Insurance Coverage under the Trump Administration. *New England Journal of Medicine* 2018;378:1061-3.
25. Sommers BD, Goldman AL, Blendon RJ, Orav EJ, Epstein AM. Medicaid Work Requirements - Results from the First Year in Arkansas. *N Engl J Med* 2019.
26. Aaron HJ, Fiedler M, Ginsburg PB, Adler L, Rivlin AM. Turmoil in the Individual Insurance Market - Where It Came From and How to Fix It. *N Engl J Med* 2017;377:314-5.
27. Agarwal S, Goldman AL, Sommers BD. Blue-Collar Workers had Greatest Insurance Gains after ACA Implementation. *Health Aff (Millwood)* 2019;38:1140-4.
28. Agarwal SD, Sommers BD. Insurance Coverage after Job Loss — The Importance of the ACA during the Covid-Associated Recession. *New England Journal of Medicine* 2020.
29. Garfield R, Claxton G, Damico A, Levitt L. Eligibility for ACA Health Coverage Following Job Loss. Washington, DC: Kaiser Family Foundation; 2020.
30. Gangopadhyaya A, Karpman M, Aarons J. As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured. Washington, DC: Urban Institute and the Robert Wood Johnson Foundation; 2020.

Ms. ESHOO. Thank you very much, Dr. Sommers, for your superb testimony.

It is a pleasure now to recognize Douglas Holtz-Eakin. You are recognized for your 5 minutes. And please unmute.

STATEMENT OF DR. DOUGLAS HOLTZ-EAKIN

Dr. HOLTZ-EAKIN. Well, thank you, Chairwoman Eshoo, Ranking Member Walden, members of the committee. It is a privilege to be here today. And I will make three brief points in these remarks, and then I look forward to answering your questions.

The first is the obvious one, which is that the large-scale job losses in the second quarter of 2020 really raised the specter of sharp increases in the number of uninsured in the United States. We saw 22 million people lose their jobs in March and April, 20 million in April alone, ten times more than the previous 1-month job loss in U.S. history. And I was among those who was deeply concerned that there would be a sharp decline in employer-sponsored insurance, and as a result, the specter of large increases in the uninsured during the middle of a pandemic.

Since then, we have had a number of studies which have tried to get a handle on just what the risks are on this front. The Kaiser Family Foundation estimated about up to 27 million Americans were at risk of losing their insurance, but pointed out that all but a few million of them would have some other option, a spouse's employer-sponsored insurance, Medicaid, Affordable Care Act, things like that.

There was some work done by the Urban Institute that said about 10 million people might lose their insurance, but all but 3 million of those would find coverage somewhere else. Similarly, we have seen estimates of about 5.5 million by Families USA and about 6 million from the Economic Policy Institute. So all of these suggest that, you know, you could have potentially a 25 percent increase in the uninsured, and that is a serious concern for this committee.

The Census Bureau, as I noted in my written testimony, has undertaken a remarkable effort to keep track of the welfare of American families during the pandemic through a weekly Household Pulse Survey which they have constructed. This asks a wide range of questions about the economic and personal welfare of the families and includes questions about health insurance status.

Remarkably, if you look at those data, which began on April 23 and have been collected through August 31, they show that over that period, there has been a tiny increase in the rate of insurance in the United States. I think a correct reading of those data is that they bounce up and down on a weekly basis, but we have seen no significant change in the number of uninsured, the rate of uninsurance, in the United States.

That is, I think, promising news, that the large-scale losses, which we feared early in the downturn, have not yet come to happen, but I don't think it is truly a cause for complacency. We need to keep an eye on the options that people will have if they do lose their employer-sponsored insurance. And certainly among those options, first and foremost, is the marketplaces of the Affordable Care Act, where it seems to me that the major question is the issue of

special enrollment periods. If an individual loses their employer-sponsored insurance due to job loss, they are automatically eligible to enroll in the ACA marketplaces. The question is whether we want to have special enrollment periods to actively recruit those who were not insured prior to the pandemic and now want to take up the opportunity to get into the ACA.

Similarly, we have options for Medicaid as coverage. In the Great Recession and as a precedent, the Congress undertook to subsidize COBRA coverage. Giving people help in their COBRA makes some good sense from the point of view of keeping them in their current insurance product, keeping them in their—as a result, their current care networks, not switching their physicians in the midst of a pandemic.

The downside to that is, the takeup wasn't particularly good in our last experience with this, and so whether it would be an effective outreach or not, I think, is an open question.

And then as a matter of completeness, the last option on the table would be the short-term, limited-duration insurance plans, which are a recent innovation. These may not be ideal for long-term insurance coverage but seem good as a stop-gap measure in the midst of the pandemic.

So I am thrilled to have the chance to be here today. I am pleased that the committee is looking at this issue, and I look forward to answering your questions.

[The prepared statement of Dr. Holtz-Eakin follows:]

Testimony on:
Insurance Coverage and the COVID-19 Pandemic

Douglas Holtz-Eakin
President, American Action Forum*

U.S. House of Representatives, Committee on Energy and Commerce
Subcommittee on Health
September 23, 2020

*The views expressed here are my own and not those of the American Action Forum. I am indebted to my colleague Christopher Holt for his assistance.

Introduction

Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the privilege of appearing today to discuss insurance coverage and the COVID-19 pandemic. In this testimony, I hope to make three main points:

- The enormous scale of job losses in the 2nd quarter of 2020 has raised the specter of widespread loss of employer-sponsored health insurance;
- To date, however, there is no compelling evidence of a dramatic change in the fraction of the population without health insurance; and
- To the extent that there is diminished employer-sponsored insurance, the marketplaces of the Affordable Care Act should be positioned to provide alternative coverage.

Let me discuss these issues in greater detail.

The Pre-Pandemic Insurance Baseline

Released last week, the Census Bureau's report on health insurance coverage in 2019 is a timely look at insurance coverage prior to the onset of the COVID-19 pandemic. The report includes data from two different surveys: the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) and the American Community Survey (ACS). According to the CPS ASEC survey, in 2019, 26.1 million (8 percent) of people residing in the United States were uninsured for the entire year. The ACS survey found similar but slightly higher uninsured numbers with 29.6 million (9.2 percent) of respondents reporting being uninsured at the time they were interviewed. Both surveys show that roughly 56 percent of the population was receiving health insurance coverage through employer-sponsored insurance (ESI) in 2019.¹

The CPS ASEC survey provides characteristics of the uninsured, giving more perspective on those most likely to be uninsured prior to the pandemic. Unsurprisingly, those age 65 and older were least likely to be uninsured in 2019, with only 1.1 percent reporting having been uninsured that year. Adults age 19 to 64 were the most likely demographic to be uninsured at 11.1 percent, while only 5.2 percent of children were uninsured in 2019.

Race and ethnicity showed some of the largest disparities in rates of insurance coverage. Only 5.2 percent of White, non-Hispanics, and 6.2 percent of Asians were uninsured in 2019, while 9.6 percent of African Americans reported being uninsured. Most notably, 16.7 percent of Hispanics (inclusive of all races) reported being uninsured for all of 2019.

Poverty and employment also contribute to insurance disparities. Almost 16 percent of individuals below the federal poverty level (FPL) reported being uninsured in 2019. In contrast, 11.3 percent of those between 100 percent and 399 percent of FPL reported being uninsured, and only 3 percent of those at or above 400 percent of FPL. Similarly, 8.9

percent of full-time, year-round workers reported being uninsured in 2019, while 13.4 percent of those who worked less than full-time or were seasonally employed and 12.2 percent of those who did not work at all reported being uninsured in 2019.

Finally, marital status drove additional disparities, with 7.6 percent of married individuals and 15 percent of unmarried individuals reporting that they were uninsured in 2019. The report notes that this is likely indicative of the reality that many adults access health insurance through a spouse's employer.

The Pandemic's Impact on Insurance Coverage

According to the ACS and CPS ASEC surveys, between 178.9 million and 183 million U.S. residents received health insurance through an employer in 2019. In the second quarter of 2020, the spread of COVID-19 produced a sharp downturn, and furloughs and layoffs began to roil the American labor market. In total the U.S. economy lost 22.2 million jobs in March and April of 2020,² and according to the Bureau of Labor Statistics, as of August there were 13.8 million unemployed, as opposed to 4 million in February.³ The substantial job loss, paired with the large number of Americans who receive ESI, has led to appropriate concerns about how many individuals have lost insurance coverage during the pandemic. The reality is that we do not yet have a full picture of the pandemic's impact on insurance coverage, but new census data along with several recent studies do allow us to sketch out in broad strokes the range of impact we may be facing.

The Kaiser Family Foundation (KFF) estimated in a May 2020 report that 78 million individuals lived in a household that experienced job loss between March 1, 2020, and May 2, 2020. The report further estimated that 61 percent of those households were receiving ESI at the time they became unemployed, and that 9 percent were uninsured. Both figures are roughly consistent with the findings of the ACS and CPS ASEC surveys. KFF concludes that "nearly 27 million people could potentially" have lost insurance coverage because of pandemic-related job loss between March and May. The report indicates that as many as 19 million other individuals may have lost ESI initially but were able to switch to another family member's ESI. KFF found that the vast majority of the 27 million people estimated to have entirely lost ESI had alternative insurance option available to them. Roughly 12.7 million were eligible for Medicaid, and 8.4 million qualified for subsidies through the Marketplace under the Affordable Care Act (ACA). KFF found that 5.7 million people who lost ESI coverage between March and May 2020 did not qualify for federal assistance. Of those, 3.7 million had incomes too high to qualify for ACA subsidies (though they may have accessed COBRA or non-subsidized individual market coverage), 150,000 fell into the coverage gap, and 530,000 individuals were ineligible because of their immigration status. Finally, 1.3 million had offers of ESI through another family member that precluded subsidies. By 2021, the report expects that even fewer of the uninsured will remain without options as more qualify for Medicaid and ACA subsidies the longer their unemployment continues.⁴

A second study, released by the Urban Institute in July, estimated—based on microsimulation modeling—that 10.1 million individuals will live in households that lose ESI coverage as a result of unemployment in the last three quarters of 2020. The modeling predicts, however, that of those 10.1 million, 32 percent will switch to another family member’s ESI, 28 percent will enroll in Medicaid, and 6 percent will purchase individual coverage, mostly using subsidies under the ACA. The modeling concludes that 3.5 million individuals will be left without insurance coverage as a result of pandemic-related job loss by the end of 2020.⁵

A third study, by Families USA, concluded that 5.4 million workers who experienced job loss between February and May 2020 became uninsured, but this study does not extrapolate those figures to account for additional household member who may have lost coverage.⁶

Finally, the Economic Policy Institute found in August that as many as 9 million workers have lost ESI coverage as a result of the pandemic but that recent job gains have erased some of this loss, for a net of 6.2 million workers losing ESI through June. This report also does not account for additional household members, and the authors note that not all those 6.2 million workers have become uninsured because some will have been eligible for Medicaid and subsidized exchange coverage under the ACA.⁷

More recently, there has been some direct surveying of the health insurance status of Americans in the Household Pulse Survey (“Pulse”) from the Census Bureau.⁸ The first Pulse survey was conducted between April 23 and May 5, while the most recent survey (week 13) took place between August 19 and August 31. Before turning to the evolution of insurance status, two comments are of note. First, the Pulse reported a total of 23.2 million uninsured in week 1, substantially lower than the results from 2019 reported above. This is likely due to the differences in sampling techniques and the fact that Pulse is restricted to individuals 18 years of age and older. Second, the first week of the Pulse is toward the end of April; there were quite likely substantial job losses and potentially lost insurance coverage in late March and early April.

With those caveats in mind, Table 1 shows the change in health insurance status between week 1 and week 13. The table paints a striking picture quite different from the fears of large-scale insurance loss. Indeed, taken at face value, the first row shows that overall the uninsurance rate fell by 0.6 percent, attributable to a rise in both private and public insurance (respondents were permitted to respond with more than one source).

The remainder of Table 1 shows how insurance status changed for individuals of varying characteristics. Rather than stressing individual data points, I would argue that the most important feature of the table is the lack of uniformity; the rate of uninsurance moves up and down across nearly all the characteristics. Since these are noisy survey data, probably the best way to interpret the results is that they suggest little dramatic change in insurance status over the time period covered.

In summary, microsimulation modeling, the number of job losses, and common sense all suggest that there may have been a large rise in the fraction of uninsured individuals. In contrast, direct survey data indicate little dramatic change in insurance relationships. Only time and more data will resolve this discrepancy.

Table 1 Change in Health Insurance Status, by Select Characteristics Census Household Pulse Survey – Week 13 versus Week 1 Population Aged 18 and Older				
	Insured			Uninsured
	Total	Private	Public	
Total	0.6%	2.3%	0.7%	-0.6%
Age				
18 - 24	0.7%	3.2%	-3.5%	-0.7%
25 - 34	-0.1%	2.3%	-3.8%	0.1%
35 - 44	0.4%	1.3%	-1.0%	-0.4%
45 - 64	0.9%	1.7%	1.3%	-0.9%
65 and over	-0.2%	4.4%	1.5%	0.2%
Sex				
Male	0.8%	2.2%	0.9%	-0.8%
Female	0.4%	2.5%	0.4%	-0.4%
Race				
Hispanic/Latino	-1.9%	-1.1%	1.4%	1.9%
White	0.8%	2.6%	0.1%	-0.8%
Black	1.3%	4.4%	2.3%	-1.3%
Asian	2.0%	2.1%	1.5%	-2.0%
Education				
Less than HS	-4.4%	-3.2%	2.3%	4.4%
HS / GED	2.5%	3.9%	1.2%	-2.5%
Some college	0.0%	2.9%	-0.4%	0.0%
BA or higher	0.2%	1.0%	1.4%	-0.2%
Marital status				
Married	0.5%	1.5%	1.8%	-0.5%
Single	-9.8%	3.9%	-37.2%	9.8%
Children				
Children	0.9%	2.1%	0.2%	-0.9%
No children	0.4%	2.4%	0.8%	-0.4%
Lost employment income				
Yes	0.7%	1.9%	1.2%	-0.7%
No	0.2%	2.3%	0.1%	-0.2%
Employed				
Yes	-0.2%	0.0%	1.7%	0.2%
No	0.9%	2.0%	4.2%	-0.9%
Income (1000s)				
Less than \$25	-0.9%	2.1%	-2.0%	0.9%

\$25 - \$34	-0.9%	0.4%	0.6%	0.9%
\$35 - \$49	2.0%	-0.2%	6.8%	-2.0%
\$50 - \$74	0.4%	-0.4%	4.2%	-0.4%
\$75 - \$99	0.3%	1.6%	2.4%	-0.3%
\$100 - \$149	0.8%	1.5%	1.5%	-0.8%
\$150 - \$199	0.2%	0.8%	2.6%	-0.2%
\$200,000 +	-0.7%	-0.2%	0.3%	0.7%

Addressing the Problem of Insurance Coverage Loss Due to the Pandemic

Several policies have been put forward since the onset of the pandemic, and corresponding job loss, aimed at addressing the problem of the newly uninsured. As we have seen, however, the problem may be less expansive than originally thought, and many of the proposed policies are not well targeted.

Medicaid and the Affordable Care Act

There was understandable concern about the potentially significant impact of job loss on insurance coverage during the early days of the pandemic. While a complete picture is not yet available—as discussed in this testimony—a variety of sources indicate the impact on insurance coverage may not have been as great as feared. While undoubtedly many individuals have lost ESI coverage, most appear to have had other coverage option available—in particular Medicaid and subsidized individual market coverage under the ACA.

Existing federal programs paired with alternative sources of ESI should be filling much of the gap in coverage. Indeed, in many ways the pandemic and recession are the test of the ACA. Some have also suggested increasing ACA subsidies or expanding Medicaid eligibility in response to the pandemic, but the data to this point do not indicate that either course of action is necessary uniquely because of the pandemic. Social safety net programs exist for moments like these and appear to be meeting the need without additional expansion or increased federal spending.

Individual Market Special Enrollment Period

One proposal, included in the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, is to establish a special enrollment period (SEP) for individuals seeking coverage through the ACA's insurance exchanges. SEPs allow individuals to enroll in subsidized coverage outside of normal open enrollment periods. There are several existing circumstances that would trigger a SEP for an individual, for example a life event such as giving birth. The value of a SEP specific to those who have lost work because of COVID-19, however, is likely negligible given that a loss of ESI already triggers an automatic SEP for the individual and their dependents. In other words, this remedy is already in place.

COBRA Subsidies

Another proposal has been to provide a federal subsidy for COBRA premiums. COBRA is a transitional insurance program dating back to 1985 that allows employees to continue with their existing ESI plan for between 18 and 36 months in most cases, provided they pay both the employee and employer shares of the premium. COBRA provides continuity, but it also can be prohibitively expensive for the individual.

Subsidizing COBRA premiums would help recipients, but it's not clear this would be the best use of federal dollars. As evidenced above, most people who have lost ESI already have access to either other ESI coverage through a family member, Medicaid, or subsidized coverage on the exchange. HEROES included a proposed 100 percent federal financing of COBRA premiums between March 1, 2020, and January 31, 2021.⁹ Such a proposal would almost certainly be more costly to taxpayers than covering these individuals through Medicaid or subsidized exchange coverage.

There is some precedent for subsidizing COBRA; the American Reinvestment and Recovery Act—passed in response to the financial crisis—provided a tax credit covering 65 percent of the cost and an unemployed worker's COBRA premiums. The subsidy did not prove particularly popular, however, with only an estimated 38 percent of eligible enrollees taking advantage of it.¹⁰

At the same time, there may be value in keeping people in the insurance plan and provider network they are already familiar with for the remainder of the plan year. Amid all the other disruptions buffeting the country, having millions of newly unemployed Americans trying to acclimate to a new insurance plan and provider network in the middle of a public health crisis could be counterproductive. To preserve continuity, the newly unemployed could be granted a COBRA subsidy equivalent to the ACA premium subsidy they would receive on the exchange through the end of 2020, at which time they could transition to exchange or Medicaid coverage for the start of the new plan year.

Short-Term, Limited-Duration Insurance

Short-term, limited-duration health insurance plans (STLDIs) have been around for years. Traditionally they have functioned as a bridge to longer-term health insurance options. For example, an individual moving between employers who expects to have a two-month gap in their health insurance might consider enrolling in one of these plans for the gap period. The plans became controversial because they exist outside of the ACA's insurance market reforms, which gives insurers a lot of flexibility. Insurers can pick and choose what they cover and who they sell to, and they can set charges based on health status. These plans can be dramatically cheaper than what's available in the ACA exchanges—in part because they can offer dramatically less coverage—but this can make them an attractive option for healthy people with incomes too high to qualify for federal subsidies. The Obama Administration issued a rule in October 2016 limiting the duration of these plans to less than three months, significantly shorter than their traditional duration of less than 12 months. The Trump Administration has reversed course on that rulemaking and allowed

STLDIs to be issued for up to 364 days. Additionally, STLDIs are now renewable—at the discretion of the issuer—for up to 36 months.¹¹

The reality is that these plans are not ideal for everyone, or even most people, long-term. They do, however, already exist, and provide an option for those who are recently unemployed and seeking low cost, catastrophic coverage for a limited period.

Thank you. I look forward to answering your questions.

Notes

¹ <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>

² <https://www.whitehouse.gov/articles/june-jobs-numbers-shatter-expectations/#:~:text=From%20February%20to%20April%2C%20nearly,of%20those%20jobs%20have%20returned.&text=According%20to%20the%20BLS%2C%20the,percentage%20points%20for%20Black%20Americans.>

³ <https://www.bls.gov/news.release/pdf/empst.pdf>

⁴ <https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>

⁵ https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf

⁶ https://www.familiesusa.org/wp-content/uploads/2020/07/COV-254_Coverage-Loss_Report_7-17-20.pdf

⁷ <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/>

⁸ <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>

⁹ <https://www.americanactionforum.org/insight/health-policy-provisions-in-the-heroes-act/>

¹⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513614/>

¹¹ <https://www.americanactionforum.org/weekly-checkup/sizing-up-short-term-insurance/>

Ms. ESHOO. Thank you very much for your testimony and for joining us once again. The gentleman yields back.

Now it is a real pleasure to welcome Dr. Aviva Aron-Dine. You are now recognized for 5 minutes. And please unmute. Thank you again.

STATEMENT OF AVIVA ARON-DINE, PH.D.

Dr. ARON-DINE. Thank you, Madam Chair and members of the committee, for inviting me to testify today. I will talk about the role that Medicaid and the ACA are playing in the crisis, the need for action to further strengthen health coverage programs, and the catastrophic harm that would occur if the Supreme Court struck down the law.

Medicaid has long played a key role in protecting coverage during recession. During the Great Recession, for example, increased Medicaid in CHIP enrollment fully offset the loss of private coverage for children, preventing any increase in the children's uninsured rate.

But before the ACA, this safety net had a gaping hole. It left out many of the adults who were most vulnerable to recessions. With Medicaid expansion and the ACA marketplaces now filling that gap, we would expect coverage programs to be even more responsive to need than in the past. The data suggests that is exactly what is happening.

Through July, Medicaid enrollment in States with available data was up about 8 percent and expansion enrollment was up about 13 percent. Extrapolated nationwide, that would mean Medicaid is covering about 6 million people who might otherwise have become uninsured, with about a quarter covered through expansion. Mid-year sign-ups for ACA coverage seem to be up too, especially in those States that created special enrollment opportunities that are easier to access than the standard SEP.

Medicaid and the ACA are also aiding the response to the crisis in other ways. In States that expanded Medicaid, the program covers almost 40 percent of low-income essential workers, such as home health aides, and hospital, transit, and grocery store workers, and low-income people in those jobs are about half as likely to be uninsured in expansion compared to nonexpansion States.

States are also using Medicaid authorities to respond to the pandemic, for instance, by increasing payments to nursing homes and other health providers, expanding access to home- and community-based services, and increasing the use of telehealth.

Congressional action is needed to make sure that the safety net doesn't fray under strain. The growing need for Medicaid coverage and other demands on the program coincide with the historic State budget crisis. In past budget crises, States restricted Medicaid eligibility, made it harder for eligible people to get in-State covered, eliminated or cut important benefits, cut provider payments, and cut other non-Medicaid health programs, especially behavioral health. Cuts like those would be especially harmful right now.

Congress, with bipartisan leadership from this committee, took a crucial first step back in March, temporarily raising the Medicaid match rate and pairing those funds with strong protections for beneficiaries coverage. But the growing number of States that are

making or considering harmful cuts to Medicaid shows that additional Federal funding is needed.

Congress should also strengthen the health safety net for this and future recessions by filling remaining gaps. That involves both reversing administration policies that have undermined coverage and taking affirmative steps to improve the ACA's premium tax credits, to make it easier for eligible people to get and keep their coverage, and to add to the incentives for States to expand Medicaid.

Unfortunately, as we have already talked about this morning, there is also a very real danger that the ACA could disappear altogether due to the lawsuit. Before the pandemic, Urban Institute researchers estimated that would cause 20 million people to lose coverage, which means that about 1 in every 14 nonelderly people in the country would lose their health insurance, and about 1 in 10 among Black and Hispanic people. And this year or next, those coverage losses would be significantly larger, because more Americans are turning to ACA programs due to the crisis, as all of today's witnesses discussed in our written testimony.

Striking down the law would also end protections for people with preexisting conditions, from heart disease to cancer to diabetes, to the millions of Americans who just acquired a new preexisting condition, having had COVID-19. And striking down the ACA would weaken health insurance for those still covered, from the tens of millions of people with employer plans, whose plans imposed annual or lifetime limits before the ACA, to Medicare beneficiaries for whom striking down the law could raise prescription drug costs.

It is worth noting that the lawsuit would, at the same time, cut taxes for the highest income, one in a thousand Americans, by an average of \$198,000 per year, which would also reduce the revenue flowing to the Medicare Trust Fund and speed its insolvency.

Before I close, I would like to just address the notion that there is some viable alternative to the ACA or a forthcoming plan that would avoid those harmful consequences. Examining the actual ACA replacement proposals put forward since 2010 show that they near, rather than avert, the harmful consequences of the lawsuit. That includes jeopardizing coverage for people with preexisting conditions.

Thank you, and I look forward to answering your questions.

[The prepared statement of Dr. Aron-Dine follows:]



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September 23, 2020

Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic

Testimony of Aviva Aron-Dine, Vice President for Health Policy, CBPP Before the House Energy and Commerce Subcommittee on Health

Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the opportunity to testify before you today. My name is Aviva Aron-Dine. I am the Vice President for Health Policy at the Center on Budget and Policy Priorities (CBPP), a non-profit, non-partisan policy institute located in Washington. The Center conducts research and analysis on a range of federal and state policy issues affecting low- and moderate-income families. Previously, I served in government in a number of roles, including as the chief economist at the White House Office of Management and Budget (OMB), as Acting Deputy Director of OMB, and as a Senior Counselor at the Department of Health and Human Services (HHS), where my portfolio included Affordable Care Act (ACA) implementation and Medicaid, Medicare, and delivery system reform policy.

The title of today's hearing is apt: the ACA, along with the broader Medicaid program, is indeed providing a lifeline for millions during the COVID-19 pandemic and recession. We would be in a stronger position to address these crises had the law been fully implemented nationwide and if policies adopted over the past four years hadn't chipped away at ACA coverage gains and protections. But we would be in a far weaker position if the law had been repealed in 2017 or if it is struck down in court, as the Administration and 18 state attorneys general continue to urge. Going forward, there are many opportunities for Congress to continue to strengthen our health care safety net for this and future crises.

Coverage Programs Are Growing to Meet Need

As we are all well aware, the COVID-19 pandemic has brought economic devastation in its wake, with tens of millions of people losing their jobs or experiencing sharp reductions in income. Alongside increases in other forms of hardship, the deep recession is putting upward pressure on the uninsured rate, since job losses cause people to lose job-based coverage, and income losses can make it hard for them to pay premiums (whether for employer or individual market health plans). While the precise magnitude is uncertain, data confirm that large numbers of people have lost job-based coverage since the start of the recession.¹ These losses are likely to grow.

¹ Kaiser Family Foundation analysis, drawing on data from the National Association of Insurance Commissioners, shows a 1.3 percent drop in fully insured group market coverage from March through June. If extrapolated to the full

Medicaid has long played a critical role in protecting coverage during recessions, especially for children. During the Great Recession period, much of the loss in private coverage was offset by an increase in public coverage, resulting in a net coverage loss of about 5 million people, much smaller than the drop in private coverage. The children's uninsured rate remained stable (and then fell following the enactment of children's coverage improvements at the start of 2009).²

But prior to the ACA, many of the people most vulnerable to losing their jobs during recessions were excluded from Medicaid. In the typical state, parents were ineligible for Medicaid if their income was above about two-thirds of the poverty line, while adults without children were not eligible for Medicaid at all. For adults with incomes too high to qualify for Medicaid and without coverage through their jobs, individual market plans were generally unsubsidized, expensive, full of benefit gaps, and often unavailable altogether to people with pre-existing health conditions.

With Medicaid expansion and the ACA marketplaces now offering coverage to this group, we'd expect health coverage programs to be even more responsive to need during this recession than in the past. Data on Medicaid enrollment suggest this is indeed the case. Overall Medicaid enrollment has risen by 8.3 percent through July in 30 states for which the Center has been able to obtain data, and by 9.4 percent through August (with data available for 13 states). Meanwhile, expansion enrollment has risen by 13.2 percent through July across 18 states and by 14.8 percent through August (with data available for ten states). (See Figure 1.)³ If one were to extrapolate the July figures nationwide, they would imply that total enrollment has risen by about 6 million people, with about a quarter enrolling through expansion.

Evidence suggests mid-year sign-ups for ACA marketplace coverage have risen as well, particularly in state-based marketplaces that created special enrollment opportunities and conducted

market, that would imply a roughly 2 million drop in employer coverage, though coverage losses among workers at self-insured firms may have been smaller. Urban Institute analysis of Census Household Pulse survey data shows a 3.3 million drop in job-based coverage from late April/early May through July, although the underlying data are quite noisy. The drop in job-based coverage is likely to grow over time, because people who lose their jobs do not always immediately lose their coverage and because a larger share of early job losses during the pandemic were temporary layoffs, while a larger share of subsequent job losses were permanent. Even so, coverage losses may be smaller than some initially expected, because job losses in the recession to date have been unusually concentrated among low-wage workers who did not have coverage to start with. See Cynthia Cox and Daniel McDermott, "What Have Pandemic-Related Job Losses Meant for Health Coverage?" Kaiser Family Foundation, September 11, 2020, <https://www.kff.org/policy-watch/what-have-pandemic-related-job-losses-meant-for-health-coverage/> and Anuj Gangopadhyaya, Michael Karpman, and Joshua Aarons, "As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured," Urban Institute, September 2020, <https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf>.

² These calculations are based on the National Health Interview Survey.

³ These figures update those published in Matt Broaddus, "Medicaid Enrollment Continues to Rise," Center on Budget and Policy Priorities, September 9, 2020, <https://www.cbpp.org/blog/medicaid-enrollment-continues-to-rise>. Methodology and sources can be found in Aviva Aron-Dine, Kyle Hayes, and Matt Broaddus, "With Need Rising, Medicaid Is At Risk for Cuts," Center on Budget and Policy Priorities, July 22, 2020, <https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts>.

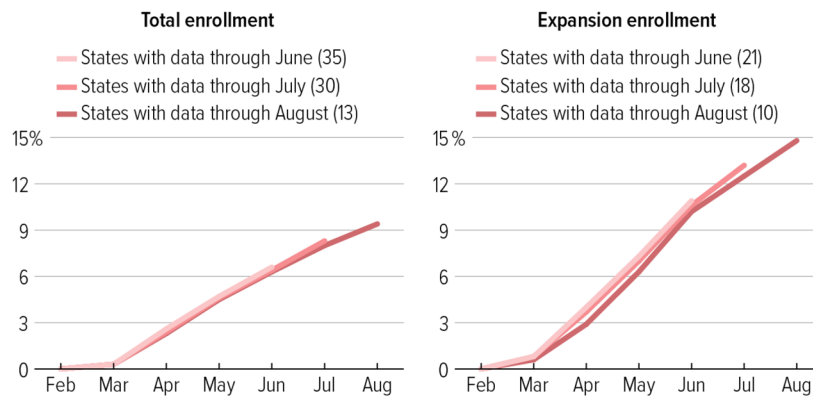
other outreach during the pandemic.⁴ It's worth noting that, during a recession, we would expect more people to enter the marketplaces after losing employer coverage but would also expect fewer people to enter from Medicaid and more people to shift from marketplace to Medicaid coverage. Thus, *total* marketplace enrollment might not rise (or rise only a little), even though the marketplace is playing a critical role for people losing employer coverage.

The hope is that, as solid data on 2020 uninsured rates become available, they will confirm that the ACA's improvements to the health safety net are largely working as intended, and coverage losses will be smaller than during the Great Recession period.⁵

FIGURE 1

Medicaid Enrollment Rising Steadily in COVID-19 Recession, With Especially Rapid Growth in Expansion Enrollment

Percent growth since February



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⁴ Sarah Lueck and Matt Broaddus, "Emergency Special Enrollment Period Would Boost Health Coverage Access at a Critical Time," Center on Budget and Policy Priorities, July 30, 2020, <https://www.cbpp.org/research/health/emergency-special-enrollment-period-would-boost-health-coverage-access-at-a-critical>.

⁵ Of the established federal health insurance surveys, the first data on post-pandemic coverage will come from the National Health Interview Survey, which generally releases second-quarter estimates in mid-November. While the Census Household Pulse survey (a new survey introduced during the pandemic) provides an initial glimpse at trends since late April/early May, the health coverage numbers in the new survey have fluctuated significantly from week to week. However, the Urban Institute analysis of these data referenced above does find that increases in public coverage have offset well over half the loss in job-based coverage among adults in states that have expanded Medicaid, which is a larger share than for adults nationwide during the Great Recession.

Policies Undermining ACA and Medicaid Have Weakened Response to Crisis

Fewer people had coverage at the start of the pandemic, and more will become uninsured during the downturn, due both to some state policymakers' refusal to take up the ACA's expansion of Medicaid and to federal policies that have undermined Medicaid and the ACA marketplaces. The consequence is that more people will go without needed care or will incur unaffordable medical expenses during the crisis. Higher uninsured rates also weaken the response to the pandemic, since some people without health insurance may forgo testing or treatment for COVID-19.⁶

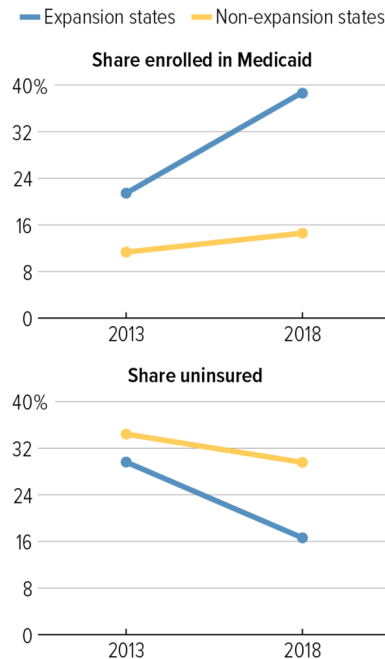
Non-Expansion States Less Prepared for Crisis

Prior to the crisis, 3.9 million people were uninsured due to state decisions not to expand Medicaid, the Urban Institute estimates.⁷ Black and Hispanic people are more likely to reside in states that have not expanded Medicaid and are less likely to have other sources of coverage, so they make up a disproportionate share of this group: more than half, compared to less than a third of the U.S. population.

State decisions not to expand have heavily impacted low-income workers such as home health aides, hospital workers, grocery store workers, public transit and truck drivers, food production and pharmaceutical manufacturing workers, pharmacy workers, and warehouse workers — the “essential workers” whose jobs have often put their health at risk during the pandemic. The uninsured rate for low-income

FIGURE 2

Medicaid Expansion Boosts Coverage for Low-Income Essential Workers



Note: “Low-income essential workers” refers to essential or front-line workers — those likely required to go to work despite stay-at-home orders — with incomes up to 200 percent of poverty. States can expand Medicaid coverage to low-income adults under the Affordable Care Act. Expansion took effect in 2014.

Source: CBPP analysis of Census Bureau data

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⁶ An April Gallup survey found that 14 percent of Americans would forgo care for COVID-19 symptoms due to cost, with higher percentages for groups with higher uninsured rates. Dan Witters, “In U.S., 14% With Likely COVID-19 to Avoid Care Due to Cost,” Gallup, April 28, 2020, <https://news.gallup.com/poll/309224/avoid-care-likely-covid-due-cost.aspx>.

⁷ Michael Simpson, “The Implications of Medicaid Expansion in the Remaining States: 2020 Update,” Urban Institute, June 2020, https://www.urban.org/sites/default/files/publication/102359/the-implications-of-medicaid-expansion-in-the-remaining-states-2020-update_0.pdf.

people with these jobs was about twice as high in non-expansion states than in expansion states, prior to the pandemic.⁸ (See Figure 2.)

Non-expansion states' already higher uninsured rates are also likely to *increase* more during the downturn, since many people losing coverage will fall into the coverage gap, ineligible for Medicaid but with incomes too low to qualify for marketplace premium tax credits. Uninsured rates for unemployed adults fell in both expansion and non-expansion states between 2013 and 2018, due to the availability of marketplace coverage, but they fell but far more dramatically in expansion states. (See Figure 3.) Prior to the pandemic, more than 40 percent of unemployed adults in non-expansion states were uninsured, over twice the rate in expansion states.⁹

Federal Policies Have Eroded ACA Coverage Gains

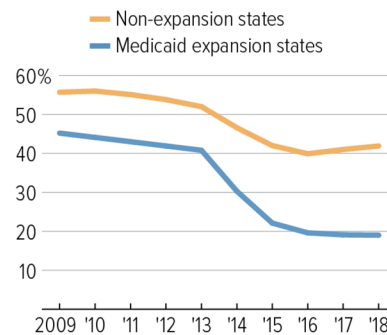
Meanwhile, Census data released last week show that the number of Americans nationwide without health insurance rose by 2.3 million between 2016 and 2019, including an increase of over 700,000 in the number of uninsured children.¹⁰ (See Figure 4.) This erosion happened during a period when the unemployment rate fell substantially and several states were implementing Medicaid expansion, meaning that we would have expected the uninsured rate to fall, or at least remain stable.

Among the policies likely contributing to the increase were:

- **The Administration's policies toward immigrants, including the so-called "public charge" rule.** These policies have created a climate of fear among families that include immigrant members, deterring some eligible people from enrolling in Medicaid or marketplace

FIGURE 3

Uninsured Rate for Unemployed Adults Fell Sharply in States Adopting Medicaid Expansion



Note: Estimates are for adults aged 19 through 64. States can expand their Medicaid program to low-income adults under the Affordable Care Act.

Source: Urban Institute using American Community Survey data

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⁸ For an explanation of how we define low-income essential workers, see Jesse Cross-Call and Matt Broaddus, "States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession," Center on Budget and Policy Priorities, July 14, 2020, <https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and-recession>.

⁹ Anuj Gangopadhyaya and Bowen Garrett, "Unemployment, Health Insurance, and the COVID-19 Recession," Urban Institute, April 2020, https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf.

¹⁰ For additional discussion, see Matt Broaddus and Aviva Aron-Dine, "Uninsured Rate Rose Again in 2019, Further Eroding Earlier Progress," Center on Budget and Policy Priorities, September 15, 2020, <https://www.cbpp.org/research/health/uninsured-rate-rose-again-in-2019-further-eroding-earlier-progress>.

coverage.¹¹ Hispanic adults, Hispanic children, and children not born in the United States—groups disproportionately affected by this chilling effect—all experienced much larger-than-average increases in uninsured rates in 2019, with Hispanic people experiencing by far the largest increase of any racial or ethnic group.

- **State policies, some encouraged or required by the Administration, that have made it harder for people to get and stay covered through Medicaid.**¹² For example, states have introduced new procedures requiring people to provide additional paperwork or document eligibility more often.¹³ Consistent with administrative data, the Census data show a large decline in Medicaid coverage over the last couple years. They also show an increase in uninsured rates for low-income people in 2019, refuting the claim that Medicaid enrollment declines were largely driven by people finding other coverage.
- **The ACA’s individual mandate penalty (the requirement that people have health coverage or pay a fee) was repealed starting in 2019.** This likely contributed to the increase in uninsured rates for middle-income people evident in the Census data.
- **Cuts to outreach and enrollment assistance.** In 2017, the Administration cut outreach and enrollment assistance by 80-90 percent. It has maintained those meager funding levels since, despite new evidence that outreach leads people to enroll in coverage, improving their health and even saving lives.¹⁴

The Administration also refused to make use of ACA coverage programs to respond to the crisis. In particular, despite recommendations and requests from governors of both parties, insurers, consumer advocates, and others, the Administration chose not to create an emergency special enrollment period for marketplace coverage. This likely reduced the number of people enrolling in HealthCare.gov this spring and summer. It barred the door to people who were already uninsured but experienced income losses that newly qualified them for premium tax credits, while making enrollment more complicated and confusing for people losing job-based coverage (who qualify for a special enrollment period, but one with more complex rules than a blanket emergency option).¹⁵

¹¹ See for example Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman, “Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019,” Urban Institute, May 18, 2020, <https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019>.

¹² For further discussion, see Matt Broaddus, “Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment,” Center on Budget and Policy Priorities, July 17, 2019, <https://www.cbpp.org/research/health/medicaid-enrollment-decline-among-adults-and-children-too-large-to-be-explained-by> and Samantha Artiga and Olivia Pham, “Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage,” Kaiser Family Foundation, September 24, 2019, <https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/>.

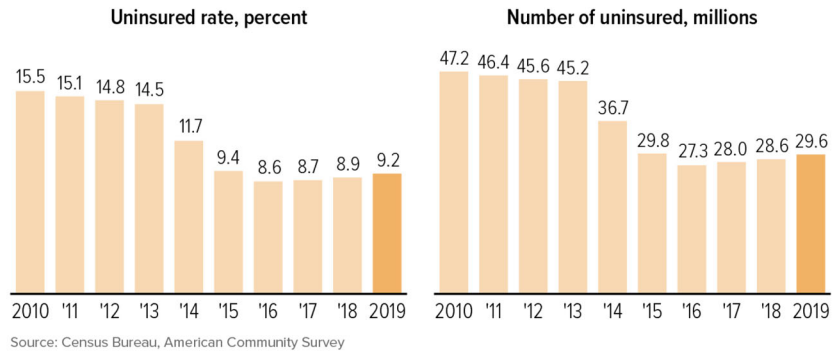
¹³ See for example, Lexi Churchill, “The Trump Administration Cracked Down on Medicaid. Kids Lost Insurance,” *Pro Publica*, October 31, 2019, <https://www.propublica.org/article/the-trump-administration-cracked-down-on-medicaid-kids-lost-insurance>.

¹⁴ Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, “Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach,” National Bureau of Economic Research Working Paper 26533, December 2019, <https://www.nber.org/papers/w26533>.

¹⁵ See Sarah Lueck and Matt Broaddus, “Emergency Special Enrollment Period Would Boost Health Coverage Access at a Critical Time,” Center on Budget and Policy Priorities, July 30, 2020, <https://www.cbpp.org/research/health/emergency-special-enrollment-period-would-boost-health-coverage-access-at-a-critical>.

FIGURE 4

Progress on Health Coverage Has Eroded in Recent Years



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Instead, the Administration relied on resources from the CARES Act Provider Relief Fund to reimburse providers for certain COVID-19-related expenses for people who are uninsured. Not only does this approach leave out people with other health care needs, it has also fallen far short of health insurance coverage even for people with COVID-19. Uninsured patients with COVID-19 report incurring large bills for expenses that don't qualify for reimbursement (such as treatment for other conditions while hospitalized due to COVID) or simply because providers failed to make use of the fund.¹⁶ Meanwhile, the fund had paid out less than \$800 million for uninsured patients' care through mid-September.

ACA Repeal Would Make Things Far Worse

While Administration policies contributed to coverage losses that have eroded about 10 percent of the ACA's coverage gains, the uninsured rate remains far below pre-ACA levels. But on November 10, the Administration, along with a group of 18 states, will argue before the Supreme Court that it should strike down the entire ACA.¹⁷

¹⁶ Abby Goodnough, "Trump Program to Cover Uninsured COVID-19 Patients Falls Short of Promise," *New York Times*, August 29, 2020, <https://www.nytimes.com/2020/08/29/health/Covid-obamacare-uninsured.html>.

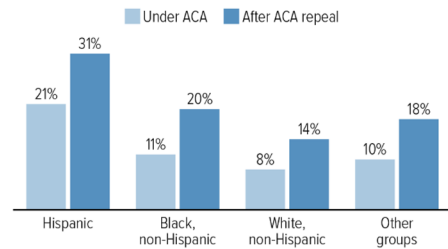
¹⁷ For background on the lawsuit, see Center on Budget and Policy Priorities, "Suit Challenging ACA Legally Suspect But Threatens Loss of Coverage for Tens of Millions," updated August 21, 2020, <https://www.cbpp.org/research/health/suit-challenging-aca-legally-suspect-but-threatens-loss-of-coverage-for-tens-of>.

A decision striking down the ACA would end Medicaid expansion, eliminate the marketplaces and premium tax credits, end protections for people with pre-existing health conditions, and eliminate the requirement that insurers let young adults remain on their parents plans until age 26. As a result, prior to the pandemic, Urban Institute researchers projected that striking down the law would cause 20 million people to lose coverage, increasing the uninsured rate by nearly two-thirds.¹⁸ While all racial and ethnic groups would experience large coverage losses, nearly 1 in 10 Black people and 1 in 10 Hispanic people were projected to lose coverage, compared to 1 in 16 whites. (See Figure 5.) Today, striking down the law would cause even larger coverage losses, since, as discussed above, the recession is causing many more people to turn to ACA coverage programs for help.

FIGURE 5

ACA Repeal Would Cause Especially Large Coverage Losses Among Black and Hispanic People

Uninsured rate among non-elderly people, based on pre-COVID-19 projections



Note: ACA=Affordable Care Act

Source: Urban Institute

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Sudden coverage losses on this scale would be completely unprecedented. And they would be all the more devastating this year or next given that the nation will still be still grappling with the pandemic and many of those losing coverage will also be struggling to afford food, rent, and other necessities due to the economic downturn.

Striking down the ACA would also weaken coverage for those who have it, further undermining the response to the pandemic and worsening access to care and financial hardship more broadly.¹⁹ For example, it would:

¹⁸ Jessica Banthin *et al.*, “Implications of the Fifth Circuit Decision in *Texas v. United States*,” Urban Institute, December 2019, https://www.urban.org/sites/default/files/publication/101361/implications_of_the_fifth_circuit_court_decision_in_texas_v_united_states_final_121919_v2.pdf

¹⁹ For additional discussion, see Tara Straw and Aviva Aron-Dine, “Commentary: ACA Repeal Even More Dangerous During Pandemic and Economic Crisis,” Center on Budget and Policy Priorities, June 24, 2020, <https://www.cbpp.org/health/commentary-aca-repeal-even-more-dangerous-during-pandemic-and-economic-crisis>

- Eliminate the ACA’s prohibitions on denying coverage or charging higher premiums to people with pre-existing conditions, at a time when millions of people will have just acquired a new pre-existing condition: having had COVID-19.
- Allow insurers to rescind coverage if someone develops health problems that could be linked to an undisclosed pre-existing condition, including if a person develops a condition that could be a long-term consequence of having had COVID-19.
- End the requirement that all insurance cover preventive services, including vaccines, without cost sharing, at a time when the nation hopes to be working to vaccinate much or all of the population.
- Allow insurers to impose annual and lifetime limits on benefits and exclude coverage for essential health benefits, such as maternity care, prescription drugs, or substance use treatment.
- Cut funding for Centers for Disease Control and Prevention public health efforts.

Strengthening Health Coverage Programs for This and Future Crises

There are many ways Congress could strengthen health coverage programs for this and future crises.

Additional Coverage Expansions

While the national uninsured rate was 9.2 percent in 2019, seven states and the District of Columbia had uninsured rates of about 5 percent or less: Massachusetts, D.C., Rhode Island, Hawaii, Vermont, Minnesota, Iowa, and New York. All of these states have expanded Medicaid, and many have additional policies in common:²⁰

- Most provide some form of additional financial assistance to moderate-income people, on top of the ACA’s premium tax credits.²¹ (California is now doing this as well.)
- Most have adopted policies to make it easier for people to get or keep Medicaid and/or marketplace coverage. For example, six have state-based marketplaces, some of which undertake additional outreach compared to HealthCare.gov. Four make it possible for moderate-income people to enroll in coverage year-round, versus just during the annual open enrollment period (or by qualifying for a targeted special enrollment period).²² And New York provides 12 months of continuous eligibility for both adults and children in Medicaid.

²⁰ These policies are, of course, not the only reasons for these states’ low uninsured rates, but examining the policies the states have in common is still instructive.

²¹ Massachusetts and Vermont provide additional financial assistance to lower-income marketplace consumers; D.C. extends Medicaid eligibility above 138 percent of the poverty line; and Minnesota and New York provide more affordable coverage to lower-income people through Basic Health Programs. Hawaii, meanwhile, has more stringent requirements for employers to offer coverage than apply nationally under the ACA.

²² For a discussion of Massachusetts’ approach and implications for federal policy, see Sarah Lueck, “Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage,” Center on Budget and Policy Priorities, June 5, 2019, <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>.

- All of these states have opted to waive restrictions on Medicaid coverage for children who have a lawfully present immigration status, and some have filled in coverage gaps for certain other groups that do not meet the immigration-related eligibility restrictions. (Nationally, uninsured rates for immigrants, including naturalized citizens and non-citizens who are lawfully present, are higher than for other groups.)
- Most prohibit or limit substandard plans that do not meet ACA coverage standards.

These policies are certainly not all that is needed to achieve universal, high-quality health coverage. But federal policies along these lines could be adopted and implemented quickly. They would sharply reduce uninsured rates, both during the current crisis and going forward, and would better prepare us for future economic downturns, by improving coverage options for people without employer plans and by making it easier for people to transition among different forms of coverage. And, if premium tax credit improvements were adopted and implemented quickly, that would also provide timely, targeted support to the economy, by increasing disposable income for moderate-income people very likely to spend the additional funds.

Many of these policies are included in H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, passed by the House in June. That bill would also create new financial incentives for the remaining states to expand Medicaid, and it would make premium tax credits available to middle-income people for whom marketplace premiums cost more than 8.5 percent of income.

Protecting Medicaid By Addressing the State Budget Crisis

Just as important, Congress also needs to prevent the existing health coverage safety net from fraying under strain from the recession. As discussed above, Medicaid is playing a critical role in covering both adults and children impacted by the downturn, through both expansion and the pre-ACA Medicaid program. States have also used Medicaid authorities to meet other needs resulting from the pandemic. For example, some states have increased payments to nursing homes or home- and community-based services (HCBS) providers, broadened access to HCBS, and expanded the use of telehealth.²³

But increased need for Medicaid coverage and new demands related to the pandemic coincide with a historic state budget crisis. State revenues have already fallen sharply, and states are projecting large budget shortfalls for this and the next fiscal year.²⁴

²³ Jessica Schubel, “States Are Leveraging Medicaid to Respond to COVID-19,” Center on Budget and Policy Priorities, updated September 2, 2020, <https://www.cbpp.org/research/health/states-are-leveraging-medicaid-to-respond-to-covid-19>.

²⁴ See, for example, Lucy Dadayan, “State Tax Revenues Surged in July 2020, But Cumulatively Are Down During COVID-19 Period,” Urban Institute, September 16, 2020, https://www.urban.org/sites/default/files/2020/09/16/monthlystrh_july2020.pdf and Center on Budget and Policy Priorities, “States Grappling with Hit to Tax Collections,” updated August 24, 2020, <https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections>.

FIGURE 6

Many States Cut Medicaid During Prior Economic Downturns

Number of states making Medicaid cuts in each state fiscal year



Note: Graph shows years in which states faced significant budget shortfalls during and following recessions; data for 2002 are not available.

Source: Kaiser Family Foundation

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The state budget crisis could easily produce a serious health care crisis as well. During past budget crises, states restricted Medicaid eligibility, including for seniors, people with disabilities, and pregnant women; made it harder for eligible people to get and stay covered; eliminated or cut key benefits; and cut payments to physicians, hospitals, nursing homes, and other providers. (See Figure 6.) They also cut non-Medicaid health programs. For example, during the Great Recession period, state-funded behavioral health programs were often targeted for cuts, with roughly 3 in 4 states cutting mental health budgets in each of 2009, 2010, and 2011.²⁵

Early in the pandemic, with bipartisan leadership from this committee, Congress did two very important things. First, it adopted a 6.2 percentage-point increase in the Medicaid match rate (FMAP) for the duration of the public health emergency, providing about \$40 billion per year in aid to states.

²⁵ Aviva Aron-Dine *et al.*, "Larger, Longer-Lasting Increases in Federal Funding Needed to Protect Coverage," Center on Budget and Policy Priorities, May 5, 2020, <https://www.cbpp.org/research/health/larger-longer-lasting-increases-in-federal-medicare-funding-needed-to-protect>.

Second, it tied those additional federal funds to protections for Medicaid beneficiaries. States receiving the additional funds cannot introduce new eligibility restrictions.²⁶ They also cannot take away people's coverage during the public health emergency. That continuous coverage requirement is a version of the continuous eligibility policies many states already apply to children, which research has shown improve coverage and access to care by preventing children from losing Medicaid and becoming uninsured due to paperwork barriers and short-term income fluctuations.²⁷

But as the state budget crisis continues and more states exhaust options to delay budget cuts, the 6.2 percentage point FMAP increase — about half the maximum increase Congress provided during the Great Recession — is now insufficient. A number of states have already made or are considering Medicaid cuts, including reductions in provider payments, reversals of planned and needed coverage improvements (such as extensions of post-partum Medicaid coverage), and furloughs and hiring freezes impacting eligibility workers, which will likely delay access to coverage for some applicants. States are also cutting behavioral health programs and, even in the midst of the pandemic, are cutting their public health budgets.²⁸

Congress should heed recommendations from the National Governors Association, the National Association of State Medicaid Directors, health plans, providers, consumer advocates, and many others and provide additional federal Medicaid funding to help states weather the crisis. The best way to structure this additional assistance would be to tie the amount and duration of the increased federal funding to state unemployment rates and to make these unemployment rate triggers *permanent*. That way, federal Medicaid match rates would rise automatically in future recessions, then fall back to normal once state economies and budgets have recovered. Legislation introduced in the House (H.R. 6539 and H.R. 6379) and in the Senate (S. 4108) provides a model for how to do this.

In providing additional assistance, Congress should also maintain strong protections for beneficiaries. These “maintenance of effort” protections are critical to ensuring that the additional funding achieves the goal of protecting health coverage during the ongoing public health and economic crises, even as it helps states avoid cuts to Medicaid provider payments, non-Medicaid health programs, education, and other critical services.

²⁶ A similar rule in place during the Great Recession explains why far fewer states restricted eligibility during the Great Recession than during the shallower recession of the early 2000s, as shown in Figure 6. Aviva Aron-Dine, “Medicaid ‘Maintenance of Effort’ Protections Crucial to Preserving Coverage,” Center on Budget and Policy Priorities, May 13, 2020, <https://www.cbpp.org/blog/medicaid-maintenance-of-effort-protections-crucial-to-preserving-coverage>.

²⁷ Judith Solomon, “Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing ‘Churn,’” Center on Budget and Policy Priorities, July 16, 2020, <https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by>.

²⁸ Aviva Aron-Dine, Kyle Hayes, and Matt Broaddus, “With Need Rising, Medicaid Is at Risk for Cuts,” Center on Budget and Policy Priorities, July 22, 2020, <https://www.cbpp.org/research/health/with-need-rising-medicare-is-at-risk-for-cuts>.

Ms. ESHOO. Thank you, Doctor. It is really a pleasure to have you with us.

The Chair now recognizes Mr. Dean Cameron. You are recognized for 5 minutes. And please unmute.

STATEMENT OF DEAN CAMERON

Mr. CAMERON. Thank you, Madam Chair. It is a pleasure to be with you. And thank you for the opportunity to testify regarding Idaho's experience regarding health insurance, the ACA, and the COVID-19 pandemic.

Idaho's perspective and experience may be unique from what you have previously heard. I hope it will be helpful as you consider broad public policies and the implications on unique demographics of each individual State.

Idaho prides itself on being creative and collaborative in finding solutions. It is that collaboration and our regulatory approach which led to the creation of our State-based exchange, the only Republican State to establish a State-based exchange. It is that collaboration and regulatory approach—and by the way, that is one of the most successful exchanges in the Nation. It is that collaboration that has provided consumers with up to five competing carriers participating in the individual insurance market. And it is that collaboration which proved critical and improved outcomes during this pandemic.

At the outset, the pandemic in Idaho's emergency declaration, the Department of Insurance began meeting virtually, weekly, with our carriers. We began collaborating on finding solutions to the barriers and dilemmas caused by the pandemic, which included everything from testing to treatment, to telemedicine, to provider support, to enrollment, to pharmaceutical guidelines.

The results are rather remarkable. Without mandating, without requiring, without threatening, all five carriers waived copayments, deductibles, and coinsurance on testing, and physician visits associated. All five carriers waived copayments and deductibles and coinsurance on treatment related to COVID-19. All five carriers expanded their telehealth network dramatically, allowing easier access for telehealth visits, allowing nearly every provider to see their patients remotely, and paying those providers as if the patient were being seen in person.

Our telehealth usage increased by 120-fold from February to April and 250-fold from April 2019 to April 2020. We went from 233 telehealth visits in February to 28,503 telehealth visits in the month of April alone. This was especially helpful to our citizens who needed their mental health provider, where we went from 97 visits in February to 11,333.

We allowed for early refill of prescriptions and the ability to obtain a 90-day supply without signature logs or in-person visits.

We waived eligibility requirements, allowing employees to maintain their coverage while working fewer hours, allowing coverage to be more quickly obtained upon return to work, or allowing furloughed employees to even stay on their group plan. We extended grace periods and reinstatement periods. All five of our carriers did this.

All five of our carriers also provided millions of dollars in timely assistance to providers and consumers of the COVID-19—as non-COVID-19 claims decreased. And I won't take the time, in the interest of time, to go into all of those.

Several of our carriers recently provided millions of dollars in refunds and credits to consumers, some as much as 50 percent in 1 month. The carriers also contributed greatly to our community efforts, participating in governor's task forces and et cetera.

From my perspective, the carriers have collaborated really well and have really stepped up at a time when all of their employees were working remotely.

There was a huge uncertainty, also, of the impacts of COVID-19. Since then, carriers have filed their individual market premium rate increases, and I am proud to report that the net increases is 1 percent. Three of our carriers actually requested a rate reduction, and two of our least expensive carriers had a slight increase.

Lastly, just a note on Medicaid. We have seen a dramatic uptick in the number of folks applying for Medicaid during the pandemic and a number who qualified for Medicaid expansion. That continues to grow. Even with the expanded FMAP match, those numbers are concerning to our State budget at this time where our economy is good but precarious.

Madam Chairman, and these collaboration efforts didn't happen by accident. They required communication, understanding, commitment to our State and our citizens, and I am honored to be part of that process. And thank you for allowing me to tell part of the story.

[The prepared statement of Mr. Cameron follows:]

Testimony Before US House Commerce Committee

Wednesday September 23rd, 2020

Madam Chairman,

Thank you for the opportunity to testify, I will testify regarding Idaho's experience with Health Insurance, the ACA and the COVID-19 pandemic.

Idaho's perspective and experience may be unique from what you have previously heard, and I hope it will be helpful as you consider broad public policy and its implications on the unique demographics of each individual state.

Idaho prides itself on being creative and collaborative in finding solutions. It is that collaboration and our regulatory approach which led to the creation of our state-based exchange – one of the most successful exchanges in the country. It is that collaboration which has provided consumers with 5 competing carriers participating in the individual health insurance market. And it is that collaboration which proved to be critical for improved outcomes during this pandemic.

At the onset of the pandemic and Idaho's emergency declaration, the Department of Insurance began meeting weekly, virtually with our carriers. We began collaborating to find solutions to the barriers and dilemmas caused by the pandemic, which included everything from testing, treatment, telemedicine, provider support, enrollment, and pharmaceutical guidelines. The results were rather remarkable.

Without mandating, requiring or threatening, all 5 carriers:

- Waived Co-payments, deductibles and co-insurance on testing AND the physician visit associated with testing
- Waived Co-payments, deductibles and co-insurance on treatment related to COVID-19
- Expanded their telehealth network dramatically to allow for easier access to telehealth visits
 - Allowed nearly any provider to see their patients remotely
 - Paid providers as if the patient were seen in person
- Our telehealth usage increased 120-fold from February to April. And over 250-fold from April 2019 to April 2020!
 - We went from 233 tele-visits in February (which was high compared to previous months and the year before) to 28,503 tele-visits in the month of April alone.
 - This was especially helpful for our citizens who needed to see their mental health provider.
 - 97 mental health tele-visits in February to 11,333 in April
- Allowed early refill of prescriptions and the ability to obtain a 90-day supply
 - And without signature logs or in-person contact
- Waived coverage eligibility requirements
 - Allowing employees to maintain health coverage while working fewer hours
 - Allowing coverage more quickly upon return to work
 - Allowing furloughed employees to stay covered on the group plan
- Extended premium grace periods and reinstatement periods

All our 5 carriers also provided millions of dollars in timely assistance to providers and consumers as non-COVID-19 claims decreased.

(Targeted provider loan programs, processing claims quicker, suspending prior authorization restrictions while extending prior authorizations previously given. \$1.4 million in total cash advances from one carrier to select provider groups; 3 of our carriers advanced \$5.5 million to providers of one hospital system (not a loan or need to be repaid); another offered \$10 million in interest-free cash advances.)

Several of the 5 carriers recently provided millions of dollars in refunds/credits to their consumers.

(One recently issued an ongoing 15% statement credit. A second provided a 50% credit for June's dental premium. Another offered 9% credit to small employers, 10% to mid-size employers, 4% to large-size employers, and a 23% dental credit to large and midsize employers, totaling \$11 million dollars.)

The carriers in Idaho contributed greatly to the community efforts.

(With their Medical Directors serving on the Governors testing task force. CEO's serving on the Governor's economic recovery advisory committee. Donating thousands of dollars to the Idaho Foodbank, the COVID-19 relief fund, and the coalition on aging. Donating thousands of dollars to Idaho Primary Care Association to support the public and to distribute PPE. Committing to donate every penny (not otherwise obligated) of the risk corridor recovery funds to mental health in rural communities. Donating \$500,000 to United Way. One carrier offered \$2 million in grants to Community Health Excellence program. Designating \$4.25 million to support testing and contact tracing.)

From my perspective our carriers really stepped up at a time when all their employees were newly working remotely and there was huge uncertainty regarding the impacts of COVID-19.

Since then, carriers have filed their individual market 2021 premium rates, and although not final, three of our carriers requested a rate reduction with two of the least expensive requesting a small increase. Overall, the net increase is 1%. (Small Group is similar with a 6% net increase)

Lastly, just a quick note on Medicaid. During the pandemic, the number of Idahoans who have APTC continues to drop while Medicaid and Medicaid expansion enrollment continues to outstrip projections. Even with the expanded FMAP match those numbers are concerning to our state budget at a time when the economy is precarious. The unknown is whether Idahoans will shift back to private coverage as the economy improves.

Madam Chairman, all these collaboration efforts did not happen by accident. They required communication, understanding and commitment to our state and its citizens. I am honored to be part of that process.

Thanks for allowing me to tell Idaho's story.

Ms. ESHOO. Well, thank you very much for telling your story. It is a good story, and we thank you for being with us.

Last but certainly not least, Peter Lee. It is wonderful to see you again. Thank you for always accepting our invitation to testify at our subcommittee. You are recognized for 5 minutes. And please unmute. We don't want to miss a word.

STATEMENT OF PETER LEE

Mr. LEE. Good morning, Chairwoman Eshoo, and thank you for your remarks. I would hope that my uncle, Phil Lee, is watching you as we speak today. Also, thank you, Ranking Member Walden, distinguished members of the committee. I am Peter Lee. I am the executive director of Covered California, which is one of the Nation's 13 State-based marketplaces.

My remarks, written testimony, and just-released report from Covered California, reflect our experience working for almost ten years to effectively implement the Affordable Care Act, and more recently, respond to the COVID-19 pandemic.

The pandemic and the resulting economic recession have demonstrated that, if implemented well, the ACA is working as it was intended to do. California, like most States across the Nation, red and blue, through the Affordable Care Act, have expanded Medicaid, providing coverage to millions.

Here in California, immediately after Governor Newsom declared a state of emergency, Covered California opened a COVID-19 special enrollment period and spent millions of dollars to make sure Californians who lost their jobs knew they could come to us. Results? Yes. We enrolled over twice as many people than the same period the year prior, with almost 290,000 Californians gaining coverage through our COVID-19 special enrollment period.

In stark contrast, we project that nearly 500,000 more Americans could have insurance coverage, had the 38 States served by the federally facilitated exchange, created a COVID special enrollment period and aggressively marketed to Americans to know they had options.

These results are not accidental. They could have been predicted. Federal inaction left as many as a half million Americans without coverage during a pandemic. This failure to act is one of life and death. Early diagnosis and treatment are critical to getting good care in COVID-19 times.

But the pandemic has also put a spotlight on the gaps and shortcomings of the ACA. The pandemic exposed the fragility of employer-sponsored insurance for many Americans and the weaknesses of high-deductible, lower-premium plans that many low-income people select in marketplaces.

Now, we have seen, and we just heard from the gentleman from Idaho, that many State, Federal Government, and insurance companies have addressed the realities of COVID-19 by having no cost sharing for consumers for testing and treatment.

It is clear that in a pandemic, the public benefits by having potentially infected individuals get tested and treated. It is less clear why the same logic does not apply to those infectious with other conditions, such as hepatitis, malaria, HIV/AIDS, or tuberculosis.

These are common diseases that are not only extremely deadly and costly to our health system, but that disproportionately impact lower-income consumers, communities of color, and those who are underinsured in their employer-sponsored insurance markets.

During a pandemic, when coverage is of paramount importance, we saw millions suddenly without coverage because they lost their job. We saw millions more discover the inadequacy of their coverage, and perhaps most problematic, we saw many people actually drop coverage altogether.

This is precisely the opposite of what should happen during a global pandemic and economic recession. It is in the public interest to have everyone have coverage so they can get help to stay healthy and get needed care, regardless of their health condition.

There are ways to strengthen and improve the ACA to make health coverage more affordable and accessible to all Americans. These are gone into in more depth in my written testimony, but I would like to highlight five of them.

First, you can do what States do: Step up, do more outreach. But I need to note, States cannot take the role of Federal action. California has taken bold steps to expand subsidies. They can't keep doing that. It requires Federal action.

Federally, we should increase subsidies for low- and middle-income consumers, such as using gold plans as a benchmark and limiting premium costs to no more than eight percent of income for all, getting rid of the cliff that is hurting middle-income consumers. We should provide options for Americans who aren't happy with and have employer coverage that isn't adequate. We need to address underlying healthcare costs, such as high prescription drug costs.

And finally, we need to, as a Nation, directly address healthcare disparities and inequities. The disproportionate impact of COVID-19 on Blacks, Latinos, Asian Pacific Islanders, isn't an exception. Sadly, it is the rule that we should be addressing.

The ACA is the right law to build upon, and we risk catastrophe if we turn our backs and abandon millions of people it protects.

I look forward to responding to the committee's questions. Thank you very much for holding this hearing today, Chairwoman Eshoo.

[The prepared statement of Mr. Lee follows:]



**United States House of Representatives
Committee on Energy and Commerce Subcommittee on Health
Hearing on "Health Care Lifeline: The Affordable Care Act
and the COVID-19 Pandemic"
Sept. 23, 2020**

**Written Testimony Submitted By:
Peter V. Lee
Executive Director
Covered California**

Good morning Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the committee. My name is Peter V. Lee and I serve as the Executive Director of Covered California – California's state-based health insurance marketplace for the individual and small group markets. I am honored to participate in today's hearing. The information and perspectives I will provide are based on seven years of experience operating a robust and successful state-based marketplace as well as over 20 years working to make sure health care better meets the needs of America's consumers.

The COVID-19 pandemic and economic crisis highlight the critical importance of the protections of the Affordable Care Act, how implementing the law makes a significant difference in who gets and keeps their coverage and provides vital lessons on how we need to improve the law. Throughout my testimony, I hope to provide the Committee with key perspectives on the following issues:

- How the Affordable Care Act is providing critical protections and access to coverage by millions of Americans, and California's approach to protect and build on the law;
- How the COVID-19 pandemic and recession are changing why consumers are seeking coverage or leaving the individual market;
- How the recent economic recession underscores the health coverage affordability challenges faced by many consumers, as well as the fragility – and often inadequacy – of employer-sponsored insurance provided to many Americans; and,
- Federal action to apply these lessons can lead to building on and improving the Affordable Care Act to deliver on its promise to ensure Americans throughout the country can access coverage.

California has Protected, Built-on, and Gone Beyond the Affordable Care Act

Today, more than 10 years after its passage, many of the transformative policies of the Affordable Care Act are generally taken for granted and the implications of turning back the clock to the days before these vital protections were commonplace would be catastrophic for tens of millions of Americans. Among its fundamental tenets are groundbreaking, consumer-protective policies that have now become almost universally accepted by Americans across the political spectrum, including:

- Protecting Americans with pre-existing conditions from being discriminated against by insurers;
- Requiring coverage by insurers to meet minimum coverage standards with requirements that premium dollars are spent on health care;
- Changing the nature of the health insurance markets to reward health plans that provide better access to affordable care, rather than rewarding them for avoiding sicker consumers;
- Expanded benefits for Medicare beneficiaries, including more prescription drug benefits; and,
- Making coverage more affordable by expanding Medicaid and providing financial help through marketplaces to Americans without employer-sponsored insurance or other forms of coverage.

The Medicaid expansion and the marketplaces created under the Affordable Care Act – such as Covered California – were always intended to provide a coverage backstop for individuals who are not eligible for other coverage through their jobs, Medicare, or other sources. Today, the Affordable Care Act is facing the first “pressure test” of responding to Americans’ needs in the face of the biggest public health crisis and economic downturn in many years. Covered California has sought to rise to the challenge as millions of Californians have lost jobs or income due to the COVID-19 pandemic and recession, and our state has invested in the Affordable Care Act through bold policies that positioned us to be able to better respond.

Before we move ahead, it is important to look back at the steps California has taken that have led us to this moment. A year ago, I sat before this very same committee to discuss how Covered California has used all the tools of the Affordable Care Act to build a strong and sustainable individual market that helps keep health care premiums as low as possible. Covered California’s 11 contracted qualified health plans vie for consumers based on price and quality. Our significant investments in marketing and outreach have led to strong, steady enrollment and a consumer pool that is consistently among the healthiest in the nation. As a state, California expanded its Medicaid program (known as Medi-Cal) providing coverage to millions of newly eligible Californians and outlawed short-term plans that do not cover pre-existing conditions or provide essential health benefits.

Leading up to the 2020 coverage year, California made coverage more affordable by offering state subsidies to eligible consumers, including becoming the first state to provide financial help to middle-income consumers earning up to 600 percent of the federal poverty level. In addition, California implemented a state individual mandate penalty in response to federal action that zeroed out the federal individual mandate penalty. Further, Covered California continued its practice of making large marketing and outreach investments – \$121 million for the 2020 open-enrollment year. These actions fostered confidence from the health insurance carriers that robust outreach would promote greater and healthier enrollment. All these actions led health insurance carriers to reduce rates by between two and five percentage points and resulted in a 41 percent increase in new enrollment during the most recent open-enrollment period.

The individual market in California has seen premium increases over the past six years that have been about half those in the federally-facilitated marketplace states. More recently, California's individual market has enjoyed two consecutive years of record-low rate changes of 0.8 percent for the 2020 coverage year and, based on preliminary rates, an increase of only 0.6 percent for 2021. Major beneficiaries of these low premium increases are the over 800,000 Californians who are "off-exchange" and receive no state or federal subsidies

A key driver of these low premium increases is larger, healthy enrollment and steady retention – by both subsidized and unsubsidized consumers. When compared to the rest of the nation, individual market health care premiums in California are estimated to be about 20 percent lower than what they would have been if the health of our enrollees was at the national average. Between 2014 and 2018, Covered California's risk scores were approximately 20 percent below the national average for the individual market, resulting in likely savings of approximately \$2.5 billion per year for enrollees and the U.S. Treasury. This translates to approximately \$12.5 billion in savings over this five-year period, and those savings are likely to have continued, if not become larger, in 2019 and now in 2020.

While we ended the 2020 open-enrollment period with strong enrollment, Covered California has continued to use all the tools of the Affordable Care Act to provide quality coverage at the best value as it has responded to the pandemic and recession. Covered California invested in outreach during the recent COVID-19 special-enrollment period and increased our marketing and outreach budget for the 2020-21 fiscal year by \$30 million to a total of \$157 million.¹ We have also allocated \$13 million for additional customer service upgrades to meet the needs of consumers who may have lost their job-based coverage.

Consumers will continue to benefit from competition and choice, with 11 carriers serving the state and two of them expanding their coverage areas. In 2021, virtually all (99.8 percent) Californians will have two or more health carriers to choose from, and about four out of five (77 percent) will have four or more plan choices.

While uninsured rates have been rising across the nation since 2016, California's uninsured rate has been reduced from 17.2 percent in 2013 to 7.7 percent in 2019². When you count only those currently eligible for coverage through Medicaid or our marketplace — not

¹ Covered California, July 16, 2020 – "Covered California Increases Investments in Marketing and Outreach to Reach Uninsured Californians During the COVID-19 Pandemic," <https://www.coveredca.com/newsroom/news-releases/2020/07/16/covered-california-increases-investments-in-marketing-and-outreach-to-reach-uninsured-californians-during-the-covid-19-pandemic/>

² U.S. Census Bureau, Sept. 15, 2020 – "Health Insurance Coverage in the United States: 2019," <https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>

including individuals who are ineligible for coverage due to their immigration status — California's "eligible uninsured rate" is about 3 percent. We in California still have work to do, but by fully implementing the Affordable Care Act and using the tools available today we are approaching universal coverage for those eligible.

Covered California's Lessons from the COVID-19 Pandemic

As described in the just released report, *Coverage When You Need It: Lessons from Insurance Covered Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic*, Covered California's overall enrollment reached an all-time high of 1.53 million actively enrolled consumers as of June 2020 (See Exhibit 1). This represents an 8 percent increase over Covered California's previous high of 1.4 million in March of 2018. The record enrollment in Covered California is what would likely be expected for marketplaces that were established to be part of the safety net for consumers with gaps in coverage, but it did not "just happen." Rather, the enrollment has been driven by significant investments in marketing and outreach throughout Covered California's history, along with patient-first policies during the current pandemic and recession.

California is the nation's most populous state, and when the COVID-19 pandemic began to rage across the country, it became the first state to issue stay-at-home orders to nearly 40 million people on March 19. One day later, Covered California announced a special-enrollment period to provide a path to coverage for those who were uninsured amid the pandemic.³ The move opened the marketplace to anyone who met Covered California's eligibility requirements, similar to the requirements in place during the annual open-enrollment period.

In the weeks and months after the launch of the COVID-19 special-enrollment period, millions of Californians lost their jobs, including many who also lost their job-based health insurance coverage. California's unemployment rate skyrocketed to a record 16.4 percent in May, and while there has been marked improvement since then, millions of people remain out of work.

Covered California also responded by launching new television ads, to encourage the uninsured to sign up for coverage, as part of a \$9 million campaign.⁴ The marketplace also worked with California's Employment Development Department so that every unemployment check includes a flyer describing Covered California and Medi-Cal (the state's Medicaid program) -- delivering 3.5 million inserts with unemployment benefits.⁵

Covered California's history of being recognized by many Californians as the place to turn if they lose coverage and the promotion during the pandemic resulted in a significant increase in consumers signing up for coverage during our COVID-19 special-enrollment period.

³ Covered California, March 20, 2020 – "California Responds to COVID-19 Emergency by Providing Path to Coverage for Millions of Californians," <https://www.coveredca.com/newsroom/news-releases/2020/03/20/california-responds-to-covid-19-emergency-by-providing-path-to-coverage-for-millions-of-californians/>

⁴ Covered California, May 4, 2020 – "Covered California Launches New Ad Campaign That Focuses on the COVID-19 Pandemic and Encourages the Uninsured to Sign Up for Coverage," <https://www.coveredca.com/newsroom/news-releases/2020/05/04/covered-california-launches-new-ad-campaign-that-focuses-on-the-covid-19-pandemic-and-encourages-the-uninsured-to-sign-up-for-coverage/>

⁵ Covered California, April 14, 2020 – "Covered California Enrolls Tens of Thousands as Impacts of COVID-19 Pandemic Hits California Households," <https://www.coveredca.com/newsroom/news-releases/2020/04/14/covered-california-enrolls-tens-of-thousands-as-impacts-of-covid-19-pandemic-hits-california-households/>

Between March 20, 2020 and August 31, 2020, more than 289,000 people signed up for coverage, which is more than two times the rate seen during the same time period a year ago (See Exhibit 2.).

These new enrollees also appear to be contributing to the individual market in California's positive healthy risk mix (See Exhibit 3.). To inform its negotiations with its contracted health plans, Covered California conducted an analysis of both the 2020 open-enrollment risk profile and the risk profile of those enrolling during the special-enrollment period, both before and after the announcement of the COVID-19 special-enrollment period. While this analysis only looks at prior health experience among the enrolling individuals, it appears that the risk profile of the new enrollees during the 2020 open-enrollment period were much healthier than the renewing members – being six percent “healthier.” The COVID-19 special-enrollment period enrollee cohort is most similar to the risk mix of the 2020 open-enrollment cohort.

The positive risk profile information was information used by health plans in California that set premiums increases for 2021 resulting in an average weighted increase of only 0.6 percent (after an increase of only 0.8 percent in 2020). By opening its doors and making more consumers eligible for coverage during the pandemic, Covered California increased its ranks of healthy consumers and drove premiums down for all consumers in the individual market.

The fact that Covered California was able to enroll hundreds of thousands of people during such a dramatic upheaval and loss of employer coverage is evidence that the Affordable Care Act can work to keep people covered when the worst happens. Individual marketplaces **should** see significant gains in enrollment during an economic downturn because they are part of the safety net that is most needed during a health crisis and recession. However, in order for that safety net to work right, consumers will be better served if it is reinforced by state actions such as we those undertaken in California: robust marketing and outreach; a history of getting the word out about the role of the marketplace; Medicaid expansion; and protection from junk short-term plans that do not ensure pre-existing coverage, and from policies that undermine comprehensive coverage.

The federally-facilitated marketplace – which provides coverage for Americans in 38 states – has significantly reduced its efforts in marketing and outreach in recent years, promoted short-term plans that put consumers and major financial risk, and did not launch a COVID-19 special-enrollment period. In contrast to the enrollment seen in California, the federal marketplace saw only a 27 percent increase in enrollment through the end of May at a time when millions of Americans were losing their job-based health insurance⁶ (See Exhibit 4.).

Our analysis finds that if the federally-facilitated marketplace had experienced the same level of growth as California did during special enrollment, then more than 500,000 Americans would have gained health care coverage instead of going uninsured during the pandemic. What this data makes clear is that not only does the Affordable Care Act provide the tools to protect consumers, but the decision to not use those tools results in many more Americans facing the pandemic without health insurance coverage.

⁶ CMS, June 2020, “Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency,” <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf>

You cannot look at the pandemic, and how marketplaces have responded, without looking more broadly at how a marketplace has served its people over time. Policies matter and the goal of any marketplace should be to promote enrollment and ensure that people have the coverage they need to protect themselves and their families during their time of need, particularly if they are one of the 130 million Americans with a pre-existing condition.

Covered California's Analysis of the COVID-19 Special Enrollment

The individual market has always served as an option for those without other coverage options and for those who experience changes in life circumstances. Transitions between coverage sources are natural aspects of the America's health care landscape, as individuals experience changes in eligibility for employer coverage, Medicaid, or Medicare (due to shifts in factors such as employment, income, and age). Each year, about one-third of Covered California's membership consists of new enrollees, and one-third of its annual membership leaves the marketplace within the plan year (See Exhibit 5.). Those "normal" ebbs and flows of coverage look very different in the months since the COVID-19 pandemic and recession hit.

Covered California conducted an extensive survey and analysis of the consumers who joined the marketplace during the special-enrollment period (See Exhibit 6.). During this COVID-19 special-enrollment period, Covered California saw nearly 300,000 consumers sign up, over twice the number who signed up during the same period in 2019. Of those enrolling, the vast majority (79 percent) would have been eligible to enroll for coverage in a normal special-enrollment period. They enrolled because they lost job-based coverage, or experienced other qualifying life events, and knew where to go to get help because of Covered California's efforts both during this period and over the past five years.

Based on our survey data, of those who enrolled during the COVID-19 special-enrollment period, about 21 percent were uninsured at the time of their plan selection, meaning they were most likely ineligible to sign up for coverage under normal special enrollment rules.⁷ The percentage who were uninsured is very similar to what Covered California sees during its open-enrollment period. Based on the overall volume of new sign-ups with Covered California the decision to declare a special-enrollment period for the uninsured allowed an estimated 60,000 more Californians to sign up for coverage than would have otherwise.

Despite Covered California's record enrollment, a critical concern moving forward is to ensure that these coverage gains do not further exacerbate disparities in health outcomes, especially as research shows that people of color are disproportionately affected by COVID-19.⁸ While enrollment in Covered California during this special-enrollment period shows the distribution among race and ethnicity to be relatively similar to prior open- and special-enrollment periods (See Exhibit 7.), more research is recommended, as people of color are believed to be overrepresented in industries most impacted by the recession.

Looking ahead, Covered California has established new paths to coverage for consumers who lose their job or suffer a reduction in income – regardless of whether that job provides

⁷ Covered California, Sept. 22, 2020 – "Coverage When You Need It: Lessons from Consumers' Moving In and Out of the Individual Marketplace in California Before and After the COVID-19 Pandemic," https://hbex.coveredca.com/data-research/library/CoveredCA_Coverage-When-You-Need-It_09-22-20.pdf

⁸ Kaiser Family Foundation, Sept. 16, 2020 – "COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data," <https://www.kff.org/report-section/covid-19-racial-disparities-in-testing-infection-hospitalization-and-death-analysis-of-epic-patient-data-issue-brief/>

them with health insurance coverage – and those impacted by the wildfires raging throughout the state.⁹

Covered California's analysis also revealed additional trends: (1) the pandemic highlights the fragility and often inadequacy of coverage for those with Employer-Sponsored Insurance; and (2) affordability of coverage for those who might be in individual marketplaces continues to be a challenge (See Exhibit 9.). These trends are further discussed below.

The COVID-19 Pandemic Highlights the Fragility and Inadequacy of Employer-Sponsored Insurance for Many Consumers

Covered California's analysis found the pandemic exposed the fragility of the employer-sponsored insurance market, where not only is the overall quality of plans deteriorating for many, but tens of millions of people across the nation have suddenly been left without coverage due to the pandemic.

Covered California's survey of consumers enrolling during the COVID-19 special-enrollment period found that 57 percent, or approximately 165,000 plan selections, were made by consumers who were previously enrolled in employer-sponsored insurance (See Exhibit 6.). This represents a nearly 20-point increase from the 39 percent of new enrollers who came to Covered California from job-based coverage during the 2019 open-enrollment period.

In addition, when you look at the consumers leaving Covered California – as people come in and out of marketplaces every month as life circumstances change – far fewer people are leaving for employer-sponsored insurance (See Exhibit 8.). The survey found that only 14 percent left the marketplace for job-based coverage during the COVID-19 special-enrollment period, compared to 54 percent during the 2019 open-enrollment member survey, which highlights the fact there are fewer employment opportunities available during the current recession.

National survey data from The Commonwealth Fund indicates that more Americans will continue to lose their employer coverage in the months to come, as results show that more than half of adults who had employer-sponsored insurance – but were furloughed due to the recession – are still covered through their job.¹⁰ It remains unclear how long employers will continue to offer coverage to their furloughed employees, but even as the unemployment rates stabilize, these results indicate that shifts in coverage transitions may be delayed for many. Future analysis of the overall rate of the uninsured will be essential to evaluate how well consumers were able to access coverage during this pandemic.

Beyond the fact that consumers are losing employer-sponsored insurance and facing greater difficulties finding jobs with insurance coverage, a challenge facing many Americans is the fact that many of those with employer-sponsored coverage are underinsured and face barriers to getting needed care. In a recent report by The Commonwealth Fund, about one-

⁹ Covered California, Aug. 24, 2020 – “Covered California Opens New Paths to Coverage for Wildfire Victims and Those Who Lose Their Job or Income During the Pandemic and Recession,”

<https://www.coveredca.com/newsroom/news-releases/2020/08/24/covered-california-opens-new-paths-to-coverage-for-wildfire-victims-and-those-who-lose-their-job-or-income-during-the-pandemic-and-recession/>

¹⁰ The Commonwealth Fund, June 2020 – “An Early Look at the Potential Implications of the COVID-19 Pandemic for Health Insurance Coverage,” <https://www.commonwealthfund.org/publications/issue-briefs/2020/jun/implications-covid-19-pandemic-health-insurance-survey>

quarter of adults with employer plans are “underinsured.”¹¹ The fact that high deductibles and cost-sharing can lead to consumers missing needed care is well documented – the same report noted the high proportions of those with insurance coverage but “underinsured” were likely to either skip recommended tests or not visit a doctor or clinic when they had a medical problem.

For those with private insurance, including both those with employer coverage and coverage through the individual market, as of 2020 almost half (46 percent) have deductibles of more than \$1,000.¹² While there are similarities between the affordability challenges faced by many in the individual market and those with employer-sponsored insurance, one major difference is that few with employer-sponsored insurance have support for their premium or cost-sharing that is adjusted for their income.¹³

State and federal actions addressed these realities by establishing policies that, irrespective of health plans benefit designs, there would be no cost-sharing for consumers receiving COVID-19 tests or for care and treatment of those diagnosed with COVID-19. It is clear in a pandemic, the public benefits by having potentially infectious individuals get tested and treated. It is less clear why the same logic does not apply to other infectious conditions – such as hepatitis, malaria, HIV/AIDS or tuberculosis. Why do we as a nation outlaw cost-sharing to ensure people with COVID-19 are effectively treated, yet we do not seem to be concerned that high cost-sharing means millions living with diabetes, cancer, heart disease or other conditions forgo needed care due to financial barriers. These are common diseases that are not only extremely deadly and costly to our health care system, but that disproportionately impact lower-income consumers, communities of color and those who are underinsured in the employer-sponsored insurance market and in marketplaces.

While California’s policies to eliminate cost-sharing – as well as similar ones instituted nationwide – helped people get care during the pandemic, they were necessary because research shows that those who are underinsured in the employer-sponsored market¹⁴, and those who have Bronze marketplace coverage, tend to avoid getting needed care because of affordability issues (See Exhibit 9.).

Pandemic Highlights Affordability Concerns

While the recession is impacting how consumers come to the marketplace and where they go after they leave the marketplace, it is also affecting whether or not consumers can maintain coverage and get access to needed care. Covered California’s survey found that the share of consumers who left the marketplace to become uninsured is increasing, with nearly one in four (24 percent) reporting they left Covered California to be uninsured – over two times the number who reported that in 2018 (10 percent). This data appears to reinforce

¹¹ Commonwealth Fund, August 2020, “U.S. Health Insurance Covered in 2020: A Looming Crisis in Affordability,” <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>

¹² Commonwealth Fund, August 2020, “U.S. Health Insurance Covered in 2020: A Looming Crisis in Affordability,” <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial>

¹³ Covered California 2018 & 2019 California Health Coverage Survey

¹⁴ Kaiser Family Foundation, Oct. 2018 – “2018 Employer Health Benefits Survey,” <https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/#figure1415>

prior research that affordability of individual market coverage remains a challenge, a concern especially in the context of a global health pandemic.¹⁵

In addition, the response to the pandemic also put a spotlight on concerns that affordability of care can be a barrier to many with individual market and employer-sponsored coverage seeking treatment. In Covered California – with 90 percent of enrollees receiving subsidies tied to their income that lower their health care premium and lower cost sharing – about 69 percent of consumers have plans that are “silver” or above – meaning their actuarial value is more than 70 percent. About 31 percent of enrollees, however, are still choosing the lowest cost plans – bronze with an actuarial value of 60 percent. With the consumer-centered benefit design, all of the bronze products provide multiple physician visits that are not subject to any deductible, but beyond those exceptions these are high-deductible products (with the individual deductible of \$6,300). Based on Covered California member surveys, about one-third of consumers with bronze plans report delaying or skipping needed care based on costs, which is two or three times the rate of those with richer benefits (see Slide 9 in attached slides).

Looking Ahead to Building on the Affordable Care Act

While the Affordable Care Act has provided a strong framework that has helped millions of Americans gain access to quality health coverage and care, there is more work to be done both in California and across the nation.

We have highlighted five areas of importance:

- **State Efforts Are Not a Substitute for National Solutions** – While several states have instituted their own policies to either build on the Affordable Care Act or restore measures that have been removed by federal action, they are not sustainable over the long-term. Policies such as reinsurance, individual mandate penalties and enhanced subsidies are best instituted on a national basis instead of a patchwork of state efforts. In some cases, such as reinsurance, a federal plan is the only plan some states will be able to achieve because of the significant cost involved.
- **Increased Subsidies for Low- and Middle-Income Consumers** – California addressed the infamous “subsidy cliff” for middle-income consumers by creating a new state subsidy program and extending those benefits to eligible people who earn up to 600 percent of the federal poverty level. The program has helped hundreds of thousands, including more than 30,000 middle-income Californians pay for their health insurance coverage. However, California’s state subsidies are time-limited, and as we are getting to ready to enter year two of the 3-year program, the policy is not perfect as consumers could still spend nearly 20 percent of their income on health insurance. The federal government would have a much greater impact by permanently expanding subsidies nationwide and eliminating the “subsidy cliff,” which can shut consumers out of receiving financial help once they reach the current income eligibility threshold and require them to spend a significant portion of their income on health insurance premiums. Increasing financial help and removing the cliff entirely will increase the number of Americans who have health insurance and move our nation closer to universal coverage.

¹⁵ The Commonwealth Fund, Aug. 2019 – “Who Are the Remaining Uninsured, and Why Do They Lack Coverage? The Commonwealth Fund,” <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage>

- Give Americans with Inadequate Employer Coverage a Path to Meaningful Coverage** – For many, employer-sponsored coverage works and works well, especially for those with coverage negotiated on their behalf by unions. However, many Americans, most of them low-income earners, have employer sponsored coverage that is inadequate. While the Affordable Care Act ties co-pays and deductibles to your income – you earn less, you pay less for a doctor’s visit – the same is not true for most people with job-based coverage. Consumers whose employer-sponsored insurance does not meet certain standards or value should be allowed to look to the marketplaces for more affordable and better coverage or the nation needs to address other routes so those with thin employer-sponsored coverage do not have coverage in name only.
- Lower Underlying Health Care Costs** – The United States continues to lead the way, by a significant margin, when it comes to high health care costs. The most recent data shows that the United States spent 16.9 percent of its Gross Domestic Product on health care, which is nearly twice the average of 10 other high-income nations.¹⁶ However, we continue to see the lowest life expectancy and highest chronic disease burden among the 11 nations. Covered California is working to improve health system performance by holding carriers accountable for assuring quality care and promoting delivery system reform.¹⁷ More effort must be made address the underlying costs of health care in our country, whether it is through making publicly negotiated pricing available to all consumers or through reforms to high prescription drug costs, the current situation is not sustainable over the long-term.
- Addressing Equity and Disparities** – The pandemic highlighted the fact that a global health crisis impacts communities differently. As noted earlier, we know that African American and Latino communities are bearing a higher cost in the battle against COVID-19 as they have suffered higher infection and death rates. Addressing this inequity, as well as dealing with the long-standing disparities facing communities of color will take a concerted and unified effort.

Conclusion

As a nation, we are at a pivotal time for the Affordable Care Act and for health care more broadly. In much of the country, the challenges we face have been exacerbated by recent federal policy actions – including the federal elimination of the individual mandate penalty, promotion of short-term, limited duration insurance, and the reduction in marketing and outreach by the federally-facilitated marketplace. As a result, these actions have chipped away at the integrity of the Affordable Care Act, forced millions to lose their coverage and steadily raised the national uninsured rate from 8.6 percent in 2016 to 9.2 percent in 2019.

¹⁶ Commonwealth Fund, Jan. 30, 2020, “U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes,” <https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019>

¹⁷ Covered California, Dec. 2019, “Covered California Holding Health Plans Accountable for Quality and Delivery System Reform,” https://hbex.coveredca.com/data-research/library/CoveredCA_Holding_Plans_Accountable_Dec2019.pdf

The Affordable Care Act remains the most significant piece of health legislation passed since the establishment of Medicare and Medicaid in 1965. While it is not perfect, it has protected Americans with pre-existing conditions and provided quality care to those who have no other coverage options. Looking forward, I hope Congress can get beyond the labels to focusing on building on the progress made in the past ten years and acting to make improvements to better meet the needs of millions of Americans.

I would like to thank the committee for inviting me to testify. I am honored to represent Covered California, and as always, I hope my testimony helps inform the health policy

dialogue at both state and federal levels. Again, please do not hesitate to reach out to us if we can provide you with any additional information that can assist you as you consider health care proposals that come before you in Congress.

Attachments:

- [*Exhibits Supporting the Testimony of Peter V. Lee, Covered California*](#)
- [*Coverage When You Need It: Lessons from Insurance Covered Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic, Covered California, September 22, 2020.*](#)
- [*Coverage Transitions in California's Individual Marketplace Pre and Post COVID-19 Pandemic: Chart Pack*](#)

Ms. ESHOO. Thank you very much, Mr. Lee. You are always welcome at our committee.

And to all of the witnesses, thank you for your testimony.

We will now move to member questions, and the Chair will recognize herself for 5 minutes of questions.

I have a few rapid-fire questions to each witness to establish a baseline of fact, so please answer yes or no.

Dr. Sommers said in his written testimony that, quote, "the ACA provides a highly effective safety net for workers who lose their jobs," unquote. Mr. Holtz-Eakin said in his written testimony that the ACA, quote, appears to be meeting the need, unquote, during the pandemic and recession.

Dr. Aron-Dine, Mr. Lee, and Mr. Cameron, yes or no, do you agree with your fellow panelists that the Affordable Care Act is a critical part of our social safety net?

Mr. LEE. Absolutely.

Ms. ESHOO. Dr. Dine? Mr. Lee?

Dr. ARON-DINE. Yes.

Ms. ESHOO. Mr. Cameron?

All yeses.

President Trump was interviewed on July 19 on FOX News and promised, quote, a full and complete healthcare plan within 2 weeks.

Yes or no, are any of you aware of the details of any comprehensive care plan, healthcare plan from the Trump administration? Dr. Sommers?

Dr. SOMMERS. No, I am not.

Ms. ESHOO. Mr. Holtz-Eakin?

Dr. HOLTZ-EAKIN. No.

Ms. ESHOO. Dr. Aron-Dine?

Dr. ARON-DINE. No, except for the repeal policies they put forward in prior budgets and proposals.

Ms. ESHOO. Yes. Well, that is a wrecking ball.

Mr. Cameron?

Mr. CAMERON. I can't say that I am.

Ms. ESHOO. Mr. Lee?

Mr. LEE. No.

Ms. ESHOO. Last week, President Trump said during an ABC News townhall, quote, we are going to be doing a healthcare plan very strongly and protect people with preexisting conditions.

Yes or no, are you aware of the details of any Trump administration policy that protects people with preexisting conditions? Dr. Sommers?

Dr. SOMMERS. No.

Ms. ESHOO. Dr. Holtz-Eakin—Mr. Holtz-Eakin?

Dr. HOLTZ-EAKIN. No.

Ms. ESHOO. Dr. Aron-Dine?

Dr. ARON-DINE. No.

Ms. ESHOO. Mr. Cameron?

Mr. CAMERON. Many State laws already protect preexisting conditions, including Idaho, who was well in front of the ACA.

Ms. ESHOO. But are you aware of any details of the Trump administration policy to protect people with preexisting conditions, yes or no?

Mr. CAMERON. Madam Chairman, I have heard the Trump administration and others speak of their intent to protect preexisting conditions, and we stand with that as well.

Ms. ESHOO. I don't know what you are standing with. Are you aware of the details? That is what I am asking. Yes or no?

Mr. CAMERON. Madam Chairman, have I seen an actual bill? No, I have not seen a bill. Have I heard them speak of—

Ms. ESHOO. OK. Mr. Lee?

Mr. LEE. No, I am not, but I would also, Madam Chair, welcome the chance to expand on that.

Ms. ESHOO. All right. Well, let's see how much time I have left.

Mr. LEE. Absolutely.

Ms. ESHOO. Yesterday, Politico reported that President Trump is planning to sign an executive order on healthcare coverage later this week.

Dr. Aron-Dine, you served as senior counselor at HHS and Acting Deputy Director of OMB. In your experience, how long does it take for the policy ideas espoused in an executive order to go through rulemaking so it can be implemented?

Dr. ARON-DINE. New rulemaking is typically a lengthy process, and that is true even when the objectives and legal authorities are clear.

Ms. ESHOO. And when you say they are extended or it takes a long period of time, give us an approximation of that.

Dr. ARON-DINE. A rapid rulemaking process, really starting from scratch, could still be a year-long process.

Ms. ESHOO. Oh. On April 3, I led a letter with every Democratic member of the Energy and Commerce Committee, to CMS Administrator Seema Verma, asking her to allow Americans to enroll in coverage through healthcare.gov during a special enrollment period. Six months later, there is still no response. No response.

Mr. Lee, California provided a special enrollment period. You spoke to it in your both oral and written testimony. That enrollment period was March 20, in response to the COVID pandemic. What was the outcome of it?

Mr. LEE. Yes. The results of that special enrollment period were a doubling of enrollment compared to the prior year, meaning we enrolled during that period almost 300,000 Californians, which means about 150,000 more than would have but for that effort.

And I do want to underscore, it is not just a special period, because many of those people would be eligible in a normal period. It is marketing, it is outreach, it is letting people know that our doors were wide open. Those were the factors that helped make sure we got so many Californians in the door.

Ms. ESHOO. Thank you.

I think that my time has expired. And I see that Dr. Burgess—am I right—Dr. Burgess has joined us. So I will call on Mr. Burgess and then—when the time is appropriate so that you can be recognized.

Do I recognize him now?

I will recognize Dr. Burgess now for his 5 minutes of questions. We missed you in the beginning, but we are glad to see that you have joined us. You can unmute.

Where are you?

I guess he is still not here. So I will recognize Mr. Walden, the ranking member of the full committee, for your 5 minutes of questions.

Mr. WALDEN. Thank you, Madam Chair. And thanks to all our witnesses for your testimony as we work together on these issues to make sure people have adequate access to affordable healthcare.

And again, I would repeat that I think we still have a lot of work to do, especially in the area of surprise billing. And it is unfortunate that this has not gotten across the finish line yet, and hopefully we can get there so that people who are covered and play by all the rules don't end up getting a bill that they should never get. I mean, there is a big rip-off going on out there, and we need to address it thoughtfully, and I think we have bipartisan legislation that will do that.

I would like to go to Mr. Cameron in Idaho. Do you all take advantage of the Children's Health Insurance Program?

Mr. CAMERON. Yes, we do, sir.

Mr. WALDEN. And what percent of that program is funded by the Federal Government in Idaho? I know in Oregon it is about 99 percent.

Mr. CAMERON. Yes. I believe it is close to 80 percent in Idaho.

Mr. WALDEN. All right. Do you know off the top of your head how many kids and mothers are signed up on CHIP in Idaho?

Mr. CAMERON. You know, I had that data, and I don't have it at my fingertips, so I can get it for you, Congressman.

Mr. WALDEN. As your neighbor just to the west, because I represent all of eastern Oregon, obviously we pay close attention on that side of the State to what you all are doing. And it has been interesting, States and laboratories. And I would like you to go through again, in terms of the—using sort of a free-enterprise model, it sounds like, in Idaho, the effects you have gotten by competition in your insurance market.

Mr. CAMERON. Thank you, Congressman. And I did find that number for you on CHIP. We are at 25,846 in 2019.

Mr. WALDEN. Is that 25,000?

Mr. CAMERON. 25,000.

Mr. WALDEN. Yes. I think in Oregon, we are over 122,000 kids. And under Republican leadership, we passed a 10-year, fully funded extension of CHIP when I chaired the committee. That is double the length of any extension that the Children's Health Insurance Program.

And I think on the issue of preexisting conditions, it was Republicans in 1996 who led the effort under ERISA. And it is my understanding, as you pointed out, your State has preexisting protections in place, irrespective of what the Supreme Court may do. I put forward legislation and multiple initiatives on the floor of the House this Congress to double-down on that so that we can protect people regardless of what the Supreme Court decision is, people with preexisting conditions would be protected.

But I want to get back to the marketplace in Idaho, what you have seen, what is working.

Mr. CAMERON. So our experience is contrary to what some others testified earlier. Our uninsured population actually went up with the passage of the ACA. In fact, it dramatically went up and then

started to wane, and then as we got into the 2013 and 2014 year, we started seeing significant numbers of individuals leave the marketplace. They were being forced out of coverage. We believe that is——

Mr. WALDEN. Why?

Mr. CAMERON [continue]. Because prices were too high, and they could not qualify for subsidies. We are a rural State, and many of our folks could not qualify for the subsidies. And it is not just because they were eligible for Medicaid expansion, but it was because they are farmers and their incomes are unpredictable, or they are spouses to schoolteachers and they couldn't qualify for subsidy.

So we have seen a dramatic exodus from our individual market. We have attempted to try and bring those individuals back, bring back the young and the healthy. Many of the provisions of the ACA, in fact, push the young and the healthy away, which drives prices up, which causes more people to leave.

And it is a little ironic, because some of the numbers that are counted on the uninsured population also include faith-based programs, which a large number of our citizenry has gone to, or short-term plans. We have created a new plan, call it enhanced short-term plan, that is more like an ACA plan and is tied to the same risk pool to try and address those issues.

Mr. WALDEN. And what kind of premiums can you get to charge for that enhanced short-term duration plan?

Mr. CAMERON. So our premiums are about 50 percent lower than the ACA plans, but I want to emphasize that we aren't pulling people away from the ACA into those programs. They are part of the same risk pool. So when the carrier filed their rate increases with us this year, that was a net 1 percent, some of them a decrease, that included those numbers from their enhanced short-term plans as well.

We have two carriers offering those plans. There has not been as great an uptick as we had hoped because of the pandemic, I believe, but I think it is a solution that is worth exploring.

Mr. WALDEN. All right. Well, I thank you for your participation, and to all our witnesses today.

My time is expired, and I yield back, Madam Chair.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize the chairman of the full committee, Mr. Pallone, for his 5 minutes of questions.

Mr. PALLONEN. Thank you, Chairwoman Eshoo.

I wanted to ask Dr. Aron-Dine about the ACA and the Supreme Court. You know, I know that the ACA has been a lifeline for millions during the pandemic, but its future hangs in the balance because of this Republican effort to repeal it, which is now before the Supreme Court hearing oral arguments November 11. And, of course, I believe that is the reason why—or a major reason why the President and McConnell are trying to push a new nominee, to, you know, vote against the—it is a vote in favor of the ACA repeal.

So, Dr. Aron-Dine, if the Supreme Court agrees with the Republican position that the ACA should be struck down in its entirety, how many individuals would lose coverage?

Dr. ARON-DINE. Pre-pandemic estimates were that 20 million people would lose coverage, and that number would be larger today

because millions of people are turning to Medicaid expansion or the marketplaces for coverage during the recession.

Mr. PALLONE. And then, Doctor, based on what you know about health insurance prior to the ACA, would people with preexisting conditions still be able to get affordable health coverage in the event of the Supreme Court repeal?

Dr. ARON-DINE. Prior to the ACA, the individual market really didn't work for people with preexisting conditions or other serious health needs. They could be denied coverage, they could be charged higher premiums, plans could have major benefit gaps, or annual and lifetime limits.

And I do just want to address this point that States could somehow protect their markets against those effects. To the extent States try to do that, they face a few big barriers. First, they don't have jurisdiction to reimpose protections in the self-insured, large-group market. Also, they generally don't have the moneys. They are not going to be able to replace the tax credits that actually make a market that helps people with—that works for people with preexisting conditions work for all. A State can't do that by itself without the Federal funding that would be eliminated.

Mr. PALLONE. Thank you.

Now, according to the Mayo Clinic, COVID-19 condemn is a long brain and hard and possibly have long-term health consequences. Given that, again, if the Supreme Court throws out the ACA, is it likely that having COVID-19 would be considered a preexisting condition?

Dr. ARON-DINE. My expectation is yes, and I think this goes for a larger problem with insurance markets that don't have any coverage standards, which is that there is a really strong economic logic behind a race to the bottom. So if you are an insurer who doesn't treat COVID as excludable preexisting condition, you would worry all your competitors are doing that and you are going to cover all of those people and have to pay their costs, so you end up excluding it, too. And that same logic applies wherever you don't have benefit standards.

So whether it is excluding maternity or excluding high cost drugs, and on and on, you get this race to the bottom that leaves people without an option for comprehensive coverage.

Mr. PALLONE. Well, thank you.

Once again, you know, I am very concerned that the Supreme Court holds the future of healthcare for millions of Americans in its hands, and the Republicans' and President's efforts to jam through a justice, you know, that would vote against the ACA jeopardizes its future even further.

Let me go to Dr. Sommers. I have a little over a minute. Could you just tell me—I know a lot of people have lost their job based coverage during the pandemic. You can comment on that or tell us, where are people turning for healthcare coverage during this time? And if individuals are still uninsured, you know, what is the reason?

Dr. SOMMERS. Well, one place that people turn is if they are fortunate enough to have another family member with employer coverage, and that does explain part of why many people losing coverage haven't become uninsured. For those without that good for-

tune, their situation is either that they are going to rely on Medicaid, which, of course, depends on the State that you live in and the eligibility criteria. And we know that 12 States have not yet expanded Medicaid. And then we also have the subsidized coverage in the marketplaces where you don't have to be qualifying based on full-time benefit eligible employment. If you have got part-time work, if your hours have gotten cut and you have got lower income, you might still qualify, and that could be an important source of coverage for people during the pandemic.

Mr. PALLONE. But, you know, my concern is—and I think it is indefensible that the Trump administration has refused to establish a broad open enrollment period or invest in outreach and enrollment efforts during this pandemic, or people don't necessarily know where to turn to, and it is sometimes difficult to enroll even when you have lost your job. I don't know if you want to comment on that as well.

Dr. SOMMERS. Yes, that is absolutely critical. We know that just making people eligible isn't enough to get them covered. Surveys show that people are often confused about how to navigate the process. So aggressive outreach, funding, and support for community efforts to assist people in enrolling is critical and is something that both States and the Federal Government should be doing during the pandemic.

Mr. PALLONE. Thank you, Dr. Sommers.

And turn it back to Chairwoman Eshoo.

Ms. ESHOO. The gentleman yields back.

Has Dr. Burgess joined us? Are you here? Dr. Burgess I don't see you.

Not seeing Dr. Burgess or hearing his voice, the gentleman from Illinois, Mr. Shimkus, is recognized for his 5 minutes of questions.

Mr. SHIMKUS. Thank you, Madam Chairman, and it is great to be with you, and it is a great hearing.

I want to first make a statement on just vaccine development. I know it is not the focus of this hearing, but I want to stress that while we are all focused on the work being done by Operation Warp Speed in expediting the development of select vaccine candidates, we still need to embrace the all-the-above strategy and continue to welcome the contributions of non Operation Warp Speed companies and products.

Operation Warp Speed investment should be purely additive and shouldn't displace other promising solutions that could prove to be superior to what we thought was possible just six months ago.

And I thank you for that.

To the panelists, a real quick, easy question, should be an easy question, and I think it should be an easy yes or no. Is the Constitution of the United States the supreme law of the land?

Dr. Sommers.

Dr. SOMMERS. I am not a lawyer, but I believe, yes.

Mr. SHIMKUS. Dr. Holtz-Eakin?

Dr. HOLTZ-EAKIN. Yes.

Mr. SHIMKUS. Dr. Aron-Dine?

Dr. ARON-DINE. I am also not a lawyer, but yes.

Mr. SHIMKUS. You don't have to be. You could have taken civics as I used to teach it.

Mr. Cameron?

Mr. CAMERON. Absolutely.

Mr. SHIMKUS. And, Mr. Lee?

Mr. LEE. Yep.

Mr. SHIMKUS. So let's talk about this court case that is coming up. The question to the Court is whether this National Government can force an individual to buy a product of service from a private company. When this case was litigated before the Supreme Court, the only thing that allowed it to stand was the right to tax, which was not what was discussed when we had our hearings and we even had this debate on the floor.

In fact, Republicans continuously said, You are standing on the principle that the government has the right to tax, but my colleagues on the left kept saying, No, no, no, we can force individual citizens to buy a product or service. And that is how the debate rolled out.

Well, under H.R.1 that tax was removed. The simple solution for Democrats is to reimpose the tax, and then that way reestablish the Affordable Care Act. That is the solution, but they are unwilling to do that.

So I would—I just want to pose that premise that to me the Constitution is the preeminent law of the land, and regardless of the good intentions of Federal legislation, that is the primary arbiter. And since I support jurists who are strict construction or originalists, that they don't interpret, based upon their experiences, how the founders would have written the Constitution, that regardless of what should happen, the Supreme Court's rule is, as they say, is this law constitutional or is it not? And that is the debate before, not whether we like it or we don't like it.

It is did the Federal Government have the right to pass this law on the citizens of the United States? I believe it was an unconstitutional law because of forcing people to buy something that they should not be forced to buy if they don't want it, regardless of the good intentions.

Now, in my final time—I can't see the clock, Madam Chairwoman, so if I need to gavel down, go ahead and do that. But in my district, like in Idaho, I hear the ACA is too expensive and it doesn't cover folks who need it. And we have seen what has happened. The co-ops proposed—there is only three of the 26 that are left. Short-term plans are maligned, and associated health plans are sabotaged.

So if we can go to Dr. Holtz-Eakin and my colleague, my friend from Idaho, if they could talk about this premise, I would appreciate it.

Dr. HOLTZ-EAKIN. Well, I think, from the beginning of the debate over the ACA, one of my concerns has been that it was coverage heavy and delivery system reform light and, as a result, wasn't addressing the underlying costs of healthcare and so insurance costs would inevitably go up. It ran into problems on top of that, in terms of pricing, poor competition, often very thin at times. Some States threatened to have parts where only a single provider was there to offer insurance. And so for ten years we have seen this continual issue of the cost of health insurance under the ACA.

Mr. SHIMKUS. Mr. Cameron?

Mr. CAMERON. Yes, I would add to it, we continue to see cost increases, although the last couple of years have not been as bad, and as those cost increases occur, and many of them occur because they are healthy—you know, I have got, like, the couple from Twin Falls, Idaho, 62 and 63 years of age, who can't afford \$1,500 a month in coverage. They don't qualify for a subsidy, and so they end up opting out. And those are the individuals we need to be back in the pool, in the system in order to make the ACA or any plan affordable.

Mr. SHIMKUS. Thank you very much.

Madam Chairwoman, I yield back my time.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize the gentleman from North Carolina, Mr. Butterfield.

Mr. BUTTERFIELD. Thank you very much, Madam Chair, for convening this hearing today, and thank you for keeping our subcommittee engaged even though we are facing some unprecedented challenges, and thank you to all of our witnesses. Your testimony today is very valuable.

Before I get into my questions, I just want to respond briefly to my friend from Illinois, Mr. Shimkus. The Supreme Court is indeed the law of the land. I served as a judge for 15 years, and certainly I recognize that, and even several years on my State Supreme Court. But sometimes the Court is wrong. I refer you to the Dred Scott case of 1857, not to mention the fact that the public loses confidence in the judiciary when it is politicized. I am just saying.

But let me just address my question to Ms. Aron-Dine, Dr. Aron-Dine. We know from experience that when the economy goes south and people lose their jobs, their income goes down. They turn to Medicaid for health insurance, and enrollment in Medicaid increases. And so Medicaid, like SNAP and unemployment insurance, is a counter cyclical program, meaning that when the economy goes down, enrollment in these programs actually go up. This isn't a bad thing. Medicaid is designed to be there for people when they actually need it.

So, Doctor, economic downturns can strain State Medicaid budgets in two ways, increase enrollment and decrease State revenues. Can you briefly describe for me how that works and what it means for State budgets?

Dr. ARON-DINE. That is exactly right. During a recession, States see large drops in their revenues, and then they also experience additional, those smaller budget strains from more people signing up for Medicaid and other programs.

In this recession, States are also seeing additional strains from specific COVID-19 related costs that they are incurring to try to address this pandemic.

Mr. BUTTERFIELD. Now, in years past during economic downturns, Congress has stepped in and provided additional financial help in the form of increased Federal funds known as FMAP. Is that correct?

Dr. ARON-DINE. Correct.

Mr. BUTTERFIELD. And let me ask you this, the Families First Coronavirus Response Act included in my bill that increased FMAP by 6.2 percentage points for the duration of the public health emer-

gency, how does that compare, if you know, to the FMAP increase that Congress included in the Recovery Act during the Great Recession?

Dr. ARON-DINE. So the Recovery Act increase went up and down based on State economic conditions, but at its peak it was about twice the size of the assistance that was provided in this recession.

Mr. BUTTERFIELD. I represent the State of North Carolina, and my State, which, unfortunately, has not expanded Medicaid, over 2 million people, including many children and seniors, receive necessary care from Medicaid. If our States are forced to make budget cuts, what coverage, what coverage would be at risk?

Dr. ARON-DINE. Based on what we have seen in past recessions, I would be particularly worried about two things.

One is States cutting back on optional services which are, in fact, quite critical, like home- and community-based services for seniors and people with disabilities, as well as dental and vision coverage.

I would also be very concerned about States seeking to introduce procedural hurdles that make it harder to get covered, and so cutting costs by reducing the number of eligible people who are actually able to get access to the program. As well as others.

Mr. BUTTERFIELD. Would reimbursement rates be affected, in your opinion, to the providers?

Dr. ARON-DINE. Absolutely. And that is something we are already seeing, even with the Families First FMAP and the protections that came with it is that a number of States are cutting provider rates, including for some providers that are particularly financially fragile right now.

Mr. BUTTERFIELD. Well, we haven't passed—the Senate hasn't passed the Heroes Act, and you certainly know that the Heroes Act contained a 14-point FMAP increase, and I am just so disappointed that our Senate Republican colleagues have just been unwilling to move that legislation.

Madam Chairman, I think I am going to stop there and yield back. Thank you.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize now the gentleman from Kentucky, Mr. Guthrie, for his 5 minutes of questions. And please unmute.

Mr. GUTHRIE. Thank you, Madam Chair, I believe that I have unmuted. Thank you very much.

Dr. Holtz-Eakin, you talked about this, I think, as your second point if I remember your three points. And like Idaho, you know, I have a district that has lost small businesses, farmers, people that are typically in the individual market, quite a bit of people in the individual market, and have seen a large increase in premiums. And so that is what we have to balance, how do we get coverage, how do we get items covered, and how do we decrease premiums?

And one of the ways the architects of the Affordable Care Act—one was individual mandate, but the other one was enrollment periods. And so now we are talking about, I think, talking about a special enrollment period has been proposed. And my understanding is if you are working—tell me if I am correct, if you have a job and employer and you have employer-sponsored health insur-

ance and you lose your job, therefore, your health insurance, due to the crisis, then you can enroll in another program.

I know we may have to do assistance, I understand that, that is expensive, and we have to look at that. But you would already have the right to enroll in another program if you lose your employee-sponsored health insurance under the current law? Is that correct.

Dr. HOLTZ-EAKIN. That is correct.

Mr. GUTHRIE. So we have a special enrollment period. A special enrollment period would benefit those who made a choice not to purchase health insurance, either through their employer or individual market, therefore, made the choice not to pay premiums; but now that we have a pandemic and we open up the enrollment period, they can go into the marketplace even though they haven't paid premiums.

So what would that do to the costs of health insurance for everybody else if people made a choice not to buy health insurance and now can buy it because there is a pandemic moving forward and they haven't been paying premiums the whole time.

Dr. HOLTZ-EAKIN. Certainly you run the risk of getting some very expensive people into the pool who are not priced by the insurers at the beginning of the plan year and running into financial difficulties for those insurers. That is not a hypothetical.

We saw this repeatedly during the startup of the ACA when there were about 13 special provisions in which you could enter the marketplaces during the middle of a plan year and the insurers repeatedly complained about how it made it impossible for them to manage their offerings effectively, how they as a result had to have price increases to anticipate people jumping in, and often those individuals would then jump back out and get a chance to reenroll somewhere else in the next year.

Mr. GUTHRIE. Well, that is not point. It is not what it does to insurers, but what insurers do to make up for that. What is the end result of that?

Dr. HOLTZ-EAKIN. It went up. They had to raise premiums to anticipate this phenomenon.

Mr. GUTHRIE. So those in the marketplace pay more—

Dr. HOLTZ-EAKIN. Yes.

Mr. GUTHRIE [continue]. If you have a special enrollment period? That is the concern I wanted to bring up.

So the second thing on this economic—and as we have seen from Idaho and experience that I have is that that causes more people to fall out of health insurance. I know the person that—I took my car in to get a transmission fixed, and the guys said, Well, I am only here certain hours because in the morning and afternoon I drive a school bus because I am driving for—he goes, essentially I am driving a school bus for \$1,600 a month because that is why he is an individual small business, sole proprietor, transmission business.

But in this economic downturn, we have had big effects. And so I want to talk about health insurance coverage and effects from this. How does this downturn differ from other, like the post financial crisis downturn? Are some of the job numbers that we have seen in recent weeks indicative of any of those differences? And as

the economy starts to come back, does that affect what policies you recommend to address any remaining coverage issues?

Dr. HOLTZ-EAKIN. This downturn is unlike any previous downturn in the United States. It is characterized by a sharp decline in household spending, particularly spending by affluent households on those services which involve personal contact. And that began in mid-March, and it was so severe that in the space of 2 weeks it turned the first quarter growth rate into a negative number.

It continued into the second quarter with these large job losses, ten times larger than anything we have seen in a single month in U.S. history.

So the onset is different, it isn't that people didn't have income and it isn't that we had a financial disturbance, it was the virus, people hiding from the virus and not spending, and especially affluent individuals. So that is an important piece.

For this hearing, one of the things that has happened is that the health sector has never before been involved in the business cycle, and the health sector is the business cycle. Of the 5 percentage point decline in the GDP in the first quarter, two full percentage points came from the diminished use of health services. People stopped going to doctors and hospitals and clinics.

And what happens to the deliver system going forward I think is a very important question. We have seen a lot of consolidation in recent years. That is why prices are high. That is why insurance becomes expensive. And the ACA actually fostered some of that. Now we have got this enormous financial distress in the healthcare delivery system that is going to be important for an online. But if there is less competition as a result, we are going to have a big problem.

Mr. GUTHRIE. OK. Thank you. And I see my time just expired. I appreciate your answers.

And I yield back. Thank you.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize the gentlewoman from California, my wonderful friend, Congresswoman Matsui, for your 5 minutes.

Ms. MATSUI. Well, thank you, Madam Chair, for calling this really important hearing, and thank you for the witnesses for being here today, and I just have to have a special shout out to Peter Lee as a wonderful Californian who has done a wonderful job.

Let me just say this. The arrival of COVID-19, as we know, has quickly turned life as we know it upside down, and overnight the pandemic created unprecedented challenges that necessitated rapid and extraordinary responses. California has been a leader in preserving and expanding access to care, and this pandemic response has been no exception. The ACA has been a lifeline for millions in California, and in our current crisis, the law has proven vital to ensuring that we can meet the increased need brought on by the recession.

Mr. Lee, I want to follow up on the previous question regarding the special enrollment period for previously uninsured. How have you seen the special enrollment impact the risk pool and what effect do you expect on premiums?

Mr. LEE. Great. Thank you very much, Congresswoman Matsui. It is great to see you. I wish I could see you in person.

Covered California is more sensitive than anyone about the importance of the risk mix. California, by enrolling more Californians than virtually any other marketplace, has enrolled healthier Californians, which means on average our premiums are 20 percent less than they would have been.

We engaged our health plan before we opened up the doors wide, and we saw 80 percent of the people signing up during the special enrollment period were previously eligible, but more came in because we marketed. But 20 percent were not eligible previously, but they weren't people in ICUs because of COVID. They were people scared about getting COVID. They were people who were healthy who we want to get tested. We saw those people come in, and we then assessed the risk mix.

So I totally agree with the broad theories that Doug Holtz-Eakin noted in the early days of the ACA risk mix. We saw a healthier risk mix coming in during our special enrollment period. It is a win-win.

You want people to not avoid healthcare during a pandemic, and we want to get more people enrolled, a healthier risk mix. It is going to lead to lower premiums as in 2021, our plans are priced to have a .6 percent premium increase. That is because they looked at risk mix; we looked at risk mix. It has been a win-win, Congresswoman.

Ms. MATSUI. OK. Thank you very much for that.

House Democrats have passed legislation to protect consumers and help make healthcare more affordable. We pushed for provisions in the Heroes Act, as has been mentioned before, to establish an emergency special enrollment period and ensure access to free COVID-19 treatment. Unfortunately, the Senate Republicans have refused to take this up.

Dr. Aron-Dine, the ACA brought the uninsured rate to historic lows. However, under the Trump administration, nearly 3 million Americans have lost coverage. Can you discuss why the number of uninsured Americans began to climb? And also what policies should we be putting forward to make it easier for people to get a State covered in this and future crises?

Dr. ARON-DINE. Thank you.

A number of policies from the administration I think contributed to the rise in the uninsured rates that we saw prior to the pandemic during a strong economy, but let me single out two.

One is the set of administration policies, but particularly the public charge rule, which have really created a climate of fear for people, for immigrants and their family members, who are eligible for public coverage programs but are worried about what might happen if they enroll. And what we saw in the latest census data is that the groups you would worry would be most affected by that, such as Hispanic people, children not born in the United States, were particularly likely to lose coverage.

A second factor I would single out is the set of administration policies that have made it harder for people to get and stay enrolled in Medicaid. The worker climate policies that Dr. Sommers spoke to were fortunately thrown out in court for the most part, but other policies have also created procedural barriers. For example, the administration actually told Idaho that they had to stop

doing something that made it easier for people to renew their Medicaid coverage and instead had to require more paperwork.

And so going forward, I think some of the areas to think about to fill in the remaining coverage gaps include continuing to work on affordability policies, finding ways to make it easier for people to get and keep their coverage instead of harder, and creating more incentives for the remaining 12 States to expand Medicaid which is just critical to filling that major gap.

Ms. MATSUI. All right. Thank you very much.

And I know that my time is gone, so I yield back. Thank you very much.

Ms. ESHOO. I am sorry. The gentlewoman yields back.

Now it is a pleasure to recognize our colleague from Virginia, Mr. Griffith, for his 5 minutes of questions.

Please unmute.

Mr. GRIFFITH. Thank you very much, Madam Chair. Can you hear me?

Ms. ESHOO. Yes.

Mr. GRIFFITH. All right. Thank you.

Look, you know, we have talked about the Supreme Court, and one of the things that I think hasn't been said is that if the Supreme Court were to rule the ACA unconstitutional, that doesn't mean that there is a vacuum that cannot be filled. Congress, as civics teacher Shinkus would tell us, Congress has an opportunity to step in and fill that and act as it sees appropriate, and if we are so concerned about the preexisting condition issue, how come we haven't we brought up a standalone bill like Greg Walden's H.R. 692 which would take care of that and make it clear to everybody? Republicans and Democrats both believe that preexisting conditions should be covered.

And to Chairman Pallone's point, those who have had COVID may now have a preexisting condition, well, science is out on that. We are trying to figure that one out. And, in fact, I have joined an NIH study to see, having had COVID, to see what are the subsequent consequence of having had COVID and are their health conditions that may come from that 2 to 3 years down the road. So we will find that out, but we can fix that if we wanted to and we have failed to act.

Now, let's go to the underlying ACA, and, you know, I have said this many times, but it is still true. More than a decade ago President Barack Obama visited Bristol, Virginia, in my district, and in front of a large crowd, he proclaimed the virtues of his healthcare plan, which is now the Obama Care or ACA.

Under the reform I propose, if you would like, you can—if you like your doctor, you can keep your doctor. If you like your healthcare plan, you can keep your healthcare plan. He went on to say, Under the Obama plan, the government would work with insurance companies to lower premiums by an average of \$2,500 per family annually for those who have insurance.

Well, here is what actually happened. According to Virginia State Corporation Commissioner of Insurance, currently seven percent of Virginia's population is uninsured. Only one insurance company, only one, covers the 29 jurisdictions that I am proud to represent, only one. And in 2019, the weighted average insurance premiums

for individuals in Virginia was \$796.29 per month. That is up from an average of \$322.41 in 2014 and even more over 2010.

My constituents feel the pain financially as well as physically. Congress continues to hear about problems with the ACA and what those problems are causing, even as the pandemic has caused more to need individual insurance claims. Since June of this year we have had—in my office, we have had at least 54 separate complaints.

Dr. Holtz-Eakin, is Virginia isolated in these experiences? Did the ACA fulfill its dream of allowing folks to keep their healthcare plans, keep their doctors, and lower their health insurance premiums?

Dr. HOLTZ-EAKIN. No. Your characterizations are shared by many other States.

Mr. GRIFFITH. I appreciate that.

And also, Dr. Holtz-Eakin, in your testimony you discuss short-term limited duration plans as a potential stopgap measure for some people who have lost their employer-sponsored health insurance because of the downturn. You mentioned particular people had previously made too much money to qualify on certain exchanges when they went to enroll in their special enrollment period.

Can you help me put into understandable terms, who would that be? How much money would someone like that had to have made and what their choices in how much they pay in the ACA exchanges versus a short-term plan?

Dr. HOLTZ-EAKIN. You get folks making, you know, \$150,000 a couple and they get hit with the downturn and now what are they going to do. So this is a degree of flexibility that was not present in prior years, and it gives people an opportunity to, you know, have insurance during what they hope is a relatively short recession and recovery.

And we have already seen job growth return to the United States. We saw that in May, June, July, August, and in the August report we saw private payrolls rising at a 20 percent annual rate. So there are reasons to be hopeful that this will turn out to be a very limited, very sharp downturn, and then a short-term plan is the way to ride that out and get back into your regular insurance after that.

Mr. GRIFFITH. Well, and I appreciate that, and the short-term plans can be helpful for some people; but let me underscore once again that while there has been a lot of discussion about pre-existing conditions, neither Republicans nor Democrats want to see people with preexisting conditions not covered.

And obviously, you know, I have told you I had COVID. I am one of those people that may be affected if Chairman Pallone is correct, and if the science bears out that there are some additional repercussions from having had even a mild case of COVID, we will just have to see what happens in the science.

But neither Democrats nor Republicans are planning to get rid of the protection that is afforded to people who have preexisting conditions. You would agree with that, wouldn't you, Doctor Holtz-Eakin?

Dr. HOLTZ-EAKIN. Yes, I would. Both sides have put together proposals to preserve that protection, so there is no evidence that anyone is against it.

Mr. GRIFFITH. I appreciate it.

And I yield back.

Ms. ESHOO. The gentleman yields back.

I would just add to this discussion that, on the Republican side of the aisle, not one Member in the entire House of Representatives has spoken up and said that this case at the Supreme Court is going to wipe this out and that they are deeply concerned about it.

So I just think it is important to place that on the record.

I now am pleased to recognize the gentlewoman from Florida, Ms. Castor, for her 5 minutes of questions. And please unmute. Wonderful to see you.

Ms. CASTOR. Thank you, Chairwoman Eshoo. This is very important hearing today on the Affordable Care Act and COVID-19. Thank you to our witnesses who are here.

And, Chairwoman Eshoo, you are right, some of this rhetoric does not match the reality. We know, it is crystal clear, that President Trump and Republicans are urging the United States Supreme Court to strike down the Affordable Care Act in its entirety.

That includes protections for 130 million Americans with a pre-existing health condition and it also means the coverage for 1.9 million Floridians who purchase their affordable health insurance on the healthcare.gov marketplace. You heard that right, 1.9 million Floridians. That is more than the population of about a dozen States.

So the stakes are high here, and it is truly unconscionable that this would be urged on at any time, but especially in the middle of a public health crisis that has tragically claimed the lives of 200,000 Americans. Trump and the GOP are attempting to rip coverage away in the courts after they failed to do so in Congress, try as hard as they might. What they are doing by bringing this case to the United States Supreme Court is cruel and it is wrong.

And, in addition to actively putting the ACA's preexisting condition protections at risk, President Trump and his administration have also recklessly expanded junk health plans. And the result has been that many bad actors have fraudulently sold junk plans to consumers.

These junk plans often do not offer comprehensive coverage, and they discriminate against people with preexisting conditions. In fact, this committee did an investigation and found that junk plans leave families on the hook for hundreds of thousands of dollars in medical bills, and they often deny claims for medical care that rightfully should be covered.

In fact, the Federal Trade Commission has gone after some of these bad actors for their bait-and-switch tactics. There are a number of Federal lawsuits filed against them. But the Trump administration has allowed them to proliferate needlessly.

The Affordable Care Act was successful in limiting these junk plans and ensuring that families can rely on the meaningful health insurance policy when they purchase one. They don't want to go back to the battle days when insurance companies could discriminate against them if they have asthma or cancer, now COVID-19.

So I understand, Mr. Lee, that California has outlawed junk plans. Can you briefly explain why?

Mr. LEE. I can. Thank you very much for the question.

I think there is a lot of confusion when people talk about short-term plans or faith-based plans. They are cheaper, they are great option, they are short term. Let's be clear, it is not just fraud. This is what health insurance was ten years ago.

These are plans that can, number one, exclude people based on their health status, so they winnow off people. But then there is no guarantee that coverage will be there when you are sick. It is Swiss cheese coverage. You don't know what is covered and what is not covered.

And they will say, sorry, this short-term plan doesn't cover mental health. This one has a cap on hospital. They are a great deal, they are cheap if you predict the future; but if you could predict the future, you don't need insurance. You don't know if you are going to get cancer or end up in the ICU.

And I would note that in California, we have 800,000 people with unsubsidized coverage because we, the State, have kept all of the costs down, and that has been a failure of many States that have priced middle class Americans out of coverage because they have allowed premiums to skyrocket by not marketing, not getting people in the door. Going back to short-term plans is a wrong solution. We have people come in and out of Covered California every month. That is a working solution because, when they are with us, if they get sick, they are covered.

Ms. CASTOR. So, Dr. Aron-Dine, do junk plans pose a risk for families who contract COVID-19? What is going on here? What would you warn consumers about here?

Dr. ARON-DINE. Yes, I do think they pose a risk to people who contract any serious illness. And I think there is a bit of a sort of myth out there that the people purchasing these plans are fully informed consumers making totally rational decisions to assume those risks.

You could question whether anyone is able to make that kind of decision about those kinds of risks, but it is also clear that these plans are being marketed in misleading ways and that they engage, your committee reports finds, in a lot of what is called expost underwriting, which is fancy word for finding reasons to deny people's claims once they get sick.

So that is not coverage that people are making an informed decision to buy. It is coverage that is really leaving them without protection.

Ms. CASTOR. Thank you.

And I yield back.

Ms. ESHOO. I am sorry. The gentlewoman yields back.

It is a pleasure to recognize the gentleman from Florida, Mr. Bilirakis, for his 5 minutes of questions.

Mr. BILIRAKIS. Thank you so much, Madam Chair. I appreciate it very much. And thanks for holding this hearing, and I thank the witnesses for testifying as well.

Like my colleagues on and off this committee and this administration, I, too, support protections for those with preexisting conditions and funding our community health centers. However, like

many Americans, I remain concerned with the continued high cost of healthcare despite the ACA's passage.

Dr. Holtz-Eakin, one of the major promises of the ACA was affordable insurance for every American. The law even went so far as to penalize those who didn't enroll. However, in the decade since its enactment, costs continue to rise. Why is that, in your opinion? Why is that?

Dr. HOLTZ-EAKIN. Well, I think one of the key features across the United States has been increased consolidation in providers, hospitals buying up doctor physician groups, and the like, which allow them to have more market power and higher prices for delivering the underlying services.

And insurance, in the end, is a product that just shifts the bill from one individual to another. If the bill is too large, insurance is going to be very, very expensive. And so I think that has been a concern among health policy experts of all stripes, that lack of competition and how to address the increase in prices.

Mr. BILIRAKIS. OK. Thank you.

Director Cameron, the pandemic has further stressed the mental health of our communities. I think we can all agree on that. Recent data from my district indicates increased overdose rates, unfortunately, this year, with August being one of the deadliest marks on record.

Congressman Soto and I introduced H.R. 5473, the Enhance Access to Support Essential Behavioral Health Services Act, which builds on landmark opioid legislation passed by this committee last Congress to expand reimbursement for behavioral and mental health services delivered through telehealth, regardless of whether someone has substance abuse disorder.

Would you agree that preventive measures like the EASE Behavioral Health Services Act would be helpful in addressing our Nation's mental health crisis? And I believe that that was placed in Ann Wagner's bill. But we would love to get that through this committee but also on the floor of the House as soon possible.

What is your opinion on that, on that particular bill, sir?

Mr. CAMERON. Thank you, Congressman. I have not seen the language, but I certainly believe that providing mental health services is paramount. We have been very successful in improving that through our telemedicine. In fact, that has been a real hallmark of what has happened this last year and, you know, certainly support any efforts in that direction.

Mr. BILIRAKIS. Yes, people have to have access, no question.

Again, Director Cameron, you mention in your testimony seeing an uptick in telehealth visits in Idaho. Pre-pandemic, some stakeholders cited a lack of clarity around Federal reimbursement for telehealth for substance abuse disorders under Medicaid.

Do you agree with that sentiment? And would additional guidance from the appropriate agencies at HHS be helpful to ultimately ensure that those who needed treatment can have access to it?

Mr. CAMERON. Well, it certainly can't hurt. I think it is more complicated than that. I think people were not using telehealth services, A, because they weren't especially comfortable with it, and they got real comfortable real quick in the pandemic.

I think providers weren't offering it because they weren't necessarily comfortable. They liked the old system of being able to see people face-to-face. And in many cases, that is ideal. But one of the things the pandemic has done is it has sort of blown the doors open and allowed consumers to be able to access and utilize it, and I think many are seeing they actually prefer it now.

Mr. BILIRAKIS. Yes. That is what we are hearing, too, because they can actually do it in the privacy of their own home and it is so very convenient.

Mr. CAMERON. Yes.

Mr. BILIRAKIS. One last question. I don't want to go over, Madam Chair.

Dr. Holtz-Eakin, CMS released a report in August of 2019 on individual insurance market enrollment trends. Data shows that between 2016 and 2018, unsubsidized enrollment declined by approximately 40 percent. If the ACA has fulfilled its promise to provide affordable healthcare to all, why has this decline occurred? Is it an affordable issue?

Again, thank you, Madam Chair, for allowing me to ask that question.

If you could respond briefly, I would appreciate it. This is for Dr. Holtz-Eakin.

Ms. ESHOO. Yes.

Dr. HOLTZ-EAKIN. I think it is an affordable issue, by and large, and I would be happy to elaborate in writing after the hearing.

Mr. BILIRAKIS. Thank you very much.

I yield back, Madam Chair.

Ms. ESHOO. The gentleman yields back.

And the gentleman from Maryland, Mr. Sarbanes, please unmute and you have your 5 minutes for questions.

Mr. SARBANES. Thank you, Madam Chair. Can you hear me?

Ms. ESHOO. Very well.

Mr. SARBANES. Excellent. I appreciate the testimony today.

Let's call a spade a spade when it comes to the Republican attacks on the ACA. This has been an obsession with the Republicans for more than ten years. The attack that is coming with the Supreme Court case in November and its effort to ram through the appointment of a new justice before the election is just the latest play out of that playbook that we have seen for years, which, in my view, is really just an effort to try to attack one of the legacy achievements of President Obama.

But leaving that where it is for the moment, Dr. Lee—or, Mr. Lee, if you could describe, we have seen the Trump administration, obviously, engage in leadership malpractice when it comes to responding to the pandemic, and we could speak about the broad GOP reluctance to embrace the opportunities of the ACA over the last ten years.

But if you are in the middle of a pandemic, you start to see huge job losses disruptive to people's coverage. It seems to me that if there is in your tool kit something that you can do using the ACA and using exchanges and you don't take advantage of that, that is leadership malpractice of the highest order.

Describe the moment when you pulled your team together to demonstrate proficiency in leadership in this moment, when you

saw what was happening and you saw the amount of people that were being thrown into this place of not having coverage, that morning, that meeting when you convened people and you said, Here are the tools we are going to use that are available to us through Covered California, because of the ACA, to make sure that we help people get through this crisis.

What were the first two or three things you knew you had to do that unfortunately were not happening at the Federal level?

Mr. LEE. Thank you very much for that question.

Now, oddly, I think the first meeting we had was six years ago. It is not just about a pandemic. It is for the last five years saying we will do everything to make every Californian over there for them. And I think there has been a failure of action at the Federal level since March but also for about three years, cutting back on spending, not supporting navigators, promoting short-term plans which weaken the risk mix.

But what we did this year, March 19 our Governor declared a state of emergency. March 20 we declared a special enrollment period. And we have spent \$9 million in advertising, and every day since then, when a Californian got an unemployment check, they got a flier from Covered California, and our 500 storefronts across California were open virtually taking enrollment by phone, and we promoted that. It is a matter of saying again, in America, there is half a million more Americans uninsured today because of Federal inaction. Those are people—

Mr. SARBANES. Can you imagine—thank you for that.

Can you imagine if the President of the United States in the midst of this crisis had led with all of the efforts that you just described at the national level, had gotten on the phone with Governors across the country and States who had their own health exchanges and said this is what we are going to do as a team to respond to this crisis? But he didn't do it. And now he is trying to take down the ACA in the middle of this pandemic once again.

Let me turn to Dr. Sommers because my head is exploding when I keep hearing my colleagues across the aisle talk reverentially about their desire to protect people with preexisting conditions, but you can't just pull that out of thin air. I mean, there are actuarial dynamics to this, the way insurance pools function, and all the rest of it, that can allow you to do that effectively, i.e., through the mechanism that we have set up through the ACA or to just try and pull it out of thin air, which is what I think their approach is going to be.

Can you just talk to why, if you really want to do that effectively, cover people with preexisting conditions, you need to do it inside of a structure, an insurance structure and a coverage structure that actually makes sense and is sustainable?

Dr. SOMMERS. Yes. So States before the Affordable Care Act did try this, and what they found was that if they made rules that said you have to take all comers, but they didn't have the infrastructure of the ACA, they didn't have the tax credits and the subsidies, basically what happened was only sick people signed up, premiums went through the roof, and the markets collapsed. You need to hold infrastructure of the ACA. You can't just put out that edict that says cover everybody.

Mr. SARBANES. Thank you.

I yield back.

Ms. ESHOO. The gentleman yields back.

Pleasure to recognize the gentleman from Missouri, Mr. Long, for his 5 minutes of questions. And please unmute.

Mr. LONG. Thank you, Madam Chair, and thank you all for being here today.

Dr. Holtz-Eakin, much has been made of how the affordable healthcare is under the—excuse me. I am going to start again.

Much has been made of how affordable healthcare is under the current system, but can you talk about any trends you have seen that relate to the actual cost of care, not what the patients pay at the counter in the form of co-pay or coinsurance, but the underlying costs of care?

Dr. HOLTZ-EAKIN. I think we saw in the 2 or 3 years in the aftermath of the Affordable Care Act a noticeable diminishment in the pace of so-called excess cost growth, the rate at which healthcare costs go up faster than incomes in the United States.

But more recently we have seen that go back to something closer to the bad old days, and acceleration in those costs. A lot is made of prescription drugs and particularly retail prescription drugs, but they are a small fraction of the healthcare bill. The vast majority of the costs are hospitals and doctors and other providers, and it is there that the attention needs to be focused if we want to slow the pace of the healthcare billing in the United States.

Mr. LONG. OK. Thank you.

And, Director Cameron, I understand that in Idaho you offer a specific type of short-term plan that might be useful during the time period when folks may have a few months' gap between their loss of a job-based coverage and the next open enrollment plan. Can you talk about these plans and what kind of feedback you have gotten on them?

Mr. CAMERON. Certainly. Thank you, Congressman.

So these plans should not be confused with traditional short-term plans. They are what we call as enhanced short-term plans. They are designed to be renewable. They have all of the same essential health benefits or requirements or coverages. They are not what one Congressman has called as junk insurance. They have the same.

They have the same preexisting predictions or very similar preexisting condition protections to an ACA plan, but they are available and allow enrollment year around or at open enrollment if a person chooses to.

They have provided an answer for us because we keep them in the same risk pool. So they are tied—their rates are tied to that of the ACA plans, and it helps attract and bring back those young and healthy individuals and families that need coverage, like the family in Oakley, Idaho, who are—the wife is a breast cancer survivor who knows the importance of coverage but can't afford \$2,100 a month. They are cattlemen. Their prices change every day, and they don't qualify for a subsidy.

So for them they are being forced out of ACA coverage out of no desire of their own but simply because of price. This has provided

an alternative for them that, in essence, helps all of those that are enrolled by keeping it in the same risk pool.

Mr. LONG. OK. I might add that my sister has been a resident of Ketchum, Idaho, for 40-some years now, so I don't think we are getting her back to Missouri.

And do you regulate these products to ensure that they are marketed fairly and honestly to consumers?

Mr. CAMERON. Absolutely. We very strongly regulate them. We make sure—and, by the way, I need to tell you, when I talked earlier about the traditional plans waiving co-payments and deductibles and co-sharing for COVID, so did these enhanced plans. They did the same things, and we regulate to make sure that their advertisements are not misleading, that they fulfill the conditions of their policies, and we go after those that do so inappropriately.

Mr. LONG. So instead of issuing broad mandates and restricting plan design, is it safe to say you have opened up the markets, collaborated with your health plans, and increased competition to make more choices available to your citizens?

Mr. CAMERON. Absolutely. Our goal is to have more people insured. The original goal of the ACA was to insure more people, and then some of the provisions actually started limiting who could actually obtain coverage. So our goal is to have more people insured. We have collaborated with our carriers. We will now have three carriers offering these type of plans this coming year.

Mr. LONG. During the pandemic you had plans set up and volunteered to offer credits back to consumers, make advance payments to providers to help get them through the downturn?

Mr. CAMERON. Yes, yes, sir.

Mr. LONG. And what effect have these policies had on premiums for your citizens?

Mr. CAMERON. Well, in many cases they have actually lowered the price from where they were previously. One of our carriers lowered the price by 50 percent on dental premiums, others lowered it by 15 percent over this next year.

What has happened is that we don't have as many people taking advantage of, you know, treatment that wasn't as necessary, and so the amount of claims being spent has dramatically decreased, and so they have been refunding that money back.

Mr. LONG. OK. Madam Chair, I don't have any time to yield back, but if I did, I sure would.

Ms. ESHOO. The gentleman yields back.

I would just like to say to the witness from Idaho, it would be, I think, instructive for you to read the June 25 report that the Energy and Commerce Committee all put together that found short-term plans denied and rescinded coverage for millions of people. And after reading that, I would look forward to your kind of written response to it. But I do think that it would be instructive. It was highly instructive to me.

Now it is a pleasure for me to recognize the gentleman from New Mexico, Mr. Luján, for his 5 minutes of questions.

Mr. LUJÁN. Thank you, Madam Chair.

Before I begin my remarks, Madam Chair, I do have a unanimous consent request.

Ms. ESHOO. Would you please state it.

Mr. LUJÁN. That is to submit a GAO report, the Government Accountability Office, August 24, 2020, "Private Health Coverage Results of COVID Testing for Selected Offerings."

Ms. ESHOO. The unanimous consent request is approved. It is already a part of the record, and at the end of the hearing, I will name everything that has been placed in the record.

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

Mr. LUJÁN. Thank you, Madam Chair. I am not sure if my clock can be reset. But nonetheless, Madam Chair, the reason that that report is so very much is when you go into the summary findings of that report, what the GAO found is when they were out there looking at folks that were selling what my colleagues on the other side of the aisle are calling short-term plans, that I have heard everyone else call a junk plan, they found that there were deceptive marketing practices similar to the findings from the Energy and Commerce Committee.

And what is clearly listed here is that those short-term plans, the plans that I refer to as junk plans, they do not cover people with preexisting conditions. People need to stop lying to innocent folks that are out there and convincing them that these plans are going to cover their cancer, their diabetes, or if they get in an accident.

Many of these plans don't even cover prescription drug costs. They don't cover ambulatory care. Enough. Let's just be honest. If you want to sell people these short-term plans, let's be honest with the American people as to what they are buying so that way people are not left without. That is all we are saying here.

Truth and transparency. Why is it that the Trump administration eliminated the requirement on those junk plans to list exactly why they were so bad? I have screenshots from superintendent sites across America before President Obama's administration—or sorry, before President Trump's administration changed that rule and after, and you see that its name has changed. But that is a conversation for another day, Madam Chair.

At this very moment, the Trump administration and Republican Governors and Attorney Generals are leading efforts with the U.S. Supreme Court in a case where they are seeking to strike down the entire Affordable Care Act.

They aren't asking the U.S. Supreme Court to keep the parts they claim they like, such as protections for people with preexisting conditions. They are asking the Supreme Court to strike down the whole law during the public crisis that has taken the lives of more than 200,000 Americans.

If the ACA is struck down, protections for people with preexisting conditions would be gone. That now includes the nearly 7 million Americans who have been infected with COVID-19 who could be denied coverage for the rest of their lives. More than 20 million people would lose their healthcare coverage, including 226,000 New Mexicans, more than doubling the number of people in our State who are uninsured.

The 9 million people who receive subsidies to make their premiums more affordable would be on their own. In the middle of a

State budget crisis, States like New Mexico would be left to shoulder the full cost of keeping people covered through Medicaid.

Now, remember that bill that Republicans tried passing in 2017? That actually eliminated every dollar with the Federal Government's investments in Medicaid. Private insurance plans wouldn't have to cover preventative care, maternity care, mental and behavioral health, and other essential services.

Young adults could no longer stay on their plans until the age of 26. And insurance companies could go back to charging more just because you are a woman, you have a health issue, or because of your age.

My Republican colleagues have no plan to cover the preexisting conditions or to protect the American people. Their last proposal from a few years ago allowed insurance companies to charge ridiculous prices for people with preexisting conditions. They slapped an age tax on older Americans and enforced States to ration care by drastically cutting Medicaid.

President Trump has not put forth a plan at all, although he has promised it for four years every two weeks. But what we have seen from him already is deeply troubling.

The Trump administration has promoted those junk plans that we were just talking about, which looked cheaper until you get sick and realize the plan doesn't cover basics like emergency room visits or prescription drugs.

Now, Madam Chair, I have a couple of questions.

Dr. Aron-Dine, or Dr. Sommers, in both of your testimonies you talked about how Trump administration policies have chipped away at coverage gains achieved during the first few years of ACA implementation.

Would either of you like to comment on short-term limited duration junk plans or other Trump administration efforts to sabotage not just the number of people covered but the quality of coverage?

Dr. SOMMERS. Sure, I am happy to answer that.

I think there are a couple of issues that I analyzed. The first is that people have to know about the coverage and be able to navigate the system to get there. And if you make the period that they can sign up shorter and spend less money on outreach and less money on assisting people on those applications, they don't get them covered. These are my patients. They struggle with the complexities of our healthcare system. If you make it harder for them to shine up, a lot of them won't.

The other thing I will just say is that this is not a story where some States really suffered under the ACA. We have heard numbers that maybe Idaho, or Virginia, other places have suffered. Well, the numbers in Idaho, 100,000 more people were covered in 2016 compared to 2013; in Virginia, 300,000; in Florida, 1.6 million. Every single State in the U.S. experienced substantial increases in coverage under the ACA Act.

Mr. LUJÁN. And, Dr. Aron-Dine, what would striking down the ACA mean for Medicaid and State budgets?

Dr. ARON-DINE. As a starting point, it would eliminate Medicaid expansion, which covers 12 million people not eligible under pre ACA law. It is incredibly implausible that States could continue to

cover those people who rely on that coverage. It would also undermine Medicaid in a host of other ways.

Mr. LUJÁN. Thank you.

Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back.

And now I would like to recognize the gentleman from Indiana, Dr. Bucshon, for your 5 minutes of questions. And please unmute.

Mr. BUCSHON. Thank you, Madam Chairwoman, and thanks for holding this very important hearing.

First I would just like to say, you know, Republicans want people with preexisting conditions to have health coverage.

I think really what we are talking about is people that are high-cost individuals that otherwise couldn't afford coverage before the mandate was put in place. But one of the biggest flaws of the Affordable Care Act is the way to solve this issue was done in a way that has resulted in dramatically increased costs for everyone.

Republicans have a healthcare plan that will cover people with high-cost medical care, preexisting conditions but will allow others to get more affordable health coverage by putting those high-cost individuals in a separate insurance pool.

Anyone that understands insurance knows if you put high-cost individuals in the same pool as everybody else, everybody's cost goes up.

As a provider, I had patients with preexisting conditions, high-cost health problems, and that couldn't get insurance, and that is just wrong. We want to solve that in a different way. So it is really not a good narrative—it is a false narrative that we don't.

Dr. Holtz-Eakin, in the GAO report that was just discussed, were there any of the short-term limited duration plans found guilty of false marketing?

Dr. HOLTZ-EAKIN. I am not instantly familiar with that, but I would be happy to get back to you after reading it.

Mr. BUCSHON. That would be great. And also, I have seen some comments that, in the press, people saying the Republicans are undermining the Affordable Care Act, a lot of it tied to the repeal of the individual mandate. But I would like to ask you whether you agree with that sentiment or whether you agree with the recent story from The New York Times that ran the headline—and this is the actual headline—Republicans Killed the ObamaCare Mandate. New Data Shows It Really—It Didn't Really Matter.

Dr. HOLTZ-EAKIN. So this has been a long debate among researchers as to just how much the mandate was effective in getting people into the ACA insurance, and I think the Congressional Budget Office, in particular, has rethought the effectiveness of the mandate. It really wasn't as effective as people had thought.

Instead, they pointed at some things that have been mentioned in this hearing, which is marketing, navigators, the kind of outreach that recruited people and got them into the ACA. That was a bigger part of the story than the mandate.

Mr. BUCSHON. Yes. I mean, I think—thank you for that answer. I think the issue was, from my perspective, is that the Federal Government was mandating the American people purchase a product, which, in this case, was health insurance. And as you pointed out, the American people don't necessarily follow Federal mandates

because, you know, we believe in individual freedom and individual choice.

As a followup, I have seen also a lot about how the administration has depressed enrollment in the ACA exchanges, but what about the health reimbursement accounts rule that the administration finalized last year that would let employees use their healthcare benefits to purchase coverage on the exchange. Wouldn't that actually increase the number of people who might join the exchanges in the coming open enrollment period.

Dr. HOLTZ-EAKIN. Certainly when the administration put out that rule, they had estimates of large-scale takeup, a very large-scale takeup, of those HRA provisions. They haven't been in place long enough for us to see if that comes to fruition, but it is a big change in the opportunities that people face.

Mr. BUCSHON. Thank you for that answer. So I think, you know, this has been a good hearing. I have one more question. I think I have about a minute left.

Dr. CAMERON, as a provider and member of the House Doctors Caucus, I was encouraged to hear about your work with health plans in Idaho to extend various forms of financial assistance to providers who are suffering during the pandemic. Can you expand on the specifics of what plans did and what the effect had on access to healthcare in Idaho?

Mr. CAMERON. Certainly. Can you hear me? Thank you.

Mr. BUCSHON. I can.

Mr. CAMERON. So—and I will just target or just list a few of the things that they did without naming specific companies. Again, we have five carriers, unlike many States who are down to one. We had targeted loan programs. Obviously, all of the carriers were processing their claims quicker and suspending prior authorization restrictions. \$1.4 million was given by one company in cash advances to select provider groups. Three of our carriers banded together and gave another \$5.5 million to providers in a specific hospital system, and another carrier offered \$10 million in interest-free loans or cash advances to providers in order to assist them in getting through this pandemic.

Mr. BUCSHON. Thank you very much. I would just like to say finally that, you know, as a provider, I want everyone that has high-cost health problems, so-called preexisting conditions, to have affordable health coverage. I just believe that it needs to be done in a different way, because the way that it has been done in the ACA has increased the costs for everyone in the system. We can do it in a better way.

With that, I yield back.

Ms. ESHOO. Dr. Bucshon yields back. We thank him.

And it is a pleasure to recognize the gentleman from Oregon. Mr. Schrader, you have 5 minutes for questioning. And please unmute.

Mr. SCHRADER. Thank you very much.

Ms. ESHOO. Is Mr. Schrader there?

Mr. SCHRADER. Yes. Thank you very much, Madam Chair. I appreciate the opportunity here, and I appreciate the panelists.

I would agree with my good friend and colleague from Indiana that, you know, the individual mandate has not been as important as we had originally anticipated, but as our good friend and col-

league from California has pointed out, Mr. Lee, that, you know, the outreach is, and, you know, that is important. That has been curtailed, unfortunately, under the current administration, and caused some problems over the last couple years.

Hopefully, one of the few good things comes out of this pandemic is the fact that people are now realizing that healthcare is an opportunity and they have access. It has been pretty amazing to me that we have not had a huge uptick in uninsured people as originally expected.

Mr. Holtz-Eakin, you testified that there are basically three elements that have contributed to that, you know, some special enrollment periods, and ability to utilize the ACA, some of these short-term plans, and COBRA coverage. Do you have any feel for which of those has contributed more or less or what the rough percentages are that each of those options contributed to keeping people insured?

Dr. HOLTZ-EAKIN. Yes, I don't have any firm data on that. It is quite frustrating trying to sort it out. My instincts are that COBRA has been the least important and that we have seen people go Medicaid, ACA, and then perhaps some short-term plans.

Mr. SCHRADER. OK. You know, a testament to, I think, American healthcare system. It is not a one-size-fits-all. We have many options for folks that are out there depending on your personal circumstances and your personal inclinations about how you want to get healthcare.

I have a bill, actually, with a colleague, Rodney Davis from Illinois, that talks about COBRA coverage and making it, hopefully, a better option. I would hope the committee and Congress would consider this as one of the things in the mix by making sure that, you know, it pays at least what, you know, the premium for that employee that would have been covered under that employer-sponsored healthcare program, to make it—at least during the pandemic here, make it so that there would be an option.

Do you think, Mr. Holtz-Eakin, that that would be an incentive for COBRA to be a more effective help to keeping people insured?

Dr. HOLTZ-EAKIN. Well, as I said in my opening remarks, one of the advantages to COBRA is it avoids the churn that was mentioned by Dr. Sommers. And churn comes with the downside that you are often changing provider networks and your care gets disrupted, and that is the last thing you want in the middle of a pandemic. So getting people to stay on their insurance, using COBRA augmentation, is a way to avoid that entirely.

And, you know, one of the difficulties for everyone, the experience to the American worker and for policymakers, is that we just cannot get a good, firm handle on how many of the job losses will turn out to be temporary. Of the 20 million we got in April, 18 million were reported as temporary layoffs. Some of those are going to turn into permanent job losses, and so, you know, which vehicle you want to use. If you are permanently going to lose that job, you might think very differently than if you are just temporarily laid off. It has been a real struggle thus far.

Mr. SCHRADER. Thank you. Thank you for that.

Mr. Sommers and Ms. Aron-Dine, a question on what is the—do you have any feel for what this issue, economic makeup, is of those

people that are using these special enrollment periods to sign up for healthcare? Is it reflective of the population writ large or is there some difference there?

Dr. ARON-DINE. Certainly, in general, use of the marketplace is as concentrated among moderate-income people. And job losses have also been really concentrated among low-wage workers, which is a consideration in thinking about COBRA. A big problem is a lot of the people losing their jobs may not have a COBRA option, particularly lower-income workers, particularly workers of color, who are especially vulnerable to becoming uninsured.

Dr. SOMMERS. And I would just add briefly that, in addition, when workers might have had a plan that worked well for them when they had a higher income, if they become uninsured and lose their income, those copays from their employer coverage may no longer be adequate for them, and Medicaid may provide much better protection for them in terms of being able to get the care they need.

Mr. SCHRADER. So it sounds like we need an all-of-the-above option like we have got currently in this country with the ACA and COBRA coverage and what all, you know, even the short-term plans for a very short period of time. But as pointed out by a lot of my colleagues, they do not offer a long-term option in terms of complete benefit protection, and we got to keep that in mind as we go forward.

And I yield back, Madam Chair. Thank you.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize really just a superb member of our subcommittee. We are just going to miss her, miss her, miss her, the gentlewoman from Indiana, Mrs. Brooks. You have 5 minutes, and I hope you are unmuted.

Mrs. BROOKS. I am, Madam Chairwoman, and thank you so very, very much. In fact, I would like to take this opportunity to thank you, to thank the ranking member, and my colleagues. First, I want to thank the witnesses for being here. And while this is an incredibly partisan hearing, so many of, in my six years of being on this subcommittee, I just want to remind the committee, we have accomplished incredible things. And there is still a lot more of incredible work to do on behalf of the American people.

And the Energy and Commerce Committee, and particularly the Health Subcommittee, has an incredible track record. And I know we are working on this incredibly difficult issue of the ACA or better ways to provide healthcare for all Americans, and affordable healthcare, but I just want to thank you because I have been able to be a part of—this is my last hearing, in all likelihood—been able to be a part of the 21st Century Cures, able to be a part of CARES Act, able to be a part of PAHPA. I could go on and on with all the acronyms, which most Americans don't know much about, but you all know, as members of the committee, the important work we have done on opioids, mental health, healthcare affordability. There is so much—and preparing and responding for this pandemic.

But there is a lot more work to do, and I just want to encourage all of you. I want to thank the staffs also. We have incredible staff. I have worked with really great staff on both sides of the aisle, and

just want to thank them for their commitment in helping us find even better ways to work together.

I am on the Select Committee on the Modernization of Congress, and we are going to be rolling out our recommendations, as we have been, and I just want you all to know that this completely bipartisan committee has more recommendations, which I hope that the body takes up, because we all have to do better to find the common ground. And I actually believe we have a lot more common ground and we can find more common ground if we just continue to really work together, talk together, find—it is difficult, I understand, in COVID and with us working remotely, but, you know, whether it is picking up the phone—I love that Kurt just mentioned that he is working with Rodney Davis on something, who is not even on the committee.

We have got to find ways to keep working on all of these really incredibly important issues that this committee works on. So I want to encourage you all. I have great hope, and we have got to get through this for our citizens and our constituents.

When it comes to COVID, obviously, healthcare has never been more important, and we are right in the middle of it. But the innovation that has come from our incredible health companies in this country, we have got to continue to support.

I am really proud of the fact that we have been able to do a lot without expanding Affordable Care Act. Insurance companies have committed to providing COVID tests to patients free of charge. We are bringing our supply chains back. That is critically important.

I am concerned that COVID, all these patients that have had it, all these citizens, will have a preexisting condition, and we have to, and must, and we are committed on both sides of the aisle, to covering preexisting conditions for all Americans. And now we have, you know, millions of people who have tested positive for COVID, and we have got to make sure we get this right.

I just, in my brief time I have left, telehealth is one of those amazing things that we have talked about but now we are doing. Mr. Cameron, can you please share with us the dramatic increase in telehealth visits your State has seen? What are areas where it has been incredibly successful? Where are areas where maybe we shouldn't be focused on telehealth? I know it is great for mental health, but I talked to some dermatologists this week where it is really tough, in dermatology, for instance, for telehealth to be incredibly helpful. So can you talk to us in my brief time I have left.

But I do want to thank the committee before Mr. Cameron answers. I have great hopes for you all, and I have loved working with all of you.

Mr. Cameron?

Mr. CAMERON. Thank you, Congresswoman, and thank you for your service, and thank you for your comments. Telehealth has been in an infancy here in Idaho and not really a lot of takeup, mostly, I think, because a lot of providers and, as I said earlier, some consumers did not want to take it.

I, myself, see a dermatologist, and I am—it is an interesting story that you shared. I actually, while in the State capitol building, did a dermatologist visit with my phone, to go over some of my

issues and show some of my concerns. So it can be done, but there still has to be some hands-on followup.

There are some health conditions, without getting into provider codes, where it doesn't fit really well, and so those need to be talked about. But we need to provide the services and the tools and the technology so that it can happen. I think consumers, as was said earlier, now actually prefer telehealth to other forms of coverage. They would rather have a telehealth visit than go to the emergency room, unless it is really dramatic,

Mrs. BROOKS. Well, thank you.

And to my committee members, we have to continue to support and expand telehealth and help—I know everyone wants to help all Americans with their healthcare needs, especially right now.

Thank you, Madam Chairwoman, and I yield back.

Ms. ESHOO. Thank you for yielding back. And when you speak, you make all of us fall in love with you all over again, which then leads to how much we are going to miss you.

And speaking of missing people, it is an honor to recognize the gentleman from Massachusetts, a really extraordinary and thoughtful member of the subcommittee, such value added, not only at our committee, but the entire Congress, the gentleman from Massachusetts, Mr. Kennedy.

Mr. KENNEDY. Madam Chair, thank you.

Ms. ESHOO.

Mr. KENNEDY. Thank you. Grateful to you and to all the members of the committee, where I will follow Mrs. Brooks' example here briefly. This is, in all likelihood, my last committee hearing as well. It has been an extraordinary honor and pleasure and privilege for me to join all of you on the best committee in Congress, to work with all of you on both sides of the aisle to try to advance the interest of the American public.

And to the incredible staff and committee staff here, a huge hats off to you, again, both sides of the aisle, for your work and collaboration and the effort that we have made together. It has been an enormous privilege for me, and I wish you all well going forward.

And a number of big issues on the agenda to tackle, including the one, obviously, before us today, and I want to thank all the panelists for being here, for your work, and for appearing once again before the committee.

Beyond the horrific loss of life caused by this pandemic and the administration's failed response, the economic consequence of job losses, business closures, imminent evictions, will last for generations.

The national unemployment rate has more than doubled since February. In States like Massachusetts, it still remains stubbornly high. Losing your job can mean much more than the loss of income. It can also mean the loss of health insurance. And this is very much a life-or-death situation for the millions of people with chronic health conditions, for parents of children with complex medical conditions that require constant monitoring and treatment. Fortunately, for millions, Medicaid provides them with continuous quality health insurance so that they don't have to worry about getting the care that they or their children need.

So, Dr. Aron-Dine, I want to start with you. What can you tell us about Medicaid enrollment since the beginning of the pandemic?

Dr. ARON-DINE. It has risen, just as you would expect. What happens is Medicaid is supposed to be there for people as they lose their jobs or see reductions in income. Medicaid enrollment is up eight percent, generally, and up more in Medicaid expansion which targets some of the most vulnerable people.

Mr. KENNEDY. In other parlance, it is countercyclical, right? When you have an economic downturn, Medicaid enrollment increases, right?

Dr. ARON-DINE. Exactly. Which helps people and also helps the economy.

Mr. KENNEDY. Right. Thank you. So I understand that many experts predict that Medicaid enrollment will continue to climb, and I would love to get your thoughts as to why that might be.

Dr. ARON-DINE. I think that is likely. Even in a, quote/unquote, normal recession, Medicaid enrollment often lags a little bit because signing up is not the first thing people do. And in this recession, as others have talked about, people haven't been seeking medical care because of the pandemic if they—healthy people haven't been seeking medical care, and that is often a mechanism by which people get enrolled and covered, is they go to a CHC and they find out that they are not doing that, they may not have gotten signed up yet.

Mr. KENNEDY. And, Doctor, you touched on this already a little bit, but just to flesh this out for us a bit more, how does Medicaid expansion specifically help States to respond to the current unprecedented health and economic crisis?

Dr. ARON-DINE. Sure. And we have talked about how it is there for the people who are newly losing their health insurance, but I think it is equally important that millions more people, 12 million more people, are covered through Medicaid going into the pandemic than would have been without expansion.

And there is, at this point, just a lot of research showing that it is improving their health, improving their financial security, reducing evictions, and actually saving lives. And, in fact, has been especially important to people with preexisting conditions for whom it has enabled them to get regular treatment for chronic conditions for the first time.

Mr. KENNEDY. We had a Medicaid director, I believe from North Carolina, testify before the committee now several months ago, back when we could do in-person hearings, and he actually testified, if I remember correctly, that they had determined that the ACA had saved literally hundreds of lives in North Carolina through Medicaid expansion.

And given that, I think a lot of us obviously are incredibly concerned that, once again, the Affordable Care Act is before the Supreme Court, and the Trump administration is urging the justices to throw out every aspect of the law. So despite what some have argued today, that is literally the legal brief that has been filed by the Trump administration.

So, Doctor, I am not asking you to read too far into the tea leaves here, but if the Supreme Court agrees that the ACA is unconstitu-

tional, what happens to the 13 million Americans currently receiving health insurance through Medicaid expansion?

Dr. ARON-DINE. Medicaid expansion would be eliminated, and I think it is likely that the large majority of those people would become uninsured and lose that access to care and financial security.

Mr. KENNEDY. And what happens, then, in the midst of—for those folks when, if that does take place, in the midst of a flu season, an unknown yet impact of another COVID-19 winter, and the economic prospects of recovery?

Dr. ARON-DINE. I think the pandemic has reminded all of us that it is very important for people to have health insurance, for their own sakes, but also as a matter of public health.

Mr. KENNEDY. Yes. Doctor, thank you.

COVID-19 has brought about unprecedented challenges to our healthcare system and our economy, and it is clear from the witnesses' responses that Medicaid has played a vital role in responding to this crisis and ensuring that adults and children continue to have access to the care that they need. However, for millions of Americans, that safety and security hangs in the balance if the Supreme Court sides with Republican attorneys general and takes healthcare insurance away from 20 million people in our country.

Doctor, thank you very much.

And, Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back.

I now would like to recognize the gentleman from Georgia, Mr. Carter, for your 5 minutes of questions. Please unmute.

Mr. CARTER there? Paging Mr. Carter?

Mr. CARTER. I am here. I didn't know I was next. I apologize.

Ms. ESHOO. That is all right. You are recognized for 5 minutes.

Mr. CARTER. Well, thank you. And thank all of you for joining us here today. I appreciate everyone who has been on the panel. And I certainly would be remiss if I did not also offer my congratulations to Representative Kennedy and Representative Brooks and all the other members of this great subcommittee and this great committee who are going to be leaving us. We are going to be losing some valuable members with great institutional knowledge, and we certainly will miss all of them.

Madam Chair, I want to begin by addressing the situation that continues to be a problem, and that is, my colleagues across the aisle seeming to want to communicate—or seem to want to put a message out there that Republicans are not wanting to protect preexisting conditions. Nothing could be further from the truth, and I think you all realize that. That is something that we have worked on and we continue to work on. In fact, if we look at the present Congress that we are in, the 116th Congress, one of the first floor votes that we tried to have was to try and protect those with preexisting conditions.

So I want to reiterate what has been said by a number of my Republican colleagues on the subcommittee here today, and that is that we are in favor of preexisting conditions. We continue to be, we have been, and we will always be. We understand, particularly in the trying times that we are in now, with the problems that we are having with the pandemic, we understand how important covering preexisting conditions are.

Dr. Holtz-Eakin, in your testimony, you mentioned that through June, there were 6.2 million workers who lost their employer-sponsored insurance due to job loss from the pandemic. And President Trump has worked to make short-term, limited-duration plans available to beneficiaries for up to 36 months, providing certainty and continuity for patients. Previously, the previous administration had made them available for only three months. How can short-term, limited-duration insurance plans fill the employer-sponsored insurance gap, and is there any indication that they have?

Dr. HOLTZ-EAKIN. So as I mentioned earlier, we don't have great data on what is happening on the ground right now, so I can't answer with any sort of definitiveness how many people are taking up short-term plans versus other options. But it is another option on the table. It is an option that was not available previously. It might hit a price point that is better than a price point on the ACA marketplace, and, you know, that would be a very valuable option in this situation.

Mr. CARTER. And wouldn't you believe that it would offer patients more flexibility and affordability in coverage?

Dr. HOLTZ-EAKIN. Certainly there is a greater variety of plan designs out there. That is one of the advantages. The concern that you have heard voiced is that people won't understand the plan design they are buying, but certainly there ought to be a way to do good consumer education, get them in a plan that is good for them.

Mr. CARTER. Well, I believe this subcommittee, this committee in general, has addressed that before. In fact, I know that I had advocated for us to publicize these plans more so that people would be educated as to the availability of these plans and how they could help them. But unfortunately, the other side of the aisle, again, are opposed to these plans, and did not want to offer education to our citizens as to the availability of these plans.

Let me ask you also, Dr. Eakin, given that premiums have more than doubled during the time that the Affordable Care Act was signed into law, what are your recommendations for how we can reduce the cost of health insurance and allow people to shop for coverage that might best fit their needs?

Dr. HOLTZ-EAKIN. There are really two broad strategies. The first strategy is to provide greater competition in the insurance markets, lower the barriers to entry, allow more products and variety, and allow people to choose among them, and thus get a plan that fits their economic situation.

The second strategy is to deal with the underlying costs and value proposition in the delivery system, and certainly there is a lot that Congress can do in that area through the big payment silos that are in Medicare and Medicaid, which really drive the delivery system in the United States.

And something can be done at the local level. You know, State scope of practice, State certificate of need, all sorts of limitations on competition need to be addressed.

I think the telehealth example is the best example of how the overregulated U.S. healthcare system couldn't respond flexibly to the pandemic, and it was only the emergency waiver of a lot of regulations that allowed telehealth to prosper. That should be made permanent. I mean, that is going to require legislation. That is a

great opportunity going forward, and I would encourage the committee to look at that.

Mr. CARTER. So you would agree, just as the free market has worked in our society, that the free market can work in healthcare, to lower healthcare costs?

Dr. HOLTZ-EAKIN. Certainly if you have high prices, you have a supply problem, and you have got to look at the conditions that are limiting supply.

Mr. CARTER. Well, thank you very much.

And thank you, Madam Chair, and I yield back.

Ms. ESHOO. I thank the gentleman from Georgia. He yields back.

Now it is a pleasure to recognize the gentleman from California, Mr. Cárdenas, for your 5 minutes of questions. Please unmute.

Mr. CÁRDENAS. OK. I should be unmuted. Can you hear me?

Ms. ESHOO. Yes, very well. Thank you.

Mr. CÁRDENAS. OK, thank you so much. Thank you, Madam Chair, and I appreciate the opportunity for us to have this important hearing. I want to thank all of our folks who are here to give us their opinion and expertise to be before our committee.

I also want to say, thanks to the ACA, approximately 20 million Americans have gained coverage through the law's various coverage protections. Nine million low- and moderate-income Americans received health insurance subsidies to make their healthcare more affordable. 130 million Americans are allowed to receive coverage, without being discriminated against by the insurance companies and made sure that, by law, the Affordable Care Act law, they have the right to coverage, even though they have a pre-existing condition, and they cannot be charged a penny more than anybody else who is getting the same coverage.

In an unprecedented and nakedly political decision, the Trump administration declined to defend the Affordable Care Act, otherwise known as the ACA, in this Republican lawsuit that is seeking to declare the entire law invalid. The Trump administration is continuing with this extraordinary decision in the middle of a pandemic that has claimed the lives of now over 200,000 Americans. If the lower court's ruling is upheld, millions of Americans would lose their healthcare overnight in the middle of a global pandemic.

I would like to ask some questions first to Dr. Aron-Dine. Dr. Aron-Dine, how many Americans would lose coverage if the decision were upheld shortly?

Dr. ARON-DINE. Prior to the crisis, the estimate was 20 million, and that number would be larger today with more people turning to these programs for coverage.

Mr. CÁRDENAS. Thank you. Could you discuss the impact of the court's decisions on Medicaid expansion?

Dr. ARON-DINE. Medicaid expansion would be eliminated, meaning that the 12 million people who are newly eligible because of the ACA's Medicaid expansion could lose their coverage, would likely become uninsured. It wouldn't be there for people newly losing their jobs and their coverage in this recession to turn to, and State eligibility would presumably revert to the pre-ACA levels where few parents and almost no adults without children were able to get coverage.

Mr. CÁRDENAS. So I think you just described that the Affordable Care Act law, once it became implemented, and still to this day, millions of Americans are actually being able to see doctors, getting healthcare basically, that before were either struggling or not receiving healthcare?

Dr. ARON-DINE. That is exactly right, and we have direct evidence of that, including from some of Dr. Sommers' research, that people are getting prescriptions filled, they are getting treatment for chronic conditions, and that the ACA's Medicaid expansion, as well as the marketplace coverage, has been literally lifesaving.

Mr. CÁRDENAS. And this also would be affecting working families with moderate and low income?

Dr. ARON-DINE. Absolutely. Particularly if you look at coverage for the people who we now refer to as essential workers, many of them get their coverage through Medicaid, especially in expansion States, and that would be wiped out.

Mr. CÁRDENAS. So one thing I would like to clarify, did the Affordable Care Act only increase the availability for healthcare for unemployed, people who are not working, or did it, in fact, increase by millions, or not, being able to have access to healthcare for working families?

Dr. ARON-DINE. I am not sure I understood your question, but—

Mr. CÁRDENAS. Let me clarify what I mean, Doctor. A low-income family is probably a family that they have low income. They are actually working, but they are, say, at minimum wage or what have you, so therefore, providing healthcare for them and their children, for example, is very difficult because they otherwise can't afford it. And the Affordable Care Act has implemented an opportunity for them to actually get healthcare, even though they are low income, whereas before, they could not go out to the market and get it because they just couldn't afford it.

Dr. SOMMERS. If I can jump in briefly?

Mr. CÁRDENAS. Please.

Dr. SOMMERS. As described in my testimony, we actually have looked at this issue of working families, and the ACA's biggest coverage gains are in blue collar families. These are people in construction and mining and agriculture, concerned with jobs where they don't get coverage through work. So you are exactly right, Representative, this is a key feature that the ACA has helped working families substantially.

Mr. CÁRDENAS. Yes. Thank you so much. I am sorry my question wasn't that clear, but I appreciate your clarity in the answer.

And then also, isn't it through the ACA now young adults can actually stay on their parents' coverage up through the age of 26, whereas before, that was not a typical coverage from the insurance industry?

Dr. ARON-DINE. That is correct. That is a nationwide protection put in place by the ACA, and it is one of the reasons that young adults would see especially large coverage losses if the law were struck down.

Mr. CÁRDENAS. Yes, thank you. My time is limited, and even though the clock stopped, what I am going to do is I am just going to close by saying that I would like to thank you, Doctor, and also

everybody testifying today, and just remind everybody that the truth is that the Republican lawsuit would have disastrous consequences on our Nation's most vulnerable Americans.

Yes, Madam Chair?

Ms. ESHOO. Thank you. The gentleman yields back.

I understand that Dr. Burgess has joined us. Are you actually there?

Mr. BURGESS. Yes, I am, and unmuted.

Ms. ESHOO. The Chair recognizes the ranking member of the subcommittee, Dr. Burgess, for his 5 minutes of questions. Glad you could join us.

Mr. BURGESS. I thank the Chair. I thank the committee's understanding of the morning where there was a lot of multitasking going on, where our time in town may be limited. There is a lot going on, as I am sure everyone is experiencing.

I would ask, Madam Chair, that my entire opening statement be made as part of the record.

Ms. ESHOO. So ordered.

[The prepared statement of Mr. Burgess follows:]

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

Mr. BURGESS. And, Dr. Holtz-Eakin, welcome to our subcommittee. Thank you so much for participating with us today. I would just note, you know, on the issue of employer-sponsored insurance—I think you talked about this in your testimony—well, employer-sponsored insurance, right, pre-pandemic levels, have actually increased significantly in the year since President Trump had taken office. I think it was in excess of three million more people had the availability of employer-sponsored insurance.

So of those employer-sponsored plans, now that we are in a situation where people are losing employment, what is the options that are available for someone who has lost coverage on an employer-sponsored insurance? They can sometimes get coverage on another family member's ESI plan. Is that not correct?

Dr. HOLTZ-EAKIN. That is correct. Their spouse could be covered, and they could acquire coverage that way.

Mr. BURGESS. So I guess, then, the question comes up, how does our existing safety net system work as intended to catch people that got hurt during the pandemic?

Dr. HOLTZ-EAKIN. The safety net really consists of the COBRA options that people have, the ACA, a place where they can, if they have lost employer insurance, they can go and enroll in a plan, and the Medicaid program. To date, I think that safety net has held up pretty well. As I noted in my written remarks, the Census Household Pulse Survey shows no strong trend in any direction on coverage, and that is not attributable to any single program but to the question of all of them.

Mr. BURGESS. OK. Well, then particularly appropriate to this subcommittee and this committee, are there any flexibilities that Congress has not provided to States and their insurance plans that would improve the uptake of other options?

Dr. HOLTZ-EAKIN. I think that something that would be really valuable for the committee to look at is to look at the waivers that have been provided by the administration on regulations that are due to the emergency—the declaration of the emergency. They have

authority to waive an enormous number of things. Like I mentioned with the telehealth, you know, you can use a commercial device, use FaceTime, a waiver of protection against minor HIPAA violations for anything disclosed over that, that would allow people to actually stay in their homes instead of going someplace to do telehealth, which doesn't really make a lot of sense.

And all that will go away when we, thankfully, get past the pandemic, but there is a lot of it that I think ought to be in law, and Congress should look at in providing flexibility. You know, we really learned that the U.S. healthcare system couldn't do two things at one time. It couldn't treat COVID-19 and continue to provide ordinary care, and that, I think, was quite revealing by the sort of overregulated lack of flexibility.

Mr. BURGESS. Yes. I would certainly echo the overregulated lack of flexibility. Much of the curtailment of practice was actually a result of governmental direction where—tried to preserve capacity in an emergency room or ICU setting, hospitals were and medical practices and clinics were required to reduce their workload of elective procedures, which subsequently killed their cash flow and made it very difficult for them to recover.

Dean Cameron, let me just ask you a question about populations of people are different and, arguably, Idaho and New York are significantly different. So the flexibility for States to develop plans that actually fit a State's population's needs is important. So could you perhaps provide us a little further detail about how Idaho insurance companies waived some of their eligibility requirements to make it easier for beneficiaries to maintain their access to high-quality care?

Mr. CAMERON. Yes, absolutely, and thank you for the question. As I mentioned in my remarks, we started meeting with our carriers and trying to talk about how we help citizens, how we keep them from being forced out of coverage, how they can access the special enrollment periods, how we can make that transition even easier.

And we pointed to and found a number of provisions in State law, and even in some rules, that didn't seem to make sense at the time. For example, we had employers say to us, well, I have laid off my folks, but now I want to hire them back, but I don't want to go through a new eligibility period. Wouldn't make sense to do that.

So we essentially issued bulletins, working with our carriers, saying, we are not going to do that. We issued bulletins allowing carriers to keep people that are furloughed on their plans even longer. Now, State law said that you had to be employed at least 20 hours a week in order to qualify for small-group coverage. We waived that.

There were a number of provisions that way, that in sitting down and collaborating with our carriers, decided in this pandemic, that wasn't appropriate. We want people to have coverage, and we did everything we could to help them keep coverage.

Mr. BURGESS. Thank you for that. I see my time is expired. I have a couple of additional questions. Madam Chair, I will submit those for the record. I yield back.

Ms. ESHOO. The gentleman yields back. I am so glad that you were able to make it, Dr. Burgess.

It is a pleasure to recognize the gentlewoman from Michigan, Mrs. Dingell, for your 5 minutes of questions. And make sure you unmute.

Mrs. DINGELL. Thank you, Madam Chair, I did. And thank you, Ranking Member Burgess, both of you, for convening this hearing, because it is really important what is happening with COVID and the positive effects ACA has had and what is happening to people.

And I too want to tell my colleagues how much I am going to miss Susan Brooks and Joe Kennedy. They are two people who deeply care about healthcare in this country, and we will miss them deeply.

I want to touch upon a topic that we haven't really talked about as much as I think we need to be, which is the impact that COVID-19 has had on long-term care in this country and how it has exposed a number of issues in the way that we deliver it. Millions of aging and disabled people in this country rely on what is a total patchwork system of care to provide them with services and the supports that they need in their daily lives, and until you are in the system, you do not understand how broken it is.

During the pandemic, we have all seen the tragic reports of how COVID-19 spreads in group settings like nursing homes. Compounding the tragedy is the fact that many people in nursing homes want to live at home with their friends and their family, but they are unable to because of the level of care that they need. And they are totally isolated, which is making it even worse as if they do become sick or what has happened to them in these last six months.

Medicaid actually pays for things like home health aides, direct service providers, to help with activities of daily living, even modifications to make the person's home more accessible.

So I would like to ask Dr. Aron-Dine some questions. Dr. Aron-Dine, there has been a concerted effort for over a decade, to rebalance long-term services and supports in Medicaid. Can you briefly explain what that means and why it matters so much?

Dr. ARON-DINE. Sure. Rebalancing refers to a rebalancing between institutional long-term care, for instance, in a nursing home, versus home- and community-based services, such as home health aides or personal care provided to help a person live at home. Institutional care has always been part of Medicaid. The availability of home- and community-based services has been really expanded over time, including through the Affordable Care Act.

It is very important for the reasons you note, that many people would prefer to receive care in their homes. It would be better for their health. It is also often more cost effective for a given person to receive care at home versus in an institutional setting.

Mrs. DINGELL. So—thank you for that. I understand that not everyone who wants to receive home and health community-based services, or HCBS as we call it, are able to receive them right away. What are some of the barriers currently for people who want to receive care in the community?

Dr. ARON-DINE. One of the biggest barriers to receiving these services through Medicaid is State finances. I alluded to so-called

optional services in Medicaid which makes them sound like frills, but actually optional services are really crucial things like home- and community-based services which States are allowed to limit because they are not mandatory. And there is a really big risk that during this recession, as in the past, that States are in a big budget crunch, this is one of the places they might look to cut, which can make the problem of HCBS waiting lists worse.

Mrs. DINGELL. Well, let me ask you two other questions. It is not funded enough even before COVID, is it? And is there an institutional bias against home-based care?

Dr. ARON-DINE. I would agree, certainly even before COVID, you had this challenge, and it is a place where the Medicaid program has made progress over time through continued expansions, including the ACA's, and more is needed.

Mrs. DINGELL. So given these barriers and the threat that COVID poses to people in group settings, it is now more important than ever that we make it easier for people to receive care in the community. I was glad to see that the HEROES Act contained a policy that I, quite frankly, did work on to increase Federal funding for State Medicaid programs to spend on HCBS. And I have been working on it with my good friend, Mr. Guthrie, and we are trying to get more of this.

But, Dr. Aron-Dine, the HEROES Act would provide State Medicaid programs with a ten percentage point increase for their HCBS programs. How would this help States to provide services to the people who need this type of care?

Dr. ARON-DINE. I think both the targeted HCBS increase in HEROES and the general FMAP increase in HEROES, the 14 percentage point bump, could be readily critical in helping to fill these holes in State budgets, discouraging them from cutting Medicaid, and making it possible for them to make some investments, particularly directly responsive to the pandemic.

Mrs. DINGELL. Madam Chair, I am out of time, so I may ask more questions for the record, and I yield back zero time.

Ms. ESHOO. The gentlewoman has completed her questions. I love the red in the background, Debbie. It really jazzes up our hearing. We need that. It is wonderful. And I like "Women Can Do It." We know that we can and we do.

At this time, I would like to recognize the gentleman from Oklahoma, Mr. Mullin, for his 5 minutes of questions.

Are you with us, Mr. Mullin?

I don't hear his voice or see his face, so we will move to the gentlewoman from New Hampshire, Ms. Kuster. You have 5 minutes for your questions. Great to see you.

Ms. KUSTER. Great to see you, Madam Chair. And thank you so much to you and the ranking member for holding this critical hearing on the Affordable Care Act. I have said it before, I will say it again, that across this country, 135 million people under the age of 65 have a preexisting condition. So we know the total number is much, much higher.

In New Hampshire, over 500,000 Granite Staters—and that is over half the population that are nonelderly—live with preexisting conditions every single day, and could be denied access to healthcare, either prior to the passage of the ACA or if the ACA

is repealed by the Supreme Court, as we now know our Republican colleagues are rushing to make happen.

So even today, during this pandemic, COVID-19 would be a pre-existing condition for an additional 7 million Americans. That is why I introduced the Protecting Americans With Preexisting Conditions Act, which has passed the House twice and still sits on Mitch McConnell's desk.

And I want to particularly address my colleague, Mr. Carter, who said that Democrats are trying to create an illusion that Republicans oppose protections for preexisting conditions. It is no illusion, Mr. Carter. You and your colleagues have voted twice against my bill, and it is very clear that you do not want to protect Americans with their preexisting conditions, even COVID-19.

Despite what this administration has claimed, this administration does not support protecting Americans with preexisting conditions. They haven't supported it when they encouraged repeal and replace without a replacement plan, or when they issued destructive guidance through the 1332 waivers, or when they fight in the courts to dismantle the entire law. And we now know that that hearing is coming just one week after the election in November. This is dangerous and destructive to the lives of the American people.

They certainly have not supported the ACA in the midst of this global pandemic, which has needlessly taken the lives of now over 200,000 Americans. And because the stark reality is that every year of the Trump administration, the rate of Americans without health insurance has increased, this year has proven no different. So today, I will focus my remarks on the ways this administration has continued to sabotage the ACA.

Over 40 million Americans have filed for unemployment benefits during COVID-19. Millions of Americans and their families have lost job-based healthcare, and yet this administration refuses to establish a broad special enrollment period which would allow uninsured Americans to sign up for coverage in the Federal marketplace. It is especially critical in States like my own that depend on the Federal Government as a partner in the ACA marketplace.

So, Dr. Sommers, most State-based marketplaces established broader enrollment periods. Can you briefly discuss how enrollment in State-based marketplaces has compared to the Federal marketplaces like our own right here in New Hampshire?

Dr. SOMMERS. Yes. So 12 of the 13 States that fully run their own marketplace have created COVID-specific special enrollment, and what you can see in the enrollment statistics that are available through the middle of the year is that there has been about a 15 percent increase over the open enrollment totals in those States. And that compares to just 11 percent in the States that are on the healthcare.gov platform.

And of note, you know, the ranking member asked about flexibility, more than a dozen States on the healthcare.gov platform requested that flexibility to create a new special enrollment period for COVID, and so far, CMS has not granted that.

Ms. KUSTER. And, Mr. Lee, Covered California established a special enrollment period for COVID-19. How many individuals signed up for coverage during this period?

Mr. LEE. Yes. About 300,000. And I want to underscore, it is both a special period, because 20 percent would have been ineligible, and they were healthy and needed coverage, but the rest were eligible but needed marketing, needed to be told to come in the door. And they doubled our enrollment from the prior period.

Ms. KUSTER. And based on your analysis, how many individuals could have gained coverage if the Federal marketplaces experienced the same level of growth as your State did during this special enrollment period?

Mr. LEE. Yes. Our analysis is, if Federal marketplaces had done what we had done, half a million Americans would not be uninsured today. They would have insurance during a pandemic when you want them to have insurance to be able to get tested and get the care they need.

Ms. KUSTER. Madam Chair, I apologize, I have lost the clock on my screen. Should I yield back or if I have—

Ms. ESHOO. Well, let's see. My clock has zeros going across.

Ms. KUSTER. All right. I will yield back and submit my questions. Thank you, Madam Chair, for your patience.

Ms. ESHOO. Thank you. Thank you for your important questions and your great work at the committee.

It is a pleasure to recognize the gentleman from Montana, Mr. Gianforte, for your 5 minutes of questions. And please unmute.

Mr. GIANFORTE. Thank you, Madam Chair. I appreciate the witnesses being here today.

I first want to say that my State has expanded Medicaid eligibility. I support a social safety net for those who need help, and I voted to protect coverage for individuals with preexisting conditions.

Today we keep talking about coverage. Coverage does not equal access to care. Montana faces a provider shortage, and many individuals travel hours to receive the care they need. Besides protecting individuals with preexisting conditions, my guiding principles for healthcare are improving rural access to care and reducing cost.

In the CARES Act, we voted to waive several rules regarding the provision of telehealth services. We waived rules regarding the origination and requirements for physicians to be reimbursed for services provided by audio and video. I think this is a great first step, and I hope we can build on ways to improve these waivers.

Director Cameron, what can you tell us about what you are seeing as far as telehealth utilization in Idaho?

Mr. CAMERON. Thank you, Congressman, and thank you for your comments, and thank you for what you did pass in the CARES Act to eliminate some of those rules, because that has been very helpful, along with, as a State, we also eliminated rules.

We really believe telehealth will provide that affordable access, particularly to rural States like yours and mine. We went from—we had a 250-fold increase. We went from—up to 28,000—where is my numbers—we went from 28,503 televisits in the month of April, from the previous year was 233. Dramatic increases in those that are accessing telehealth, and we think that will continue to grow.

Mr. GIANFORTE. Great. Do you have any indication that emergency room utilization is down with the increased use of telehealth?

Mr. CAMERON. Thank you, Congressman. We do have that indication. I don't have those numbers in front of me. We could certainly provide that, but we have seen dramatic increases in—or decreases in the emergency room utilization, but a lot of that is driven based on what was having to happen with the pandemic, who could access the emergency room. And so it might be a little difficult to pare out whether that is caused because of telemedicine or whether it is caused because of the pandemic. And people themselves did not want to go to the emergency room where they could potentially be exposed. They could sit at their home and they could talk to their doctor and get their treatment needed.

Mr. GIANFORTE. Yes. In my own experience, talking to emergency room docs, they tell me that up to 80 percent of emergency room visits could have been handled through telehealth, if it were generally accepted, and that is particularly helpful in States like yours and mine where the farm or ranch house might be hours away from the emergency room. It is certainly more convenient, higher quality of care. Certainly, the emergency room needs to be there for folks that need it, but having that telehealth option can provide more immediate care and also lower our costs.

In a followup, what else could we do in Congress to help advance telehealth adoption?

Mr. CAMERON. That is an excellent question. I think, first of all, continue to make those rules you have set aside more permanent, and continue to encourage and allow for carriers to be able to handle those visits through the marketplace. Additional support towards the technology that is needed in order for those providers to be able to offer telehealth services. I think all of those are solutions. And then, really, flexibility in the marketplace, allowing the marketplace to work, it will work. It can work.

Mr. GIANFORTE. OK. So the temporary waivers we put in place in the CARES Act, you are saying we should consider making those waivers permanent. Is that correct?

Mr. CAMERON. Absolutely.

Mr. GIANFORTE. OK. Well, I appreciate your testimony today.

And with that, Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back. And it is a pleasure to work with you on telehealth, which is so important and has really worked into its full benefits during the pandemic. We need to make sure that that continues.

The Chair is pleased to recognize the gentlewoman from Illinois, Ms. Kelly, for your 5 minutes of questions. And please unmute.

Ms. KELLY. Thank you, Madam Chair. This is a very, very important hearing.

And to Rep. Gianforte, I would love to work with you also. I have legislation, I work a lot with Congressman Will Hurd, but he is leaving me. So I would love to work with you on the telehealth issue.

I am chair of the Congressional Black Caucus Health Braintrust, and Black Americans make up 12.5 to 13 percent of the U.S. population, but we have accounted for 22.4 percent of COVID-19 deaths.

Dr. Sommers, given the number of minority individuals who gained coverage under the ACA and the decreases we have seen in the last few years, if the ACA were to be rolled back, how would that affect the already severe health disparities we are seeing because of the emergence of COVID-19?

Dr. SOMMERS. We know that the Affordable Care Act produced particularly large coverage effects in communities of color, and helped narrow, though not eliminate, the large disparities in coverage rates in the U.S. So any effort to undermine or repeal the ACA would likely worsen those disparities dramatically at a time when communities of color have been hit particularly hard by the epidemic.

Ms. KELLY. Thank you.

And, Dr. Aron-Dine, without opening a new enrollment period for individuals and the increase in the FMAP included in the HEROES Act, how can we prevent the deaths and health disparities that we see from the lack of insurance coverage and healthcare access, frankly, that disproportionately affect communities of color?

Dr. ARON-DINE. Well, I think you would want to start with a do-no-harm principle. So the most important thing is to make sure that the coverage options people currently have don't go away. And then as you alluded to, it is also important that States not be making cutbacks in coverage in this time, and that is going to require additional funding to States.

But more affirmatively, there are lots of things that could be done to make progress on coverage, especially for communities of color, including improving affordability and making it easier for people to access these programs.

Ms. KELLY. I know we have gone back and forth and everyone has their opinion about the ACA, and who knows what is going to happen with the Supreme Court. But just to all the witnesses, if there was one thing you could suggest to improve the ACA, what would that be? I know you are not in a line, so—

Dr. SOMMERS. I can start. I would find ways to get the 12 States that have not expanded Medicaid to do so. And these States have some of the most restrictive Medicaid policies in the country, even before the law. These are very low-income populations. They are disproportionately communities of color, concentrated in the South. There are large health disparities, and Medicaid expansion could be a life-saver.

Ms. KELLY. Next.

Dr. ARON-DINE. And I think the second place you would go after that is to sort of fill the next coverage gap, which is low-income people who are eligible for the ACA as marketplace coverage but aren't enrolled, and could start by addressing affordability issues as a number of States have done.

Ms. KELLY. OK.

Mr. LEE. And if I could, I would build on those two, with a third of addressing needs of lower income underinsured people with employer coverage. Twenty-five percent of people with employer coverage have coverage they can't afford to get access to. Those people need access to have a choice to get to a marketplace or get affordable coverage that addresses their income, which is done in marketplaces, but not by most employers.

Ms. KELLY. Thank you.

Mr. CAMERON. Thank you for the question, a very insightful question.

First of all, I would work on affordability, and I would work on drawing those young and healthy people back into the risk pool, creating one singular risk pool, regardless of the product style, adding flexibility. If you are going to have subsidies—and I think we need to have subsidies—Idaho's market is mostly a subsidy market, but we have got to figure out how to fix the cliffs and the mechanisms to keep people from taking advantage of those subsidies or keep them from being able to access those subsidies.

Ms. KELLY. Thank you.

Dr. HOLTZ-EAKIN. Never go last on a panel like this. I just want to echo—

Ms. KELLY. You can say ditto or—

Dr. HOLTZ-EAKIN. I will echo number one and number two. In particular, you know, half of the 30 million people who were uninsured prior to the pandemic were eligible for the ACA. That is low-hanging fruit, and there is no reason not to pursue that.

And then just keep an eye on the underlying competition and the value proposition in the delivery system. That remains the place that the ACA just really was not aggressive enough, and that has to be the challenge going forward.

Ms. KELLY. Thank you all so much. Thanks for your patience.

And to all my colleagues that are leaving the E & C Subcommittee, I wish you well, I wish you the best. Thanks for all your input and insight. And, of course, a special shout out to Rep. Shimkus because he is from my home State of Illinois, so thank you.

And I yield back.

Ms. ESHOO. That is really lovely. We really are going to miss the colleagues that are leaving the Congress. There is no question about it. And as I said earlier, they are really value added, not just to our internal work, but once those words become law, they walk into people's lives, and they are a part of that.

And we are—I think I speak for all of us when I say that I think that we have been blessed to have you on the committee. It is where we really get to know each other very well when you serve on the committee together.

Now I would like to recognize Mr. Mullin, the gentleman from Oklahoma. You have 5 minutes for your questions. And please unmute.

Are you there?

Mr. MULLIN. Madam Chair, thank you so much. And you are right, it is bittersweet to have people leave our side.

On one hand, I hate to lose them because they are a value and an asset to Congress. On the other hand, I get to move up on asking questions. So there is a side of me that is very selfish about that.

But I do—I will say, Madam Chair, you are right, when we are able to meet in person and we are able to have these hearings in the hearing room, it is something that adds a lot of value and friendship, from my friendship with Lisa to Joe Kennedy, to even yourself and Diana DeGette, and just a whole host of people to everybody on our side, it is something that is tough to replace.

And as you know, the stuff that I am going through personally with my son, our committee has just been phenomenal to me, so I will do the same. I will miss everybody that is here and we look forward to meeting everybody in person again.

To jump into where I am going with these questions, we have heard a lot about ACA, and I think we all agree people with pre-existing conditions need to have the access to market. I think we disagree on how to do that, obviously, and a one-size-fit-all approach doesn't work, and we have seen that in Idaho, as Mr. Cameron has pointed out in your testimony. You stated that in your collaboration and regulatory approach, that it has led Idaho to have one of the most successful exchanges in the country, and it is because you went at it on your own. You designed it specifically for the people of Idaho, and that approach has been very successful.

Could you kind of point out to us, what regulatory actions you have taken to improve the outcomes for your patients during the pandemic?

Mr. CAMERON. Certainly. Thank you for the question.

As I mentioned earlier, we began meeting with the carriers and talking about issues that were barriers to our consumers, things like prescription drugs, being able to obtain their prescriptions both early, both in larger supply, 90-day supply, and both without signing signature logs.

We said to the PBMs and to the carriers that were contracting with them, You can't require a signature log and you can't go back and audit them. We also worked with the carriers in expanding how people who are on coverage, how they could stay on coverage, and if they left coverage, how they could get back on coverage without going through all of the hoops and the previous provisions.

So employees that were furloughed could stay on coverage. Employees that lost coverage and went to a special enrollment period, we made it easier for them to make that transition, working with our State-based exchange because we have that connection that was able to make it helpful.

And then we made sure that people had access to coverage. We actually considered an extra special enrollment period, but in conversing with a lot of our colleagues found that, for most of our citizens, it really wouldn't address the numbers like Mr. Lee is talking about in California. And I am glad, happy for him, but it wasn't what fit for us. So we believe that we have taken care of our consumers.

We issued about 12 different bulletins that lightened the load or the responsibility on carriers and encouraged them to give money back to consumers, helped them so that they could give money to providers without it showing up as an adverse asset or giving back to consumers without it showing up as a rebate or an illegal inducement. We had them work through all of those things.

Mr. MULLIN. Well, can you maybe help us on the Federal level, we see a lot of States that only have one choice in the markets. How could the Federal Government help maybe incentivize competition in the individual markets like you have in Idaho?

Mr. CAMERON. Yes, I think that is a great question and one that warrants a lot more deeper discussion than what I am going to be able to give you in less than a minute.

First of all, collaboration and working in the regulatory environment, discussing those rules that are keeping carriers out of the business, looking at their profitability and how—you know, in our case, we have a co-op that we share with Montana. We have two not-for profits. All of those aren't really interested in making profit, but they are not interested in losing hundreds of thousands of dollars either.

So you have got to provide a balanced approach by which we are bringing young and healthy in order to help that risk pool be more stable.

Mr. MULLIN. Well, thank you. And we look forward to working with you more going forward.

Switching gears real quick, just in closing remarks here, I heard Gianforte and Lisa both talk about telemedicine. I have got a whole new approach to it because the way my son has been having to receive healthcare lately with specialists all over the country through telemedicine, and it is something that is underutilized and something that we as a Federal Government should be playing a huge role in.

It is something that has become very passionate, and I would like to maybe have a deeper discussion. So, Lisa, I look forward to working with you moving forward on this thing, too.

With that, Madam Chair, I yield back.

Ms. ESHOO. The gentleman yields back. And know, Markwayne, that our prayers follow your son every day, every night, all week long, all month long. We are with him, and we are with you, and I couldn't mean that more.

Mr. MULLIN. Well, thank you. I will tell you real quick, my son is going to be discharged from up here October 8.

Ms. ESHOO. Isn't that wonderful? See?

Mr. MULLIN. And so we get to come back home, so we are super excited. God has just been so good to us. It has been a miracle throughout the whole process.

Ms. ESHOO. And that is wonderful news. And we always have to remember to go back and say prayers of thanks. We are good at asking. We have to remember to say thank you.

I just want to add something—and I appreciate Mr. Cameron's work—I also think we need to highlight what California has done. Idaho has a population of 1.7 million people. The State of California is a Nation State, 39.5 million Californians, and we are a highly diversified state. I don't know how diversified Idaho is. But the more homogeneous a population is relative to an insurance pool, frankly, the easier it is.

So I tip my hat to Mr. Cameron for his work. But I also want to highlight what is taking place and has taken place in the largest State in the Union. If the ACA can succeed in California, my contention is it can succeed anywhere.

With that, it is a pleasure to recognize the gentlewoman from Delaware, a wonderful, wonderful member of our subcommittee, Lisa Blunt Rochester.

Ms. BLUNT ROCHESTER. Thank you so much for the recognition, Madam Chairwoman, and for your incredible leadership on this subcommittee, and thank you to the witnesses that are here today.

The passage of the Affordable Care Act ushered in a new era for healthcare and expanded coverage to more than 20 million Americans. This landmark law resulted in the highest insured rate in our Nation's history. It included a comprehensive set of measures to protect Americans with preexisting conditions. Millions of Americans have access to affordable quality health insurance because of the law. The law's tax credits make healthcare affordable for millions of Americans, but millions more are still under or uninsured.

Unfortunately, Republican Governors continue to refuse to expand Medicaid in some States, as was mentioned, and the Trump administration has deliberately made attempts to undermine this law.

My question is for Mr. Lee, my first question. Mr. Lee, your State implemented a new program that provides enhanced subsidies for low and middle class consumers. How many individuals have benefitted? And can you briefly discuss the program?

Mr. LEE. I can. Thank you very much for the question.

I appreciate Chairman Eshoo's note about California's breadth of diversity. We are a very diverse State with about 30 percent of our population is Latino, about a third Asian Americans, many African-Americans, but we know the ACA is not enough. So Governor Newsom and the Legislature expanded subsidies that about 600,000 or 1/3 of our enrolled has benefitted from, 600,000. But it included having element of having subsidies for people that are above that 40 percent poverty clip. They now, instead of spending 10, 15, 30 percent of their income, are getting financial help, on average \$500 a month to lower their coverage. That contributed to our last open enrollment period a 40 percent bump of new enrollment, healthier people, and lower costs for everybody, as well as the unsubsidized.

And if I may, just very briefly. We have heard all about healthcare costs, and we should. The healthcare costs are a problem. But recognize, in the last six years, while premiums have doubled in much of the Nation, they have risen at half that rate, half that rate in California because of what we have done to implement the Affordable Care Act.

So, yes, let's address pharma cost, let's address consolidation, but recognize getting people insured is a benefit to everyone by a better risk mix as well.

Ms. BLUNT ROCHESTER. Great.

And I want to shift a little bit to the marketing and outreach that was mentioned before. And I know Covered California invested in outreach during the COVID-19 special enrollment period and I know—and is increasing their marketing and outreach budget by \$30 million for fiscal year 2021.

What benefits has Covered California seen from their robust investments in marketing and outreach?

Mr. LEE. So I want to be really clear. If you are a Nike, if you are—I think Timberline is in your State, if you are a Ford Motor, you don't say people knew about us a few years ago, we stopped marketing. You always had a market. But beyond that, healthcare is different. People don't want health insurance because they don't think they are going to get sick. They need to be convinced, reminded, cajoled, nudged. We spent a lot of money on marketing, but for every dollar we spend on marketing \$6 or \$7 comes back

to the State by lower premium costs, by enrolling healthier people. It is the right thing to do and creates a virtuous cycle by lowering healthcare costs.

Ms. BLUNT ROCHESTER. And, Dr. Aron-Dine, how could investments in the ACA's marketing and outreach and in consumer assistance play a role in helping people recently uninsured because of this pandemic? Talk to me a little bit about that in the minute that we have.

Dr. ARON-DINE. I think restoring funding for outreach and marketing could play a very big role, so could opening up a special enrollment period, so could improvements in premium tax credits, similar to what was done in California.

And if I could just say one word about unsubsidized marketplace premiums, because that has come up a lot, when studies have looked at this, unsubsidized marketplace premiums are ballpark in line with premiums for comparable employer coverage. But people don't see the sticker price for their employer plan. They don't see the \$7,000 because their employer is paying part of it, plus we provide a tax subsidy for those plans. And so, of course, people are surprised by those sticker prices in the marketplace and some find them unaffordable.

You can go two directions with that. You can eliminate protections for preexisting conditions with the risk pool and make things a little cheaper for the healthy at the expense of the sick, or you can extend premium tax credits to people at higher income levels as the bill passed by the House earlier this year would do. I think that is a more logical solution.

Ms. BLUNT ROCHESTER. Thank you so much for all of your work and to the panelists, and now is not a time in a pandemic to get rid of the Affordable Care Act, this landmark piece of legislation.

Thank you, and I yield back.

Ms. ESHOO. The gentlewoman yields back. We thank her for her excellent questions.

And it is an honor to recognize another outstanding member of our subcommittee, the gentlewoman from the State of Washington, Mrs. McMorris Rodgers.

Mrs. RODGERS. Thank you, Madam Chair. It is great to be here today, and I appreciate you holding this hearing and to all of the witnesses for participating today.

It has been more than ten years now since the ACA was signed into law, and yet today Americans are still left to deal with expensive and burdensome policies. The ACA, Obama Care, was well intentioned, but it has failed in meeting many of its goals and failed in meeting many of its promises. Obama Care promised affordable health insurance for every American and even penalized those who refused to buy it.

The law has distorted markets and not controlled the underlying costs of care. Tens of millions of Americans today cannot afford health insurance, and the number of people who delay doctor's visits because they can't afford care just keeps going up.

In 1 of 5 counties, a 40-year-old making \$50,000 would have to pay more than ten percent of their income for the lowest cost plan in the Obama Care marketplace. According to healthcare.gov itself, this is considered unaffordable.

Unfortunately, some of my colleagues refuse to acknowledge some of the issues that continue to plague the ACA, such as higher premiums, higher taxes, and tax penalties, and even more Federal regulation of health insurance.

I believe that this type of government-knows-best approach is what is leading to more support for one-size-fits-all government takeovers of healthcare like Medicare for All.

All Americans deserve a health insurance system that embraces transparency and choice, protects Americans with preexisting conditions, like my son, supports medical innovation for better care and, most of all, lowers cost across the country.

To Dr. Holtz-Eakin, what changes in the way that private health insurance has covered certain services, such as telehealth visits, have you seen in your examination of the market? And what effect are those changes having on patients, the delivery of care, and the costs of care?

Dr. HOLTZ-EAKIN. Well, again, telehealth has come up a number of times, and it is a really good example of a loosening of the regulations that allows a new service to be offered that is now a competitor service to the existing delivery system.

It is not going to compete on everything. It is not a great way to do an initial intake of a patient, a lot of other examples. But in many situations it can provide a lower cost alternative to an in-office visit, and that is something that we want to always allow to flourish wherever possible.

And we shouldn't rely on the people at CMS to sit and think what could we provide to. We should simply have a regulatory structure that is flexible enough that if someone decides they want to do telehealth, they can start up and do it. And I am hoping that what we will learn from the experience of this pandemic is that a lot of the restrictions on the delivery system are really unnecessary. The notion that scope of practice laws are as tight as they are really restricts competition.

In the pandemic we saw doctors cross State lines and practice with zero problem whatsoever. There is a lot about this that I think is a real wake-up call to how we deliver health in the United States.

Mrs. RODGERS. Thank you.

And as a follow-up to you and to Director Cameron, obviously, this pandemic is tragic, and we can't underscore the personal costs and the toll that it has had on our country. From a healthcare policy perspective, it has forced us to adapt in ways to the environment and change the way healthcare is delivered in some cases.

Using telehealth in my rural district in eastern Washington as an example, there are many ways that healthcare is covered or paid for and, in the long run, would improve the efficiency of this system and improve patient access. In other words, there is lessons that we can learn and any policies that we have implemented on a temporary basis I think we should consider for a permanent basis.

And I would just like to ask both of you to highlight, what are those temporary policy changes that we should consider to make permanent?

Dr. HOLTZ-EAKIN. Want to go first, Dean?

So I would encourage you to take a look at the list we compiled at the American Action Forum. We have a list of all of the emergency waivers that HHS has done using the health emergency declaration and go through that list, and anything on that list is fair game to be made permanent.

I think that that has been—you know, if you needed to do it to address the biggest crisis we have seen in America, then it is something that needs to be gotten rid of permanently.

Mrs. RODGERS. OK. Well, thank you. Thank you very much. Always good to hear your insights.

And with that I will yield back. Thank you, Madam Chair.

Ms. ESHOO. The gentlewoman yields back. It is great to see you.

And now it is a real pleasure to recognize just an outstanding member of our committee. We are really lucky to have him, always thoughtful.

Mr. Welch, you have 5 minutes, and we want to hear everything that you say, so unmute.

You need to unmute. Can't hear you.

Mr. WELCH. Well, I said I was——

Ms. ESHOO. There you are.

Mr. WELCH. I was listening to you, and you embarrassed me with that introduction. I am not quite sure you got that right.

But I am actually delighted to be here, of course, with my colleagues on the committee, and I am not going to rehash the ACA issues. I want to focus on some of the things we can do to address the high cost of medical care. In this country, as we know, we pay the most and get the least. And whether we have a taxpayer-funded system, an employer-based system, or an individual pay system, if the cost of healthcare keeps escalating like it is, none of us are going to be able to afford it.

I am going to ask, Dr. Holtz-Eakin, you make some very good comments, and I really do always enjoy your testimony. And the question I have is this. Some of the information we have now is that easing regulations helps. It helps on delivery and it may help on the cost. You mentioned telehealth, something that I am a very strong supporter of. But here is the question.

If you ease regulations, do you maintain standards? Because, for instance, if you allow for insurance companies to sell policies that deny preexisting conditions, then that is an option for somebody. But then when they get sick, they may well not have coverage.

My view—and I want your reaction to this—is that if you are going to ease regulations, you have to have standards so that a person, whether he or she is in Texas or in Vermont, has confidence that they will get the healthcare they need when they need it.

Can you comment on that tradeoff between regulations and standards?

Dr. HOLTZ-EAKIN. So I think of this in two different areas. One of it is the insurance arena, as you mentioned. There is a difference between saying this is insurance that you are allowed to offer, having a strict regulatory structure that says what you may or may not offer, and a set of standards to say, OK, you can offer insurance with a minimum standard, it is not really insurance if it doesn't cover anything, so that is minimum standard to get Federal subsidies and preferred tax treatment.

And then you get into transparency and consumer protections and adequate financial backing for the insurance company itself. You can't—

Mr. WELCH. OK. Let me interrupt here because that is a very good point. But all of those things that you just mentioned do require some kind of governmental action, not just free market action, correct?

Dr. HOLTZ-EAKIN. Free markets operate within a legal structure and the legal structure is essential. There is no way around that.

Mr. WELCH. Correct. No, I appreciate that.

And I want to go to Dr. Lee. I was extremely interested in the point that you made that, despite the escalating premiums, your increase in premiums has been half of what the national experience has been. Is that what you said?

Mr. LEE. That is absolutely right, Congressman Welch. I think it is important to note that underlying costs are still too high in California. We have consolidation problems, but premiums would have gone up half as much in the rest of the Nation if the rest of the Nation had implemented the Affordable Care Act that we did, marketing, Medicaid expansion, getting everyone in the door to have a healthier risk mix.

Mr. WELCH. And, Dr. Aron-Dine, could you comment on steps—well, first of all, just comment on what is the incredible pressure of high costs on any kind of sustainable healthcare system, number one, and, number two, what recommendations you would make to bring down the costs.

Dr. ARON-DINE. Sir, I think you really put your finger on it. High costs are a systemwide issue, and they need to be addressed in large part on the provider side of the system, thinking about prices, thinking about utilization, thinking about delivery system reform.

And so I just want to contrast that with the sort of implication that somehow ACA costs are especially high or the marketplace costs are out of control. We have a systemwide healthcare cost issue and then we have some affordability gaps in the ACA structure that are pretty easily solvable and could address the concerns of unsubsidized marketplace consumers.

With respect to continuing to work on costs, I think we actually have a lot—there are many ideas in common among the panel. I was also really struck by—in thinking about regulatory barriers and other barriers that have been relaxed during the pandemic.

Many States have also relaxed access barriers in Medicaid and changed and streamlined their eligibility procedures to make sure that people could get coverage during this period. And I think similar to how there are lessons on scope of practice, there is some lessons on eligibility there, practices that we could continue to take nationwide and get eligible people covered without compromising program integrity.

Mr. WELCH. Thank you.

My time is up, but I want to acknowledge the testimony of Mr. Cameron and the successes that he was able to talk about in Idaho. Thank you.

Ms. ESHOO. The gentleman has completed his questions.

And it is a pleasure to welcome back to the subcommittee, she is an honorary member of our subcommittee, Ms. Schakowsky of Il-

linois, who waves on, and we are happy to have you, and you are recognized for 5 minutes for your questions. Please unmute.

Jan, we can't hear you. You need to unmute.

Ms. SCHAKOWSKY. I should be unmuted now, I hope.

Ms. ESHOO. You are.

Ms. Schakowsky. Thank you so much. I really appreciate your indulgence to let me wave on, and it has been an amazing, amazing hearing.

I don't want to go over old testimony—or I mean old messages, but I do want to say that on this day when there are now 201,000 people who now have died from the COVID crisis, and I just want to say they deserve recognition and mourning, the families who have lost their loved ones, the essential workers who have died, and the nursing home residents that we have been trying to focus on who failed to be protected.

And the one bright light really has been the Affordable Care Act. No one disagrees that there aren't ways that it could be improved; but, thank goodness, for the Affordable Care Act and the difference that it has made. And really the terrible travesty of the sabotage that we have seen—I mean, I listen to all of the complaints about the Affordable Care Act, and still there is nothing else right now that has been suggested.

But, Mr. Lee, I have a very specific question that affects my State of Illinois. According to your testimony, California has done a number of things on its own, spent the past decade protecting, building on and going beyond the ACA. But my home State of Illinois still relies on the Federal Government exchange. We don't have our own exchange in Illinois.

And so what I really wondered was how has your State-based exchange allowed you to do better to serve Californians, especially during this COVID crisis? And what would you recommend to other States in terms of relying just on the Federal exchange and instead moving toward having its own exchange and the options that become available?

Mr. LEE. Well, thank you so much for the question, and thank you also for your observation about taking a moment to mourn the losses we have seen around the entire Nation.

California is an independent exchange, but from day one we said we are committed to building on and making the Affordable Care Act work, building on. Covered California has patient centered standard benefit signs. There are great economic theories about more choices, better, but we want consumers to choose between plans with good choices. We have robust competition.

We bring health plans in, but we also hold the health plans to account to make sure they deliver quality care. It is not just about people getting an insurance card. So we look at health equity. We hold our health plans to account. We have very robust competition. 80 percent of our enrollees have four or more carriers to choose from, 99.8 multiple plans. We have competition.

But it is also about marketing. It is about marketing and getting the word out and promote it. As I note, we spent a lot of money on marketing. We spent \$150 million in marketing and outreach in the coming year, and it lowers costs. It is not extra Federal money. It is coming out of the premiums, but the premiums are lower be-

cause of that spending, but part of it is we have navigators, we have 10,000 insurance agents.

We have storefronts with Covered California's name on streets across California, 500 storefronts. Behind those storefronts are not government workers, but some of our 10,000 independent insurance agents. It is navigators we fund.

And these are the investments that the Federal Government should be making to stand up and make sure that all Americans get coverage or saving marketplaces many are doing similar things, and this is about getting everyone insured something we have wanted to do from day one.

Ms. SCHAKOWSKY. I thank you so much. I really think that—I would hope that we could get Illinois to follow your lead and to adopt many of the suggestions that you have already implemented. So thank you so much.

And I yield back.

Ms. ESHOO. The gentlewoman yields back.

I am sure that Peter Lee would be happy to assist you, Jan, but here is a warning. Do not take him away from us. He is far too valuable. We need him.

I don't think that—oh, I thought that we were finished. It is really a pleasure to recognize a long-standing member of our committee, really salute him for the work that he has done over so many years, his conscientiousness, his friendship, his effectiveness, his caring for his constituents and country.

I am pleased to recognize the gentleman from New York, Mr. Engel.

Mr. ENGEL. Thank you, Madam Chair, and thank you for those kind words, and thank you for being such a good friend of mine all of these years.

You have done a terrific job as Chair of this subcommittee, really making the subcommittee rise to an eminent place.

We all know healthcare is just so important, and we come with a whirlwind of knowledge, and you actually feel it when people are suffering. I think you have done a fantastic job as Chair of the subcommittee, and I was proud to be part of it.

This may be the last time I speak, so I want to say that the fight, obviously, that we have all been doing for healthcare and other things needs to go on because there are many people that want to kill it, and we know that that would be a tragedy.

The ACA has helped nearly 20 million Americans get covered, including nearly a hundred thousand of my constituents. Many of these Americans gained coverage through the ACA's landmark Medicaid expansion.

If the remaining 12 nonexpansion States would join the rest of the country, an estimated two million more Americans would gain coverage, and during the current COVID-19 pandemic in which millions of Americans have lost their health coverage, this would provide many low income and working families peace of mind.

House Democrats passed the Heroes Act, which would provide a trillion dollars in State and local relief to help support Medicaid expansion.

Let me ask Mr. Cameron, could you describe why Federal dollars to State and local relief are critical to supporting Medicaid expansion?

Mr. CAMERON. Well, excellent question. Certainly Idaho is one of those that did expand Medicaid, although we took our time in doing so, and certainly the increased FMAP has certainly been very helpful to us, and we have seen dramatic improvement in the number of folks—or dramatic number increases during the pandemic in the number of folks who actually accessed Medicaid.

We do see some that prefer not to, and the way the laws are—the way the ACA is drafted, it doesn't give them a choice.

So we do have some consternation over that. We would like to give consumers the opportunity to choose whether to be on Medicaid or to choose whether to be on a private sector plan and think that there is a solution there as well.

Mr. ENGEL. OK. Thank you.

Millions of Americans have lost their job-based health insurance through the economic crisis caused by the coronavirus pandemic, and Congress has taken steps to preserve their health coverage by providing more funding to States with Medicaid coverage.

Like my home State of New York, we have also opened up special enrollment periods for the Affordable Care Act's exchanges to enable individuals to purchase high quality of coverage. And so far, 8,000 New Yorkers have used this opportunity to get coverage. So it is really something that is really important.

Thank you, sir, for your good work.

And I yield back the balance of my time—oh, I am sorry; one more here.

Dr. Aron-Dine, what steps can States which run their own exchanges take to inform their residents about their special enrollment periods? And piggybacking with that, what else should Congress do?

Dr. ARON-DINE. I think there are a lot of lessons for Congress in things States have successfully done to expand coverage, both before the pandemic and during the pandemic.

I would put those in a big bucket of improving premium tax credits, improving affordability, both for the lower income people who are still most likely to be uninsured and also for people who are not currently eligible for subsidies but could be offered subsidies if premiums are unaffordable as a share of their income.

Another big bucket is improving access, making it easier for people to access both Medicaid and marketplace coverage. That is something that New York has really been a leader on through its basic health program where people can enroll all year and can more easily move between different types of coverage, and then, of course, making sure that the remaining States expand Medicaid.

I wonder if Peter Lee would like to answer your question about the best ways to promote a special enrollment period.

Mr. LEE. Well, if I may very briefly. It really has to be about being all in every channel. Again, we spent \$150 million. That is a lot of money, but we are a really big State. Any State should be spending, to our mind, about one percent of your premium dollars on marketing, and that means TV, radio, social media.

In California, it means material in Spanish, in Korean, in Vietnamese. It is in language; but it is also on the ground. It is so important. We have learned half of our enrollment is through insurance agents and navigators. These are people in communities.

Now, you cannot be a storefront and have our name emblazed unless you agree by our rules. But the fact that we have these storefronts, you know, in every community, we have got them on Wilshire Boulevard in L.A., Mission Street in San Francisco, but we have got them on Roscoe Boulevard in Panorama City, Q Street, in every city, which means people know we are there, but it is because we support agents and navigators.

So it needs to be everything from social media to on the streets, which right now people still use the phone.

So thank you for that handoff, Aviva.

Mr. ENGEL. OK. Thank you very much.

And thank you to all our witnesses again, and thanks to Chairwoman Eshoo.

Obviously, we need to protect not dismantle the ACA. And, frankly, what the President is doing now is really a disgrace, and I just cannot believe that a government which is supposed to protect the people would do something to take away people's coverage which they rely on. It is absolutely mind-boggling. So we need to be vigilant.

We need to make sure that these things are not taken away and that the American people can get equality of coverage.

And I yield back the balance of my time.

Ms. ESHOO. The gentleman yields back.

It is a pleasure to recognize the gentleman from Arizona, Mr. O'Halleran. Please unmute. You have 5 minutes for your questions.

Mr. O'HALLERAN. Thank you very much. Good afternoon. And, Ranking Member Burgess, thank you for allowing me to wave on today. It is an important hearing, and I appreciate the subcommittee's attention to the importance of the Affordable Care Act as our Nation is grappling with the COVID-19 pandemic.

The lifeline caps on healthcare cannot be imposed by insurers and that young people can remain in their parents' healthcare until they are 26, these are a couple of the issues that are basically different than what we knew before affordable healthcare, along with preexisting conditions. And for the healthcare industry, it is costly.

Something that is seldom discussed is the Affordable Care Act's role in addressing healthcare disparities among racial and ethnic groups, as well as by income.

Dr. Sommers, as you note in your testimony, a staggering 19.6 percent of Native Americans lacked health insurance, according to a 2018 American Community Survey, public data.

The COVID-19 pandemic has hit Indian country hard, with the per capita rates in the Navajo and the White Mountain Apache Tribes in my district, both of which had suffered amongst the highest in the Nation at their peaks.

A lack of preventative healthcare, lack of clean drinking water, and access to healthy food, and a high number of individuals without high quality health insurance worsened the impacts of COVID-19 in these communities. Much work still needs to be done, especially in light of COVID-19.

I sponsored the legislation that would fully fund Indian Health Services facilities construction program to contract and improve the critical issues, projects across Indian country. The urgent need for attention to this matter is why I am proud to serve on the Racial Disparities Working Group led by my colleague, Congresswoman Clarke, and Congresswoman Kelly, which provides an outlet to dive deeper into some of these issues and work to ensure access to quality healthcare and insurance for all.

Dr. Aron-Dine, thank you for joining us and for all of your work showing how important the Affordable Care Act has been for millions of Americans. My district is larger than the State of Illinois, meaning that we have a lot of particularly rural and underserved areas. We have broadband issues that I and this committee have been working on since I came to Congress and before.

Clearly, more needs to be done. I would like to hear more about what ACA could do to be improved to ensure that community health centers, rural hospitals, and rural providers can continue to provide important care that those living in rural areas need desperately.

Dr. ARON-DINE. It is no urging that the ACA has improved coverage and access to care for people in rural areas similarly to people in nonrural areas, and that is especially noteworthy given the people in rural area disproportionately live in States that haven't expanded Medicaid, and so they have been left out of some of those potential coverage bands.

I think one of the most urgent needs right now, particularly to address or at least make sure some of these rural access issues don't get worse, is to address the State fiscal crisis that States are facing, which could easily become a healthcare crisis, particularly as States look to their Medicaid budgets as a place to cut, look to provider rates as a place to cut, and look to nonMedicaid health programs as a place to cut.

Mr. O'HALLERAN. Thank you.

Dr. Sommers, the pandemic has had economic impacts throughout our country, but that impact has been particularly felt throughout poor and underserved areas, including many Native American communities. What specific improvements can we see Congress take to make the Affordable Care Act work better for these underserved communities?

And I wish to point out one other issue, and that is that some of my constituents have to drive 10 hours round trip to see a specialist. Many of them do, in fact. Many of our veterans have to do that, too. And this is just unacceptable in the America that we all love. And please help us, give us some concepts and ideas.

Dr. SOMMERS. I think there has been a lot of bipartisan support during the discussion today on the bolstered efforts for telehealth, which are critical in rural areas and especially in some of the communities that you are talking about, you know, where you have things of value, commutes are hours from the nearest provider in some of the reservations, in the Navajo Nation, for instance.

The ACA has produced substantial gains in coverage. A study we published looked at coverage for Native Americans and found that not only did Medicaid expansion lead to big increases in those with

insurance, it was particularly a large increase for those living on or near reservations.

And then the final comment I will make on this topic is the Representative from Montana raised a very good question of if you give people insurance but they can't see a provider or there are shortages, does it matter? Well, when we looked at impact of giving people Medicaid expansion in counties that had specific provider shortages, we still found that coverage was better than being uninsured. People were better able to get care.

So shortages matter. We need to address them. But having no coverage, you don't even have an entry into the system, whether there are shortages or not. So coverage first, and then we need to also bolster the work force.

Mr. O'HALLERAN. Thank you very much.

I would just end with saying that we can have all the coverage in the world, which is extremely important, especially in Indian country because the Affordable Care Act is so important to it.

But it doesn't do as much good as it needs to in light of the needs of the size of the State of Illinois, you know, 750,000 people, they have to travel a long way. There is not enough specialists. People are sick in those areas. And we have to find a better way to address the needs of all of our citizens, not just some of them.

I think the Affordable Care Act is the way to do it, but changes do have to be made in light of the need for covering all of Americans.

So thank you very much.

I think you had something to say?

Dr. SOMMERS. Congressman, I was going to say one other thing is the chronic underfunding of the Indian Health Services is something that we have to talk about in this context, too, and that is direct funding to creating the infrastructure that can then provide the care that is needed. Health insurance coverage is important, but the Indian Health Services plays such a critical role, too.

Mr. O'HALLERAN. And we are doing that.

And, Madam Chair, I yield. Thank you.

Ms. ESHOO. The gentleman yields back. And it is always a pleasure, we want you to know, to have you wave on.

Mr. O'HALLERAN. Thank you.

Ms. ESHOO. You are an honorary member of our subcommittee. How is that?

Mr. O'HALLERAN. That is great.

Ms. ESHOO. Exactly.

It is wonderful to recognize the colleague from California, Dr. Ruiz, for his 5 minutes of questions. Please unmute.

Mr. RUIZ. Thank you, Chairwoman.

I want to also echo the sentiments of our colleague, Congressman O'Halleran, who has been a champion for Indian country and health equity in our Nation.

You know, it is kind of stunning to me that we still have to hold these hearings on the importance of the Affordable Care Act, that the Affordable Care Act is still under attack, that it is still under the threat of repeal.

Even now, during this nationwide pandemic, where families all across the country have relied on coverage through Medicaid ex-

pansion and subsidies and exchange plans, many after having lost employer insurance, this pandemic has laid bear the importance of access to affordable healthcare with comprehensive benefits.

House Democrats tried to expand that access in the Heroes Act, which included my bill, the Care for COVID Act. The Care for COVID Act expands access to healthcare by creating a special enrollment period for anyone without insurance and requires insurance plans to cover treatment for COVID with no out-of-pocket costs for their patients so that co-pays or high deductibles would not be a deterrence for seeking care.

You know, as an emergency medicine physician, I know we need more access to care, not less. But you don't need to be a doctor to get that. You don't need an M.D. To realize that during a pandemic we want to get more access to the proper care and precautions, not less.

And yet this administration and some House and Senate Republicans continue to try to chip away at the ACA, while also attempting to completely overturn the law in court, completely overturn the law in court.

We have been fighting this for years, even as millions more Americans have insurance because of the ACA, even as 130 million people with preexisting conditions across the country can no longer be denied health coverage just because they had been sick before.

But the Trump administration and if these Republican leaders get their way and the ACA gets overturned, there will be no protections for people with preexisting conditions. Keep in mind that anyone who has had COVID will have a preexisting condition.

This means that they may have to pay much higher premiums for their coverage, possibly even be denied or that coverage might not cover anything related to their COVID illness, which I should add we do not know the full scope of the long term affects of COVID-19 yet, or they will be subject to annual lifetime caps or what insurance will pay. That is if they will be able to get insurance at all, because without the protections of the ACA, all of those scenarios are possible, if not likely, as we all remember from pre Affordable Care Act days.

Dr. Aron-Dine, can you just expand on some of the impact on individuals with preexisting conditions if the ACA were to be struck down by the Supreme Court?

Dr. ARON-DINE. I think you described we would really be reverting to a pre ACA world, where the individual market really didn't work for people with preexisting conditions or others with serious health needs because they could be denied coverage, charged higher premiums and because plans could have massive benefit gaps or caps on coverage.

And if you don't mind, if I could say one word about the idea that we have been hearing that there are proposals out there that would replace the ACA's preexisting conditions protections. Looking at one of those bills introduced by Ranking Member Walden, I have some real concerns.

Not only would it not replace the Medicaid expansion in any way, which is, first of all, the loss of people with preexisting conditions, and not replace premium tax credits in any way, which is crucial

to making a market that protects preexisting conditions actually work.

Even if you just look at the impacts on the market, on the insurance market reforms, people with preexisting conditions could still be charged more either on the basis of their condition or certainly on the basis of gender or age, and plans could leave out high-cost drugs, could leave out any other benefits, or just cap coverage with low annual and lifetime limits, so back to the economic logic that pushes you to a race to the bottom in an insurance market without standards and you really haven't protected people with preexisting conditions in any way.

Mr. RUIZ. You know, this attempt to repeal the ACA through the courts is opposite of what health equity means because it is precisely people with underlying illnesses, precisely with people that have chronic illnesses that are most at risk of dying from COVID-19.

Repealing and chipping away from the ACA will add to the numbers of those who die and who suffer from this pandemic, which would only prolong the pandemic and its economic devastation for our Nation. It is the opposite of doing good. It is doing harm.

Mr. Lee, good to see you again. Can you talk about how individuals who have had COVID will be impacted by not having preexisting coverage protections and what this might mean with any long-term health effects of COVID-19? Since we know it can cause scarring of the lungs, this could lead to longer term health effects.

Mr. LEE. So, Dr. Ruiz—I am not sure which is a better honorific, Congressman or Doctor, but first it could have 7 million people not just being precluded from getting coverage, but potentially being charged higher premiums, imposing higher out-of-pocket costs and, if I may, and Aviva noted this, but remember, under the pre ACA, being a woman was treated as a preexisting condition.

Women were charged more for insurance. And returning to that reality, to my mind, would be virtually medieval.

If I may, saying that you have a policy that could preserve preexisting condition protections of the ACA without addressing the other elements is like saying, We will keep this plane in the air by committing to not chopping off its wings, but not address that you have an engine, the need to have flaps and rudders to steer, the need to have a landing gear to land. While an airplane needs wings to fly, it also needs other parts to keep it in the air to get passengers on the ground safely.

You can't separate out preexisting condition protections from subsidies, insurance rules. So to say you can do one thing alone is just both an economic and healthcare fallacy.

Mr. RUIZ. Thank you very much.

I yield back.

Ms. ESHOO. Thank you very much for that exchange and, Mr. Lee, for, I think, really an outstanding description that really speaks to this whole notion of I am for preexisting conditions and that somehow that that is something that can just take place like this without any other architecture relative to insurance surrounding it.

I don't see any other members that are waiting to participate in the hearing. So I want to request unanimous consent to enter into

the record the following documents: An April 2020 letter to CMS Administrator Seema Verma from Members of the Energy and Commerce Committee on establishing a special enrollment period; a letter from AFSCME Council 57; a statement from Margaret Murray, chief executive officer of the Association for Community Affiliated Plans; an August 2020 GAO report entitled "Private Health Coverage, Results of COVID Testing for Selected Offerings"; a letter from the National Taxpayers Union; a statement from Community Catalyst. And without objection, hearing no objections, so ordered.

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

Ms. ESHOO. Let me just close on this note, and it really is with all of my thanks, and that is on behalf of all of the Members of the Subcommittee.

Dr. Sommers, you spoke so clearly and with a knowledge that is so broad and deep because you are caring for patients every single day, and you know their stories and you related them to us so beautifully. Thank you. Thank you for being willing to testify and for the quality of your testimony.

To Mr. Holtz-Eakin, you are always welcome at this subcommittee. Both sides of the aisle draw a great deal of every testimony that you have offered, so thank you for doing that today. You are always thoughtful. And you are direct in your answers. Which we all appreciate.

To Dr. Aviva Aron-Dine, you are outstanding. You are absolutely outstanding. You have deepened and broadened our knowledge, never being menacing in terms of your responses, but with a knowledge that is dazzling, and that for those of us that think that we understand these policies really quite well, you did something today to really deepen it and broaden it. And you are always welcome back at the committee. You added so much to our hearing.

To Mr. Cameron, thank you for your testimony. To have an individual that represents, even though the population of Idaho is relatively a small one in comparison to my home State of California, your experience and your work to help insure people was high value testimony, and we appreciate it. And I think you have a good sense of that because you evoked important questions from both sides of the aisle.

And to Peter Lee, there simply is no one like you. There is simply no one like you. As when we opened the hearing and I introduced you, I spoke you are one of the most distinguished—you come from one of the most distinguished families in California, in our country, and at the heart of their service and their care was healthcare. You are all physicians. So you are—you stand on the broadest shoulders.

You have not disappointed anyone in generations of your family. You carry on that tradition, and Californians are deeply grateful to you. Our entire delegation from both sides of the aisle are grateful to you and grateful to you not only for your knowledge and your know-how, but that all of us can really sense and feel from a deep place what kind of commitment you have. It is called the Lee commitment, your fortitude.

So bless all of you for working with us to really make our country better. We are in troubled times. It is up to us to help bring the American people through.

And at the heart of that, at the heart of that, is the dignity of each human being. Each one has a spark of divinity to them, and honoring that spark of divinity is that they will have healthcare that they and their families can depend on. That is the way that we honor them.

So thank you to all of my colleagues. Thank you to the witnesses.

And with that, the Health Subcommittee of Energy and Commerce is now adjourned.

[Whereupon, at 1:58 p.m., the subcommittee was adjourned.]

PREPARED STATEMENT OF MICHAEL C. BURGESS

Thank you, Madam Chair. I would like to set the stage by walking through the robust support that Congress has provided already this year to protect American patients during this novel coronavirus pandemic. In various supplemental relief packages, Congress has provided or required coverage for different coronavirus-related services. For example, Congress has required that commercial insurance cover coronavirus testing. We have also waived all cost sharing requirements for Medicaid and the Children's Health Insurance Program for labs and diagnostic services related to a coronavirus diagnosis. Uninsured individuals are protected because we allowed states the option to pay for these individuals under Medicaid and established a separate funding stream for provider relief to ensure that physicians, hospitals, and other providers are reimbursed for the care that they provide to uninsured patients. We have provided similar protections for Medicare beneficiaries, in addition to increasing access and reimbursement for telehealth services.

We have championed policies that would keep money in American patients' pockets. We allowed high deductible health plans to cover telehealth under the deductible for two years, and we allowed patients to use funds in Health Savings Accounts and Flexible Spending Accounts for the purchase of over-the-counter medical products, including those needed in quarantine and social distancing, without a prescription from a physician.

You have called this hearing today, in part, to celebrate the Affordable Care Act. If it is so comprehensive and working so seamlessly, then why have you called us here to discuss how it has struggled to provide adequate protections for individuals during this pandemic? From what I have heard, states and insurance plans have been able to adapt quickly to ensure flexible yet comprehensive coverage for individuals.

My constituents continue to tell me how unaffordable the Affordable Care Act is. Many of those laid off because of the economic impact of the virus are eligible for a special enrollment period to sign up for an ACA plan or have become eligible for Medicaid. If they are choosing not to enroll, that is probably because of the astronomical cost of doing so.

I would like to make it clear that there is vast, bipartisan support for protecting coverage for individuals with pre-existing conditions. Many of us on our side of the dais have experience with pre-existing conditions in our own families or providing insurance for the employees of their businesses. If there was a real concern about addressing this issue, the Majority would have voted with Republicans on numerous occasions this Congress to support protections for individuals pre-existing conditions. They also could have called a vote on a severability clause bill to ensure that if the Affordable Care Act were struck down, these protections would stand. They have not taken any of these actions.

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.

This hearing is also in direct contrast with the hearing that Chairman Pallone and Chairwoman Eshoo called last December. The hearing notice for the December 19, 2019 hearing stated, "universal healthcare coverage has long been the North Star of the Democratic Party." Their agenda is to pave that road to the North Star—to accomplish one-size-fits-all healthcare coverage. The reality is that one-size-fits all is really one-size-fits-no one.

It is critical that states maintain the flexibility to address the unique needs of their citizens. Forcing every state and every American to fit into the same box will not work. Americans need and deserve to have choices that will work for themselves and their families. They should not have to worry about spending a substantial portion of their income on health insurance to have an unreasonably high deductible such that they fear using the insurance they pay for.

With that, I yield back.

Congress of the United States
Washington, DC 20515

April 3, 2020

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Dear Administrator Verma,

Due to the widespread disruption in the lives and livelihoods of Americans during the COVID-19 outbreak, we request that the Centers for Medicare and Medicaid Services (CMS) allow Americans to enroll in Medicare coverage or coverage through HealthCare.gov during a special enrollment period (SEP).

Most people who are eligible for Medicare coverage are at high risk of serious illness and death from the virus because of their age or underlying health conditions, but the ability to enroll in Medicare has been severely impeded because of the outbreak. Additionally, a record number of Americans are currently seeking unemployment insurance after losing their jobs and their employer-sponsor health insurance. During this public health emergency, your agency must make enrolling in health coverage as fast and easy as possible so that all Americans can access COVID-19 testing and treatment.

For eligible Medicare enrollees, on March 17, 2020,¹ the Social Security Administration closed Social Security offices to the public, and Social Security staff are only processing “dire need” requests, which does not include Medicare applications, despite the General Enrollment Period (GEP) ending on March 31st. The public is instead being told to contact Social Security’s 1-800 number for other issues, adding a barrier to enrollment by the deadline.

Eleven states and the District of Columbia have already announced special enrollment periods for their health insurance Marketplaces due to the COVID-19 outbreak.² Today, 38 states rely on the federal government and need CMS to declare a special enrollment period so individuals can enroll in coverage through HealthCare.gov. As more Americans lose their employer-sponsored health insurance and face serious economic insecurity, they would benefit immensely from enrolling in low-cost, high quality Marketplace coverage. While the Administration has indicated that it will not reopen the site for a special enrollment period,³ that decision contradicts CMS’s previous efforts to offer special enrollment periods during natural disasters. It is imperative that CMS allow

¹ <https://www.ssa.gov/news/press/releases/2020/#3-2020-2>

² California, Colorado, Connecticut, District of Columbia, Maryland, Massachusetts, Minnesota, Nevada, New York, Rhode Island, Vermont, and Washington have announced special enrollment periods for COVID-19.

³ <https://www.politico.com/news/2020/04/01/trump-obamacare-coronavirus-160732>

American families the fast and easy opportunity to enroll in affordable coverage during a special enrollment period.

To ensure that all Americans have the time and opportunity to enroll in health insurance, I urge you to do the following:

1. **Extend the Medicare General Enrollment Period.** The Medicare GEP ended on March 31st. Because of the circumstances of the outbreak, many individuals who need to enroll in Medicare were not able to do so by the March 31st enrollment deadline. CMS should extend the GEP until after the end of a federal or state emergency declaration with respect to COVID-19.
2. **Offer a special enrollment period on HealthCare.gov.** Uninsured Americans need to have the streamlined option of a special enrollment period to access the plans offered on HealthCare.gov during this public health emergency. CMS should immediately offer a special enrollment period to allow Americans to enroll in high quality, low cost insurance coverage.

We urgently request that you do everything within your authority to extend enrollment periods for Medicare and HealthCare.gov so every American, regardless of age and employment status, can have access to health insurance during this public health emergency.

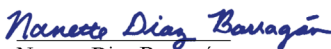
Most gratefully,



Anna G. Eshoo
Chairwoman
Subcommittee on Health



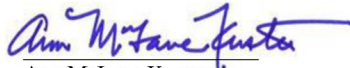
Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce

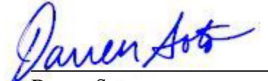


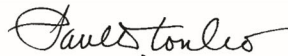
Nanette Diaz Barragán
Member of Congress



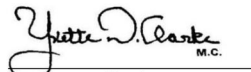
Ben Ray Luján
Member of Congress

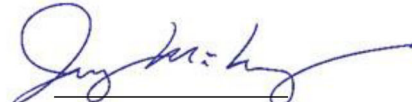

Ann McLane Kuster
Member of Congress

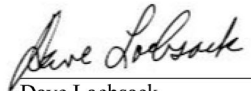

Darren Soto
Member of Congress

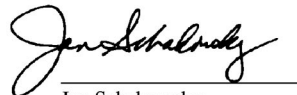

Paul D. Tonko
Member of Congress


G. K. Butterfield
Member of Congress


Yvette D. Clarke
Member of Congress


Jerry McNerney
Member of Congress

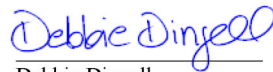

Dave Loebsack
Member of Congress


Jan Schakowsky
Member of Congress


Doris Matsui
Member of Congress

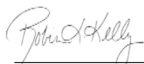

Bobby L. Rush
Member of Congress


Peter Welch
Member of Congress

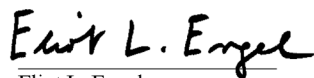

Debbie Dingell
Member of Congress


Joseph P. Kennedy, III
Member of Congress

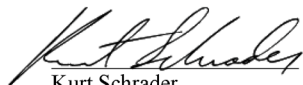

Lisa Blunt Rochester
Member of Congress



Robin Kelly
Member of Congress



Eliot L. Engel
Member of Congress



Kurt Schrader
Member of Congress



Diana DeGette
Member of Congress



Mike Doyle
Member of Congress



Kathy Castor
Member of Congress



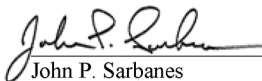
A. Donald McEachin
Member of Congress



Raul Ruiz, M.D.
Member of Congress



Scott H. Peters
Member of Congress



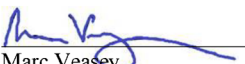
John P. Sarbanes
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Tom O'Halleran
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The Honorable Anna G. Eshoo
Chairwoman, Health Subcommittee
Energy and Commerce Committee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairwoman Eshoo:

On behalf of the 35,000 members of American Federation of State, County and Municipal Employees (AFSCME) Council 57, I applaud you for holding a hearing on “Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic.” I request that this letter be including in the hearing record.

AFSCME Council 57 Local 101 members who work at the Santa Clara Valley Water District, Scotts Valley Water District and Lorenzo Valley Water District provide safe, clean water for Silicon Valley, Santa Cruz, and surrounding areas. Our Local 829 members make Menlo Park happen. The nearly 5,000 health and social service professionals’ members of Local 2620 across the state, are on the front lines helping families and communities build resilience during this unprecedented time of crisis. As many shelter-in-place, Council 57 members are at work on the front lines. They are bus drivers taking essential worker to their jobs, clinic nurses serving the uninsured, food service workers making sure students don’t go hungry, pulmonary rehabilitation therapists at Sequoia Hospital and social workers putting their lives at risk to support our communities and protect those in need during this economic, environmental and health crisis.

For Council 57 members, their work is not just a job, it is a calling. For example, Francesca Salazar, a Licensed Clinical Social Worker, who works at a Parole Outpatient Clinic. She and her co-workers help paroles with serious mental health and medical conditions. Because of the budget shortfalls in California, her job, and the very existence of Parole Outpatient Clinics across the state were on the chopping block. For now, the vital mental health services she and others provide the state’s parolee population will continue. But the future is not certain given the increasing drop in state and local revenues.

Not all Council 57 members and the work they do have been spared. A few hundred of our members have been laid off. They work at cities, healthcare facilities, and school districts. No job is untouchable. But there are no guarantees because the steep drop in city, county and state revenues are widening holes in budgets. Furthermore, many of the anticipated layoffs have

not occurred but only due to large vacancy rates at many of these places, furloughs that have been enacted, hiring freezes that have been implemented, and negotiated early retirements.

Workers who have seen their family income drop because of lay-offs and reduced hours can find some peace of mind in knowing that their family will still be able to see a doctor, get a COVID-19 test and if needed hospital care thanks to the Affordable Care Act (ACA) and California's expansion of Medi-Cal through the ACA. California's decision to have a special enrollment period for the ACA has been a game changer in the lives of those who have lost their health care coverage when they lost their jobs during the pandemic or have been impacted by the wild fires. The ACA and Medi-Cal are truly a lifeline during these difficult and uncertain times.

Chairwoman Eshoo we thank you for leading role in developing and championing the Heroes Act (H.R. 6800) and its nearly \$1 Trillion in much needed flexible funds for states, counties, and cities. The Heroes Act would also provide our state and counties with new federal funds by increasing the federal share for Medi-Cal by a total of 14 percentage points starting July 1, 2020 through June 30, 2021. Counties in California are required to fund part of the non-federal share of Medicaid so when the federal government pays more of Medicaid costs it reduces Medicaid costs for our county. These additional federal dollars can help keep Council 57 members on the job providing the services our communities' needs. These additional federal dollars make sure those who enroll in Medicaid do not see a cut back in their care or needed services. During this time of high unemployment, adding new federal Medicaid money to our county will also lift our local economy.

This relief is desperately needed if we are to get through COVID-19, wildfires, and the economic fallout from these emergencies. We urge you to keep fighting to help fund the workers on the frontlines of COVID-19 and providing the public services our community needs. Our members are ready to do what needs to be done to help our communities stay healthy, safe and to rebuild our economy. The challenges of COVID-19, wildfires, and threat of pink slips is not stopping Council 57 members from rolling up their sleeves and doing what needs to be done without hesitation. But they need Congress to give them the resources they need to do their jobs.

Sincerely,



Charles E. Allen
Executive Director
AFSCME Council 57

Statement for the Record

**Margaret A. Murray, Chief Executive Officer
Association for Community Affiliated Plans**

for the

**House Energy and Commerce Health Subcommittee Hearing
entitled**

“Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic”

September 23, 2020



Association for Community Affiliated Plans

1155 15th Street, N.W., Suite 600 • Washington, DC 20005

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Christopher D. Palmieri, Chair • Margaret A. Murray, Chief Executive Officer

The Association for Community Affiliated Plans¹ (ACAP) would like to thank Chairwoman Eshoo, Ranking Member Burgess and the members of the Energy and Commerce Health Subcommittee for the opportunity to submit this statement for the record for the Subcommittee hearing entitled, “Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic.”

The COVID-19 pandemic is an unprecedented event in the history of our nation’s health care and public health systems, and as such it has and will continue to result in an unprecedented and unpredictable strain on the resources for all stakeholders of the United States health care system. To date, more than 6.7 million Americans have contracted the virus and nearly 200,000 Americans have died from it. Unfortunately, the virus has had a disproportionate impact on low-income populations, communities of color, and those Americans with multiple comorbidities – the exact people that Safety Net Health Plans are dedicated to serving.

At the same time, the Affordable Care Act (ACA) has provided tens of millions of Americans with access to health coverage through the health insurance marketplaces, the Medicaid expansion, and other coverage options. ACAP was proud to support the ACA and continues to work to ensure that the legislation works for all Americans.

¹ The Association for Community Affiliated Plans (ACAP) is a national trade association representing 77 not-for-profit Safety Net Health Plans (SNHP). Collectively, ACAP plans serve more than 20 million people through Medicaid, Medicare, the individual Marketplaces, and other publicly-supported coverage programs, including one-third of all individuals covered in Medicaid managed care. Our mission is to support our member plans’ efforts to improve the health and well-being of people with low incomes and with significant health care needs.



Medicaid has Protected Millions of Americans During the Pandemic

The pandemic has shown exactly why the ACA is so vitally necessary and why Congress, the states, and the Administration need to protect it at all costs. According to a study published in *Health Affairs*² based on research from the University of Minnesota, more than 2.3 million adult Americans in 26 states turned to the Medicaid program for coverage between March and May of this year. This growth in coverage comes from people losing jobs as well as a general uptake in coverage. It should be noted that this is not a “blue state” phenomenon – among “Medicaid expansion states,” Kentucky and Indiana showed the biggest per capita increases in Medicaid enrollment. Among non-Medicaid expansion states, Florida had the largest per capita increase in new Medicaid enrollees. In short, Medicaid coverage protects Americans in all states.

And there is little doubt that enrollment has increased significantly in the four additional months since May. Many of these newly covered Americans would have no coverage options at all were it not for the ACA’s Medicaid expansion. Likewise, the refusal of some states to take up the Medicaid expansion has now left millions of unemployed residents of those states uninsured and unable to access coverage and, in many cases *care*, in the midst of a health care emergency. This is an unnecessary tragedy that risks exacerbating and prolonging the pandemic, including threatening the fragile health care infrastructure (including safety net and rural hospitals) in these states.

² Frenier, Nikpay, and Golberstein, “COVID-19 Has Increased Medicaid Enrollment, But Short-Term Enrollment Changes Are Unrelated To Job Losses,” *Health Affairs*. October 2020.



FFCRA's Maintenance of Effort Requirement Eliminated Medicaid "Churn" That Would Have Cost Americans Coverage during the Pandemic

ACAP was strongly supportive of Congress providing continuous Medicaid eligibility as part of the *Families First Coronavirus Response Act* (FFCRA) passed in March of this year. As a condition for receiving an enhanced federal matching rate (FMAP) bump, states had to commit to maintaining coverage for people on Medicaid through the duration of the public health emergency. This is exactly the right thing to do. In fact, this protection should be extended permanently to all Medicaid and CHIP enrollees in the program on a year-to-year basis. By providing 12-month continuous eligibility, Congress can reduce Medicaid and CHIP eligibility "churn" – the loss of coverage due to slight changes in income (for example, from working overtime) or bureaucratic paperwork often intended to disenroll eligible enrollees for state budgetary purposes. Eligibility churn is a consistent barrier to stable coverage and care in Medicaid and CHIP. This year several state Medicaid directors have said that the FFCRA continuous eligibility provision has prevented them from reducing Medicaid rolls – meaning that the FFCRA protected low-income people's coverage when they needed it most. ACAP urges Congress to oppose any efforts to undermine that maintenance of effort requirement as long as Americans are suffering under this pandemic.

More Can be Done to Stabilize Medicaid Coverage



While the Affordable Care Act was an excellent start in providing needed health care protections for Americans, ACAP believes its well past time to build on that excellent foundation. That is why ACAP applauds the House of Representatives for passing the *Patient Protection and Affordable Care Enhancement Act* (ACEA) earlier this year. Among other things, this legislation would provide 12-month continuous eligibility for all Americans in Medicaid and CHIP thanks to the leadership and support of two members of this Subcommittee – Representatives Joe Kennedy and Debbie Dingell –who sponsored H.R. 1879, the *Stabilize Medicaid and CHIP Coverage Act*. We thank them for their efforts on behalf of this important policy.

Importantly, 12-month continuous eligibility aligns Medicaid and CHIP with private and Medicare coverage that provides continuous coverage without constantly screening for coverage eligibility. Such efforts, commonplace in the Medicaid program, create unnecessary hurdles for low-income Americans struggling with limitations of time, limited access to transportation, health literacy, and other challenges. It also is important to recognize that 12-month continuous eligibility would protect children in Medicaid and CHIP. A recent working paper by the George Washington University³ found that Medicaid continuous eligibility would reduce unmet need for specialty care and increase the use of vital preventive care among children, a critical protection to protect them and reduce health care costs in the future.

³ “Continuous Medicaid Eligibility for Children,” Ku, Leighton PhD, MPH and Erin Brantley, PhD, MPH. Working Paper, Milken Institute for Public Health, The George Washington University, May 2020.



Exchange Coverage is a Lifeline during a Public Health Crisis

The ACA also created a new set of market rules for “Exchange” coverage, which have been a lifeline for millions of consumers with preexisting conditions. Such coverage is of paramount importance in the midst of a public health crisis—ensuring consumers with incomes above Medicaid eligibility, or in states that have not expanded Medicaid, are able to purchase coverage that will protect them should they contract COVID-19. ACAP believes so strongly in the crucial role of health coverage in protecting Americans from the ill effects of COVID-19 that we embarked on a six-figure campaign directing people to find health coverage at healthcare.gov; we sent more than 100,000 people to the site as a result.

The House, and this Committee in particular, has considered various policies that would help mitigate the Administration’s efforts to undermine the ACA, and we applaud you for bringing continued light to such issues in today’s hearing. Specifically, we have long supported the need for a Special Enrollment Period (SEP) for uninsured and underinsured consumers—something which many State Based Exchanges moved forward with to great success and which the Administration has historically implemented for individual states during emergencies, yet chose not to do during a declared National Public Health Emergency. We still believe an SEP is appropriate and furthermore we believe a longer Open Enrollment for the 2021 period is appropriate. This will give plans adequate time and resources to enroll the millions of newly uninsured consumers as well as to ensure that any consumers who are struggling financially and terminated for nonpayment of



premiums during the last month of the year are able to purchase new insurance for 2021. While this Administration did provide flexibility for issuers to allow consumers longer than the usual 90 day grace period during the emergency, as a result many consumers may lose their coverage after the auto-reenrollment process for 2021 – ultimately ending their coverage after open enrollment – thus leaving them uninsured for 2021. We believe an extended open enrollment period, or SEP for consumers in this situation, is warranted to address the unintended consequences of the grace period delays.

Additionally, we applaud this Committee’s continued focus on the harms posed to consumers by short-term, limited-duration insurance (STLDI). The Committee’s Oversight and Investigations report⁴ and a recent GAO investigation⁵ detailed the harms posed by such plans and unscrupulous brokers that promote them, oftentimes deceiving consumers into purchasing coverage that will not protect their pre-existing condition needs. As lead plaintiff challenging the Administration’s 2018 rule expanding STLDI coverage to compete with individual market Qualified Health Plans, we support the House’s efforts to ensure such plans are used only for their intended purpose—filling short gaps in coverage. We have already seen examples of STLDI plans trying to get out of paying for potential COVID-related services, and COVID simply presents yet another pre-

⁴ “Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk,” US House of Representatives House Committee on Energy and Commerce Subcommittee on Health and Subcommittee on Oversight and Investigations Democratic Staff Report, June 2020.

⁵ “Private Health Coverage: Results of Covert Testing for Selected Offerings,” US Government Accountability Office, August 24, 2020.



existing condition for which such plans can deny future coverage to the millions of people with long-term COVID-related illness or complications. We thank this Committee and the House of Representatives for their continued efforts to limit the duration of STLDI offerings and ensure consumers with STLDI coverage are not left holding the bag when it comes to COVID-related testing and treatment.

Conclusion

As this pandemic is showing, strong and stable coverage is essential to combat the coronavirus and provide Americans with the coverage they need to stay healthy and be productive members of society. ACAP applauds House passage of both the *Health and Economic Recovery Omnibus Emergency Solutions Act* (HEROES Act) and the ACEA, which address so many of the important issues raised above that would protect millions of Americans during the COVID-19 crisis.

In short, the ACA in general, and the Medicaid expansion for low-income adults in particular, has been a lifeline to people with low incomes, communities of color, and the suddenly-unemployed and uninsured during this pandemic. Now is not the time to pull back on the commitments of the ACA, including the Administration's unconscionable support of the *Texas v. California* lawsuit that could repeal the ACA in its entirety. We appreciate the efforts the House has made to protect the vital strides that the ACA has made. Now it is time for Congress to take the next steps toward



protecting that coverage and making it stable for those who need it the most—both during the COVID-19 pandemic and beyond.

Again, thank you for the opportunity to submit this statement for the record. We are happy to respond to any questions the Subcommittee may have.



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

August 24, 2020

The Honorable Robert P. Casey, Jr.
Ranking Member
Special Committee on Aging
United States Senate

The Honorable Debbie Stabenow
United States Senate

Private Health Coverage: Results of Covert Testing for Selected Offerings

Millions of Americans obtain health insurance coverage in the individual market, which consists mainly of private plans sold directly to consumers without access to group coverage. While generally regulated by states, starting in 2014, the Patient Protection and Affordable Care Act (PPACA) established a number of new federal requirements for individual health insurance coverage. For example, PPACA prohibited insurers from excluding coverage or charging higher premiums for pre-existing conditions and required that individual market plans cover a set of essential health benefits, including coverage for mental health and substance abuse disorder services, prescription drugs, and maternity and newborn care.¹

Certain types of health coverage arrangements that can be sold directly to consumers do not have to comply with some or all of PPACA's individual market requirements and, as a result, may be less expensive, but also offer more limited benefits compared to PPACA-compliant plans. For example, short-term, limited-duration insurance (STLDI), which was primarily designed to fill gaps in coverage, is excluded from the definition of individual health insurance under federal law and is therefore generally not subject to PPACA's requirements for the individual market.

¹Pub. L. No. 111-148, §§ 1201, 1302, 124 Stat. 119, 154, 163 (2010).

Recent changes to federal law and regulations could result in the increased use of PPACA-exempt health coverage arrangements as alternatives to PPACA-compliant plans in the individual market.² For example, in 2018, federal regulations expanded the availability of STLDI plans, a type of PPACA-exempt arrangement. In addition, as of January 1, 2019, individuals who fail to maintain “minimum essential coverage,” as required by PPACA, no longer face a tax penalty.³ Further, the devastating economic effects of the Coronavirus Disease 2019 (COVID-19) pandemic could create additional demand for affordable health coverage, including PPACA-exempt plans.

With these changes, and because of their lower relative costs, PPACA-exempt health coverage arrangements may be attractive to consumers, particularly those who find it difficult to afford PPACA-compliant plans. However, such arrangements generally do not need to follow PPACA’s requirement that plans in the individual market be presented to consumers in defined categories outlining the extent to which they are expected to cover medical care. As a result, depending on how they are marketed and sold, PPACA-exempt arrangements could present risks for consumers, if, for example, they buy them mistakenly believing that coverage is as comprehensive as for PPACA-compliant plans. Several states have raised concerns that insurance agents and brokers (hereafter referred to as sales representatives) may try to sell PPACA-exempt arrangements to consumers regardless of their suitability for the individual—for example, to those with pre-existing conditions that would not be covered—or mischaracterize the health coverage offered because of financial incentives.⁴

You requested that we obtain insights on the marketing and sales practices of insurance sales representatives who sell PPACA-exempt plans. In this report, we describe the results of covert tests we conducted involving selected sales representatives (as described below), when contacted by individuals stating that they had pre-existing conditions.

In this regard, we performed a number of covert tests (i.e., undercover phone calls) from November 2019 through January 2020, posing as individuals needing to purchase health insurance to cover pre-existing conditions. Specifically, we performed 31 covert tests to selected sales representatives and stated that we had pre-existing conditions, such as diabetes or heart disease, and we requested coverage for these conditions to see if the sales representative directed us to a comprehensive PPACA-compliant plan, or a PPACA-exempt plan that does not cover what we requested. The results of our covert testing are illustrative only of the sales and related behaviors we experienced during the calls and are not generalizable to any specific insurance brokerage or agency, state, or the PPACA-exempt health insurance industry at large.

²For the purposes of this report, we are defining PPACA-exempt as including health coverage arrangements that do not comply with PPACA’s individual health care market requirements, such as STLDI and limited benefit plans, depending on how they are sold. We are also including arrangements whose health coverage provisions are not explicitly addressed in federal law, such as health care sharing ministries.

³PPACA required that most individuals maintain “minimum essential coverage” or pay a tax penalty. Health insurance that meets the definition of “minimum essential coverage” includes certain types of government-sponsored coverage (such as Medicare Part A or most Medicaid coverage) as well as most types of private insurance plans that provide benefits consistent with the law, but does not include coverage that provides limited benefits. Legislation enacted in 2017 reduced this tax penalty to \$0, effective January 1, 2019. Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017).

⁴Agents and brokers are generally paid by insurers and may sell products for one issuer from which they receive a salary, or from a variety of insurers and be paid a commission for each plan they sell. We use the term “sales representatives” in this correspondence to capture a variety of job titles that we encountered during our covert tests, including brokers, agents, call screeners, and compliance personnel.

As part of these tests, we gauged whether sales representatives engaged in potentially deceptive practices, such as making false or misleading statements about coverage or omitting material information about coverage. To do this, we used the Federal Trade Commission's (FTC) definition of deceptive practices to evaluate the marketing practices used during our covert tests.⁵ Deceptive practices are defined in the FTC's *Policy Statement on Deception* as involving a material representation, omission or practice that is likely to mislead a consumer acting reasonably in the circumstances.⁶ For example, given the scenarios we tested, a misleading statement could include instances in which a sales representative said that a plan covered a pre-existing condition when it did not. An example of an omission could include instances in which a sales representative did not disclose that the plan offered would not cover our pre-existing condition after we expressed that we wanted this coverage, among other things. When sales representatives indicated to us that the PPACA-exempt coverage they were selling us would cover our pre-existing condition, we purchased the product to compare its benefits as described in a plan document we obtained with the benefits advertised and described during the covert phone calls.

We made the covert phone calls to representatives in a non-generalizable selection of five states (Alabama, Florida, Kansas, Pennsylvania, and Wyoming) selected for geographic and population-size variation. Given that STLDI plans—a type of PPACA-exempt arrangement—are not available for purchase in some states due to state laws prohibiting them or simply because they are not commercially available, we selected among states that offered STLDI plans. To select sales representatives within a selected state, we performed web searches using search terms such as “affordable health insurance,” and “cheap health insurance,” similar to how typical consumers likely seek out and purchase insurance, in order to create a list of entities from each state. After we created a list of potential entities, we randomly sorted the list for each state and selected different entities for 20 of 31 tests while ensuring variability across the states. For the remaining 11 of 31 tests, we attempted to contact a health insurance provider directly, as opposed to going through a third-party sales representative identified via a web search.⁷ To do this, we identified insurance companies to select for testing using a health insurance consumer-information website that provides a listing of companies that offer STLDI plans among our selected states.⁸

⁵FTC enforces provisions of the FTC Act, including 15 U.S.C. § 45(a), which prohibits unfair or deceptive acts or practices affecting commerce.

⁶Federal Trade Commission, FTC Policy Statement on Deception, October 1983. <https://www.ftc.gov/public-statements/1983/10/ftc-policy-statement-deception>, accessed June 10, 2020.

⁷Although we attempted to select separate entities and to contact and test each of these selected entities only once, it is possible that we contacted and tested the same entity on more than one undercover call. This is because our undercover phone calls were sometimes transferred to multiple parties in the course of a single call, and we could not always identify the entity we ultimately spoke with.

⁸This website is not associated with www.healthcare.gov or the Centers for Medicare & Medicaid Services (CMS), and we did not assess the comprehensiveness of the website, but instead used it to make non-generalizable selections of insurers. As mentioned, this selection of insurers is not intended to be a representative sample of insurers.

The 2020 Open Enrollment Period (OEP) for individual health insurance coverage sold through the federally facilitated exchange⁹ ran from November 1, 2019, to December 15, 2019. We performed 16 of the 31 tests during the 2020 OEP as most individuals apply for and enroll in health insurance plans offered on the exchanges required by PPACA during this time. Performing tests during this time helped to ensure our testing closely resembled the experience most individuals have when purchasing insurance. The remaining tests (15 of 31) were conducted outside of the OEP to assess examples of marketing practices used in both time periods. For tests conducted outside of the OEP, we explained during those phone calls that we had recently moved to a new state so that we would trigger a PPACA Special Enrollment Period, and therefore, would be eligible to purchase a PPACA-compliant plan.¹⁰

Finally, to discuss the marketing and oversight of PPACA-exempt arrangements, we met with senior officials from federal agencies, including the FTC, and Centers for Medicare & Medicaid Services (CMS)¹¹ within the Department of Health and Human Services, as well as the National Association of Insurance Commissioners (NAIC).¹²

We conducted this performance audit from October 2019 to August 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Summary

In summary, the results of the covert tests ranged from sales representatives appropriately explaining to us that a PPACA-exempt plan would not cover the pre-existing condition we stated that we had, to engaging in potentially deceptive marketing practices that misrepresented or omitted information about the products they were selling. Specifically, in 21 of 31 covert tests, the sales representative appropriately referred us to a PPACA-compliant plan. In two of 31 covert tests, the sales representatives did not appear to engage in deceptive marketing

⁹PPACA introduced significant changes to the individual market including how consumers shop for insurance coverage. PPACA directed each state to establish an exchange—referred to as a state-based exchange—or elect to use the federally facilitated exchange established by the Department of Health and Human Services (HHS). The exchanges are marketplaces where individuals can compare and select among plans that meet certain standards offered by participating private issuers licensed to engage in the business of insurance in a state.

¹⁰A Special Enrollment Period is a time outside the yearly OEP when individuals can sign up for health insurance. Individuals qualify for a Special Enrollment Period if they have had certain triggering events, including losing minimum essential health coverage, permanently moving into a new state and therefore gaining access to new Qualified Health Plans, or gaining a dependent through marriage, birth, or adoption. Depending on the Special Enrollment Period type, individuals may have 60 days before or 60 days following the event to enroll in a plan.

¹¹While the business of insurance is primarily regulated by states, we met with CMS due to certain relevant federal requirements. For example, under 45 C.F.R. § 155.220, an agent or broker that assists or facilitates enrollment of individuals in PPACA-compliant plans through a federally-facilitated exchange must be registered with the federally facilitated exchange and comply with certain standards of conduct. Sales representatives who sell PPACA-exempt plans, but do not also facilitate enrollment into PPACA-compliant plans, are not subject to this requirement.

¹²NAIC is the 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. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight.

practices but were not always consistent or clear in their explanation of the type of coverage and plans they were selling. In the remaining eight of 31 covert tests, the sales representatives engaged in potentially deceptive marketing practices, such as claiming our pre-existing condition was covered when the health plan documents we received after purchase said otherwise. We plan to refer these eight cases of potential deceptive marketing practices to the FTC and corresponding state insurance commissioners' offices for follow-up as appropriate.

Background

PPACA-Exempt Health Arrangements

There are several health coverage arrangements that can be sold directly to consumers and do not need to comply with at least some of PPACA's individual market requirements. These include:

- STLDI: Health insurance that is primarily designed to fill temporary gaps that may occur when an individual is transitioning from one plan or coverage to another plan or coverage. In August 2018, the Departments of Health and Human Services, Labor, and the Treasury issued a final rule changing the definition of STLDI from coverage that has an expiration date of less than 3 months from its effective date to coverage that has an expiration date of less than 12 months, and that is renewable for no more than 36 months.¹³ STLDI is excluded from the definition of individual health insurance coverage under federal law, and therefore generally does not need to comply with PPACA's individual market requirements.
- Limited benefit plans: Different types of health insurance options that offer limited benefits, also known as "excepted benefits". For example, these include indemnity plans that cover a set dollar amount for limited prescription benefits, hospital stays or physician visits, or plans that offer accident-only coverage, limited scope dental or vision coverage, or coverage for a specified disease. These plans may be combined to mirror more comprehensive coverage, but generally do not need to comply with PPACA individual market requirements, depending on how they are offered.
- Health care sharing ministries: Entities whose members share a common set of religious or ethical beliefs and contribute funds to pay for medical expenses of other members; however, payment for member claims is not guaranteed. Health care sharing ministries in some ways may resemble insurance, but the requirements for what is covered are not explicitly addressed in federal law and typically do not comply with PPACA.¹⁴ In addition, according to NAIC officials, the majority of states have exempted health care sharing ministries from state insurance laws provided they meet certain requirements, and in states where they are not explicitly exempted, states may not regulate them.
- Association health plans (AHP): Health insurance coverage sponsored by a group or association of employers, which may include trade associations who make plans available

¹³83 Fed. Reg. 38,212 (Aug. 3, 2018). The definition of STLDI as coverage that has an expiration date of less than 3 months from its effective date was promulgated in 2016. 81 Fed. Reg. 75,316 (Oct. 31, 2016). Prior to the 2016 rulemaking, STLDI had been defined as coverage that has an expiration date within 12 months from its effective date, but was not renewable past this time. See 62 Fed. Reg. 16,894 (April 8, 1997).

¹⁴While not as common, there are other arrangements that similarly resemble insurance, but are also not explicitly addressed in federal law, such as farm bureau coverage currently offered in three states—Iowa, Kansas, and Tennessee. Farm bureau membership is open to anyone who pays a membership fee.

to their members.¹⁵ While these plans are generally considered group health insurance coverage, historically, AHPs sold directly to consumers under certain circumstances were considered individual health insurance and subject to relevant PPACA requirements.¹⁶ However, in June 2018, the Department of Labor issued a final rule that expanded provisions for determining when employers may join together to offer AHPs, which included self-employed individuals without employees. This would have broadened the types of AHPs that were considered large group insurance and could be sold to the self-employed, meaning such plans would no longer be subject to certain small group and individual market requirements, such as the requirement to cover essential health benefits.¹⁷ However, in March 2019, a federal court vacated this provision of the final rule; however, the Department of Labor has appealed the decision.¹⁸ According to NAIC officials, some states have authorized the sale of certain AHPs that meet the rule's broader definition.

Data on the extent to which consumers purchase PPACA-exempt health coverage arrangements are limited, but generally suggest that use of such arrangements is growing. For example, the most recently available estimate of the STLDI market was about 87,000 covered people in 2018, but these data are based on policies issued before the 2018 final rule that extended the allowed duration for STLDI plans. In October 2019, NAIC issued a data call to better understand the extent of the STLDI market in each state.¹⁹ In another example, while the estimated number of individuals enrolled in health care sharing ministries in 2010 prior to PPACA was less than 200,000, as of 2018 the enrollment is estimated to be about 1 million people.²⁰

Oversight of the Marketing and Sale of PPACA-Exempt Arrangements

Under the McCarran-Ferguson Act, the business of insurance is primarily regulated by states.²¹ Therefore, states are the primary regulators of private health insurance, including the marketing and sale of PPACA-exempt health coverage arrangements. As such, each state sets its own standards for most PPACA-exempt arrangements and licenses and oversees insurers, and third-party sales representatives that sell such arrangements in their state. According to NAIC officials, state insurance commissioners may take enforcement actions against insurers and

¹⁵Association health plans are formed under the authority of the Employee Retirement Income Security Act of 1974. This Act authorizes some employer associations to qualify as "employers" for the purpose of sponsoring an employee benefit plan, such as a plan that offers medical, surgical, or hospital care or benefits, so long as the group or association of employers acts "in the interest of an employer." 29 U.S.C. § 1002.

¹⁶Centers for Medicare & Medicaid Services, *Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations*, (Baltimore, MD.: September 2011).

¹⁷83 Fed. Reg. 28,912 (June 21, 2018).

¹⁸New York v. Dep't of Labor, 363 F. Supp. 3d. 109 (D.D.C. 2019), *appeal docketed*, No. 19-5125 (D.C. Cir. Apr. 30, 2019).

¹⁹For the 2018 estimate see National Association of Insurance Commissioners, *2018 Accident and Health Policy Experience Report* (NAIC, 2019).

²⁰See K. Lucia, J. Giovannelli, S. Corlette 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

²¹Pub. L. No. 79-15, 59 Stat. 33 (1945), codified as amended at 15 U.S.C. §§ 1011 - 1015.

sales representatives that engage in deceptive marketing practices, such as by suspending or revoking their license to sell insurance.²²

FTC and CMS also have a more limited role in overseeing the marketing and sale of PPACA-exempt arrangements. Specifically, FTC enforces provisions of the FTC Act, including 15 U.S.C. § 45(a), which prohibits unfair or deceptive acts or practices affecting commerce.²³ Under the law, FTC's jurisdiction in this area includes instances where entities sell health care arrangements, but are not themselves engaged in the business of insurance—such as business associations that may offer health insurance plans to their members, but are not themselves engaged in the business of insurance.²⁴ Similarly, federal regulations require sales representatives that assist or facilitate enrollment in PPACA-compliant plans sold through the www.healthcare.gov website to provide consumers with correct information,²⁵ without omission of material fact, and refrain from marketing or conduct that is misleading.²⁶ However, sales representatives who sell PPACA-exempt plans, but do not also facilitate enrollment into the PPACA-compliant plans sold through www.healthcare.gov, are not subject to this requirement. Although CMS does not provide oversight of PPACA-exempt plans, officials told us that the agency works with state insurance commissioners to confirm that insurance sales representatives listed on www.healthcare.gov—which can include those that sell both PPACA-compliant and PPACA exempt plans—have an active state license to sell insurance.

Covert Tests Identified Potentially Deceptive Marketing Practices by Some Insurance Sales Representatives

The results of our 31 covert tests—all of which included individuals requesting coverage for pre-existing conditions—ranged from insurance sales representatives appropriately explaining that a PPACA-exempt plan would not cover the pre-existing condition, to engaging in potentially

²²According to NAIC officials, states may exempt policies issued by out-of-state associations from some or all of their market standards. Specifically, in out-of-state associations—which are separate from AHPs—insurers file plans for approval in one state and sell the same plans in other states, which may lack authority to regulate such associations. Where associations are exempt from standards, they are regulated by the state of approval, rather than the state in which consumers' purchase coverage.

²³An "unfair" act or practice is one that is likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition, whereas a "deceptive" act or practice is one involving a material representation, omission or practice that is likely to mislead a consumer acting reasonably in the circumstances. For purposes of this report, we focus on deceptive acts or practices because of the results of our covert tests.

²⁴Specifically, those activities that constitute the "business of insurance" are exempted from the FTCs jurisdiction, but only to the extent that such activities are regulated by state law. 15 U.S.C. § 1012(b).

²⁵Sometimes called the "health care exchange," www.healthcare.gov is a federal government website managed by CMS. The website allows users to enroll in PPACA-compliant plans and apply for various marketplace insurance options.

²⁶45 C.F.R. § 155.220(j)(2). An agent or broker that assists or facilitates enrollment of individuals in PPACA-compliant "qualified health plans" through a federally facilitated exchange or state-based exchange on the federal platform must be registered with the federally facilitated exchange and comply with certain standards of conduct. These standards include the requirement that the individual or entity "must provide consumers with correct information, without omission of material fact, regarding the federally facilitated Exchanges, [PPACA-compliant plans] offered through the federally facilitated exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading (including by having a direct enrollment Web site that the Department of Health and Human Services determines could mislead a consumer into believing they are visiting HealthCare.gov)."

deceptive marketing practices that omitted or misrepresented information about the products they were selling. Specifically,

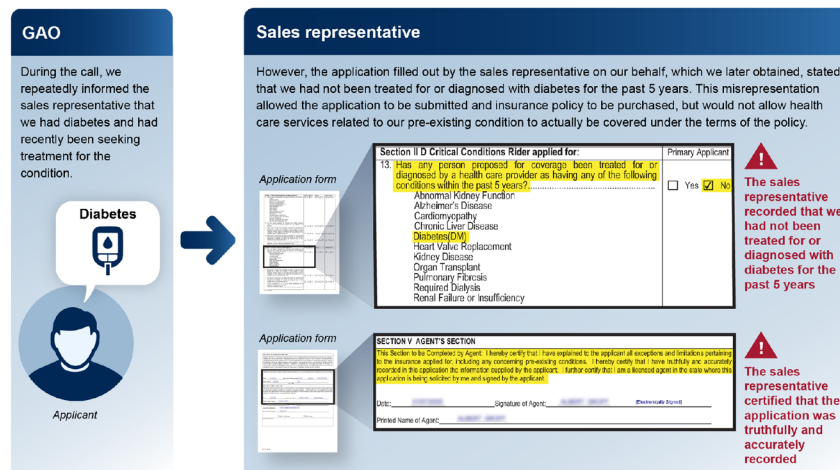
- In 21 of 31 covert tests, the sales representatives appropriately referred us to PPACA-compliant plans. In these instances, the representatives typically referred us to the federal government's PPACA health care exchange.
 - For example, one sales representative stated that a PPACA plan would be a better option for us and recommended that we contact the federal PPACA exchange for coverage required for our pre-existing condition. The representative told us that plans sold by him lacked coverage for our condition, which in this case was diabetes. The representative further told us that our condition would disqualify us from a short-term health plan and also informed us that our condition would not be covered in the event that anyone else tried to sell us such a plan.
- In two of 31 covert tests, the sales representatives did not appear to engage in deceptive marketing practices, but the representatives were not always consistent or clear in their explanation of the type of coverage and plans they were selling.
 - For example, one sales representative recommended a PPACA plan due to the pre-existing condition that we stated we had and told us that the plan also included an accidental and critical illness benefit to cover the financial gap that could be created by the plan's deductible and high out-of-pocket maximum, as well as a basic dental plan. Information we later obtained from the representative showed that the PPACA plan was free of cost due to our stated income, and that 100 percent of the price the representative quoted during the call was for the additional gap coverage and dental plans. The sales representative had not clearly disclosed that we could obtain comprehensive PPACA coverage at no cost, nor did he clarify that the additional coverage he sold us was optional and would cost additional money until we specifically requested this information and spoke to the representative in a follow-up phone call made after reviewing the documents we obtained. The representative explained that this optional coverage provided value at a cost that was significantly less money than our stated monthly budget.
- In the remaining eight of 31 covert tests, the sales representatives engaged in potentially deceptive marketing practices while we were posing as customers with pre-existing conditions, by omitting or misrepresenting information about the products they were selling.²⁷ While conducting the covert tests, we were provided with applications containing terms and disclosures about the purchase that we were required to sign electronically. However, the oral descriptions provided by the sales representatives did not always align with these terms and disclosures. We plan to refer these eight cases of potential deceptive marketing practices to the FTC and corresponding state insurance commissioners' offices as appropriate.

²⁷In performing our 31 covert tests, we purchased a total of eight limited benefit health insurance plans and one health care sharing ministry membership across nine tests. For further details on the covert tests and the products we purchased, see Enclosure.

- For example, one sales representative told us that we were purchasing a comprehensive health insurance plan, but instead sold us two limited benefit insurance plans. During the call, we repeatedly informed the sales representative that we had diabetes and had recently been seeking treatment for the condition. However, the application filled out by the sales representative on our behalf, which we later obtained, stated that we had not been treated for or diagnosed with diabetes for the past 5 years. This indicates that the broker may have intentionally falsified information on the application, which allowed the application to be submitted and the insurance policy to be purchased, but would not allow health care services related to our pre-existing condition to actually be covered under the terms of the policy. Figure 1 illustrates where the sales representative falsified information on our application. Further, during this call, the sales representative told us that the plan's pre-existing condition limitations only applied to people who were pregnant or had cancer, but plan documents we later obtained as part of our purchase showed that pre-existing condition limitations would also apply to treatment for diabetes.

Figure 1: Illustration of Falsified Information on Application for Insurance

Sales representative may have intentionally falsified information on the application



Source: GAO analysis of covert phone call and application materials. | GAO-20-634R

- In another example, a sales representative for another company told us multiple times that the plan would cover our diabetes and necessary medication, including insulin. However, plan documents we obtained after purchase stated that pre-existing conditions and prescription drug costs were not covered by the plan. While the sales representative acknowledged the plan was not comprehensive, the representative described it as a typical health insurance plan similar to coverage offered by employers. However, the representative sold us a limited benefit health insurance supplement and a vision and dental discount program,

which we had not sought. Additionally, when we asked the name of the insurance carrier, the representative instead told us the name of the plan itself instead of the insurance company.

While the results of our covert tests cannot be generalized to all sales representatives, any particular state, or the PPACA-exempt health care industry at large, they illustrate how sales representatives in some cases engaged in potentially deceptive marketing practices that could lead a consumer to make poor decisions with the potential to incur significant and unexpected costs if plans purchased do not meet their health coverage needs. The enclosure provides additional details on each of the 31 covert tests we performed. To view selected video clips of these covert tests, go to <https://www.gao.gov/products/GAO-20-634R>.

Agency Comments

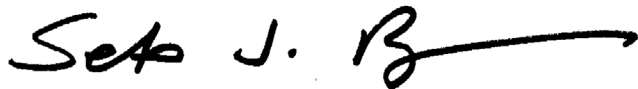
We provided a draft of this product to FTC, HHS, and NAIC for comment. FTC, HHS, and NAIC provided technical comments that we incorporated as appropriate. HHS also provided written comments, which are attached as enclosure II.

In its comments, HHS stated that it plans to conduct a review of sales representatives who we identified as engaging in potentially deceptive marketing practices to determine whether they are registered with the PPACA federal exchange and take action as appropriate. HHS also described steps it takes to validate the state licenses of sales representatives who are registered to work with the exchange and noted that these sales representatives sign agreements that prohibit them from providing misleading or false information to consumers or to the exchange. HHS also stated that STLDI plans offer another option for consumers facing rising costs of PPACA-compliant plans and noted our finding that sales representatives we identified as engaging in potentially deceptive marketing practices did not offer or sell STLDI plans. With the scope of our review, we did not evaluate HHS's efforts to validate the selected sales representatives' licenses or assess health insurance costs and other factors that may lead individuals to select STLDI or other PPACA-exempt plans.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to appropriate congressional committees, the Chairman of the Federal Trade Commission, the Administrator of CMS, the Chief Executive Officer of the National Association of Insurance Commissioners, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions concerning this report, please contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov, or Howard Arp at arpj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report were Robert Graves (Assistant Director), Jonathon Oldmixon (Assistant Director), Scott Clayton (Analyst-in-Charge), Barbara Lewis, Maria McMullen, James Murphy, George Ogilvie, Ramon Rodriguez, Daniel Silva, Rachel Svoboda, and Elizabeth Wood.

A handwritten signature in black ink that reads "Seto J. Bagdoyan". The signature is stylized, with a long horizontal line extending from the end of the name.

Seto J. Bagdoyan
Director of Audits; Forensic Audits and Investigative Service

A handwritten signature in black ink that reads "Howard Arp". The signature is written in a cursive, flowing style.

Howard Arp
Director of Investigations; Forensic Audits and Investigative Service

Enclosures – 2

Enclosure 1

The table below describes the results of 31 covert tests (i.e., undercover phone calls) we performed from November 2019 through January 2020, posing as individuals needing to purchase health insurance to cover pre-existing conditions. For tests performed outside the federal health insurance exchange 2020 open enrollment period of November 1, 2019 – December 15, 2019, we explained that we had recently moved to a new state so that we would trigger a Patient Protection and Affordable Care Act (PPACA) Special Enrollment Period, and therefore, would be eligible to purchase a PPACA-compliant plan. During these covert tests, we stated that we had pre-existing conditions, such as diabetes or heart disease, to see if the sales representative would direct us to a comprehensive PPACA-compliant plan, or to a PPACA-exempt plan that does not cover what we requested. As part of these tests, we observed whether sales representatives engaged in potentially deceptive practices, such as making false or misleading statements about coverage or omitting material information about coverage. The results of our covert testing are presented below by test outcome and are illustrative only and not generalizable to any specific insurance brokerage or agency, state, or the PPACA-exempt health insurance industry at large.

Table 1. Results of Covert Phone Tests to Insurance Sales Representatives When Contacted by Individuals Claiming to Have Pre-existing Conditions

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
1	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease ^a	No coverage purchased	 The sales representative appropriately referred us to a Patient Protection and Affordable Care Act (PPACA)-compliant plan. Specifically, during the call, the sales representative stated that a short-term insurance plan would not provide coverage for us due to our pre-existing condition. The representative further explained the steps we should take to obtain the proof necessary to qualify for a Special Enrollment Period in order to buy a PPACA-compliant plan outside of open enrollment.
2	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative told us PPACA plans covered pre-existing conditions, compared the benefits and costs of several options, and emailed us a summary of benefits to review.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
3	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The representative told us that we would not qualify for short-term health insurance because of our pre-existing condition. The representative told us a PPACA plan would provide coverage for our pre-existing condition, noted that our recent move to a different state would qualify us to obtain PPACA coverage outside the open enrollment period, and provided us with contact information for the PPACA federal exchange.
4	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative recommended we consider a PPACA plan first to cover our pre-existing condition and told us the plans he sold would not cover our pre-existing condition until after 12 months.
5	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative recommended a PPACA plan that would cover our pre-existing condition and informed us that we were eligible to receive federal subsidies that would lower the cost of our monthly premium due to our stated low income. A different representative we spoke with during the call also informed us that non-PPACA plans would not cover our pre-existing condition.
6	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative informed us that we qualified for federal PPACA subsidies due to our stated low income and stated that, unlike short-term plans, PPACA plans could not disqualify us because of our pre-existing condition. The representative also compared the benefits and costs of several options, and emailed us written information to review.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
7	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative stated that he could sell us a short-term plan, but he wanted to ensure we found a plan that covered our pre-existing condition and provided us with contact information for the PPACA federal exchange.
8	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative explained that short-term insurance wouldn't cover our pre-existing condition and recommended we contact the PPACA federal exchange for a health insurance plan that would cover it.
9	Test performed during the federal health insurance exchange 2020 open enrollment period, with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with said we would not qualify for the plans offered due to our pre-existing condition and provided us with PPACA federal exchange contact information for a plan that would cover it.
10	Test performed outside the federal health insurance exchange 2020 open enrollment period, with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with explained that our recent move qualified us to enroll in a PPACA-compliant plan outside of open enrollment and told us to visit the PPACA federal exchange web site.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
11	Test performed during the federal health insurance exchange 2020 open enrollment period, with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with informed us that we may qualify for a federal subsidy if we enrolled for a PPACA plan through the federal exchange and provided us information on how to contact the exchange.
12	Test performed outside the federal health insurance exchange 2020 open enrollment period, with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with said that she did not recommend a short-term plan due to our pre-existing condition and told us that a PPACA plan would be the best option for us, explaining that our recent move qualified us to purchase a plan outside of open enrollment.
13	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative told us that we may be eligible for federal subsidies due to our stated low income and advised us to contact the PPACA federal exchange. The representative told us that we would not qualify for a short-term insurance plan due to our pre-existing condition and also informed us that our condition would not be covered in the event that anyone else tried to sell us such a plan.
14	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with informed us that the insurance she sold would not be our best option due to our pre-existing condition and recommended we contact the PPACA federal exchange.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
15	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with recommended that we contact the PPACA federal exchange and explained that we likely would qualify to enroll outside of open enrollment because of our recent move. One sales representative informed us that short-term plans would not be good for us due to our pre-existing condition.
16	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with recommended that we obtain a PPACA plan if we had a pre-existing condition, and assisted us with determining whether we would potentially qualify to receive federal subsidies to help pay for the plan.
17	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative recommended a PPACA plan, stating it would cover pre-existing conditions, and transferred us to a PPACA federal exchange representative.
18	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with provided cost and benefit information for PPACA plans and e-mailed us information about them. The representative did not recommend a short-term plan due to our pre-existing condition.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
19	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative told us that a PPACA plan would cover our pre-existing condition and that short-term plans would not. The representative checked costs and benefits of multiple plans on the federal PPACA exchange, told us that our recent move qualified us to enroll outside of open enrollment, and provided us with contact information for the PPACA federal exchange.
20	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative stated because of our recent move we would likely qualify for a PPACA plan outside of open enrollment, referred us to a PPACA plan specialist due to our pre-existing condition, and told us that while he sold short-term plans, a short-term plan would not immediately cover our pre-existing condition.
21	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative appropriately referred us to a PPACA-compliant plan. The sales representative we spoke with told us the short-term plans she sold did not cover prescription drugs or pre-existing conditions and were not PPACA-compliant, and recommended that we contact the PPACA federal exchange.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
22	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	Limited benefit plan	 The sales representative did not appear to engage in deceptive marketing practices, but was not clear in the explanation of certain information provided to us. The representative accurately described his recommended policy as a non-PPACA indemnity insurance plan and described pre-existing condition limitations that would prevent us from immediately receiving coverage. The representative also provided us with the opportunity to review plan documents for 7 days after signing the application prior to being billed. The representative stated that the prescription discount program he was enrolling us in did not generally cover name brand medications. When we inquired about the potential need for name-brand medications, he told us he would add "prescription coverage" to our plan. However, documents we later obtained indicate that we were enrolled in two non-insurance prescription discount programs, which the representative previously acknowledged would generally not cover name-brand medications. The representative initially stated that he could not speak to whether we would potentially be prescribed name brand medications in the future because he was not a doctor, but in a subsequent phone call told us that it was unlikely. The representative also did not disclose our total cost included a membership that provides individuals with service and product discounts.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
23	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	No coverage purchased	 The sales representative did not appear to engage in deceptive marketing practices, but was not clear in the explanation of the type of plans that were being offered. The customer service representative recommended a PPACA plan due to our pre-existing condition. The representative stated that the plan also included an accidental and critical illness benefit to cover the financial gap that could be created by the plan's deductible and high out-of-pocket maximum, as well as a basic dental plan. Information we later obtained showed that the PPACA plan was free of cost due to our stated income and that 100 percent of the price quoted in the call was for the additional gap coverage and dental plans. However, the representative did not clearly disclose that we could obtain comprehensive PPACA coverage at no cost. He also did not clarify that the additional coverage he sold us was optional and would cost additional money until we specifically requested this information and spoke to the representative in a follow-up phone call made after reviewing the documents we obtained. The representative explained that this optional coverage provided value at a cost that was significantly less money than our stated monthly budget.
24	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	Limited benefit plan	 The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. Specifically, the representative stated the plan would cover our pre-existing condition, but did not inform us that illness resulting from pre-existing conditions would not be covered for 12 months or that there would be a limit on covered doctor's visits. The representative described the plan he was selling as "a national PPO" that was "a type of insurance" but did not make it clear it was not PPACA-compliant insurance.⁹ During the call, the agent denied our multiple requests to provide documentation describing the plan benefits prior to purchase. After purchasing the plan and reviewing plan documents, we found that the representative had sold us a variety of different products – none of which were major medical insurance. These products included a non-insurance prescription discount program, a limited benefit indemnity insurance plan, and a membership that provides individuals with non-insurance services and product discounts.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
25	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	Limited benefit plan	 The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. For example, the representative stated that diabetes was covered by the plan and that our diabetes was not a pre-existing condition. However, documents we later obtained indicated that our diabetes would be considered a pre-existing condition, and would not be covered for 12 months under the limited benefit plan that we were sold. The representative quoted benefits that did not match information in the documents we received. For example, the representative said our coverage included doctors' visits but did not disclose we were limited to three office visits per plan year. Additionally, we were not informed that we were being enrolled and charged monthly for membership in an association that offers discounts and other benefits or that we were enrolling in a limited benefit health insurance plan. Plan documents we later obtained showed that we were also enrolled in two non-insurance prescription discount programs, though the representative did not inform us that this was the case during the call.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
26	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	Limited benefit plan	✖ The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. The representative told us that he was enrolling us into a health plan that was subsidized by the state due to our low income, and that the state required us to purchase supplemental insurance in order to receive these benefits. Moreover, the representative told us that the state subsidy was not available to anyone if they received comprehensive medical insurance. However, when we subsequently asked another representative for clarification on this issue, the representative told us that the state had nothing to do with the product we were purchasing and that the state was not providing any financial assistance. During this call, the initial sales representative also stated that the limited benefit insurance plan he recommended was better than a PPACA plan and quoted benefits that did not match information in the documents we received. For example, the representative stated that the plan would completely cover emergency room visits, but plan documents showed that the plan does not have any benefits for emergency room treatment, and the plan's certificate of coverage does not guarantee the amount we would be required to pay for health care visits that the representative quoted us. The representative also did not inform us that there would be no coverage for our pre-existing condition for 12 months following the effective date of our plan or that the plan would limit us to three physician visits per coverage year. Further, a representative also told us that we would receive free diabetic medication, but we were enrolled in two non-insurance prescription discount programs that would not provide us with our prescription for free. During the call, this representative did not inform us that we were being enrolled in an accidental death and dismemberment policy or joining a small business advocacy, education, and service association. Before completing the purchase, a representative told us that we did not need to read the policy application prior to signing and enrolling because it did not contain information that pertained to our coverage.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
27	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes.	Limited benefit plan	✖ The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. Specifically, the representative told us multiple times that the plan would cover our diabetes and necessary medication, including insulin. However, plan documents we obtained after purchase stated that pre-existing conditions and prescription drug costs were not covered by the plan. While acknowledging that the plan was not comprehensive, the representative described it as a typical health insurance plan similar to coverage offered by employers. However, the representative sold us a limited benefit health insurance supplement and a vision and dental discount program. When we asked the name of the insurance carrier, the representative instead told us the name of the plan itself instead of the insurance company behind it. The representative also would not provide us with documentation describing the plan's benefits prior to our enrollment.
28	Test performed during the federal health insurance exchange 2020 open enrollment period, with the pre-existing condition of diabetes	Health care sharing ministry	✖ The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. The representative falsely referred to the product as an insurance plan that met the PPACA requirements and that was sold by an insurance carrier and did not state that it was a non-insurance health share plan. Unlike a PPACA plan, under this health share plan there is a 12 month pre-existing condition waiting period on inpatient hospitalization. After we provided an income that would allow us to receive subsidies and asked about PPACA coverage, the representative stated that it was difficult to find insurance and available plans in our state, and that the plan he was offering was what was available. However, we independently identified several PPACA plans that were available to our applicant in the state at that time. The representative also told us that we would be required to enroll in the plan prior to receiving documents describing the policy's coverage.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
29	Test performed outside the federal health insurance exchange 2020 open enrollment period, with the pre-existing condition of diabetes	Limited benefit plan	✖ The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. During the call, we repeatedly informed the representatives we spoke with that we had diabetes and had recently been seeking treatment for the condition. However, the application filled out by the representative on our behalf, which we obtained after the call, incorrectly stated we had not been treated for or diagnosed with diabetes for the past 5 years. This misrepresentation allowed the application to be submitted and insurance policy to be purchased, but would not allow health care services related to our pre-existing condition to actually be covered under the terms of the policy. The sales representative described our purchase as one comprehensive health insurance plan, but plan documents we later obtained indicate we purchased two limited benefit insurance plans. Further, during this call, the sales representative told us that the plan's pre-existing limitations only applied to people who were pregnant or had cancer, but plan documents we later obtained showed that pre-existing condition limitations would also apply to treatment for our diabetes for both the critical illness and the wellness and preventive plans we were sold. The sales representative also omitted additional limitations of the products being sold, such as the limited number of primary care visits that would be available to us. Prior to speaking with the sales representative who sold us the health plans, a different representative incorrectly informed us that we would not be able to obtain an PPACA plan, that PPACA coverage was expensive, and that it would serve no purpose to try to find one on our own because other representatives would tell us that PPACA was no longer in effect as of 2020, which was not correct. Specifically, during this call, we told the representative we had recently moved into a new state, indicating that we were likely eligible to enroll in a PPACA plan outside the open enrollment period. The sales representative we later spoke to, however, correctly informed us that moving into a new state qualified us to enroll outside of Open Enrollment. The sales representative also told us that private insurance was a better option due to costs associated with a PPACA plan and recommended a plan he stated had better pricing. The representative did not provide us with written information about his recommended plan prior to enrollment. We were ultimately enrolled in a limited benefit preventative and wellness insurance plan, a limited benefit health insurance supplement, a generic medication prescription plan, and a membership that provides individuals with service and product discounts.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
30	Test performed outside the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of diabetes	Limited benefit plan	✖ The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. For example, during the call, we informed the representative that we had been admitted to the hospital the prior week and suffered from diabetes. In response, the representative told us that his plan's pre-existing condition limitations did not apply to our diabetes because we were healthy and stated that this plan was offered to healthy individuals. However, plan documents we obtained after enrollment indicate that our diabetes would be considered a pre-existing condition under the plan, and plan limitations would apply, because we received medical treatment for it during the previous 90 days. The representative also stated that we could visit a provider an unlimited number of times, but plan documents stated that such visits were limited to three visits every 12 months. The representative also told us that insulin for our diabetes would be covered by the policy, but plan documents state that prescription medication is excluded from coverage. The representative enrolled us in a benefit association offering a limited benefit indemnity insurance plan. The representative would not provide us with documentation describing the plan prior to enrollment, and stated that we had to purchase the plan on the day of our call if we wanted to be guaranteed the quoted price.

Test Number	Covert Scenario	Type of Coverage GAO Purchased	Test Outcome
31	Test performed during the federal health insurance exchange 2020 open enrollment period with the pre-existing condition of heart disease	Limited benefit plan	 The sales representative we spoke with engaged in potentially deceptive marketing practices by misrepresenting and omitting information. The representative was inconsistent on her explanation of the plan, first stating that the plan included discounts that were in effect immediately while covered benefits for our pre-existing condition would not be covered right away, but later stating without qualification that half the cost of pre-existing condition medical visits would be covered by the limited benefit indemnity insurance plan she sold us. According to the plan documents, we would be required to wait 12 months to receive benefits from an illness resulting from our diabetes. During the call, the representative also stated that the PPACA federal exchange agents did not know how insurance works and stated that we could not receive major medical insurance sold by her because we had a pre-existing condition, but noted that the PPACA federal exchange may be a good option for us because it would cover our pre-existing condition. The representative also did not inform us that we were being enrolled as a member in a service and product discount association and that prescription coverage consisted of two non-insurance discount programs. The representative did not provide us with policy coverage documents prior to the enrollment process, stating that we would only receive complete policy details after we had submitted payment.

Source: GAO analysis of covert phone call recordings and associated transcripts. | GAO-20-634R

*The federal health insurance exchange 2020 open enrollment period ran from November 1, 2019, to December 15, 2019, for insurance coverage starting on January 1, 2020. Individuals can enroll in a 2020 PPACA plan after the open enrollment period by qualifying for a Special Enrollment Period due to certain triggering events, including gaining a dependent through marriage, birth, or adoption or permanently moving into a new area and therefore gaining access to new Qualified Health Plans.

^bPreferred Provider Organizations (PPO) are types of health plans that contract with medical providers, such as hospitals and doctors, to create a network of participating providers. PPOs generally allow enrollees to obtain care from any provider, but charge enrollees less if they obtain care from the plans' networks of preferred providers.

Enclosure 2: Written Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

August 6, 2020

Mr. Seto Bagdoyan
Director of Audits
Forensic Audits and Investigative Service
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Bagdoyan:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*PRIVATE HEALTH COVERAGE: Results of Covert Testing for Selected Offerings*" (Job Code 103845/GAO-20-634R).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Sarah C.
Arbes -S

Digitally signed by
Sarah C. Arbes -S
Date: 2020.08.06
17:24:02 -04'00'

Sarah C. Arbes
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED – PRIVATE HEALTH COVERAGE: RESULTS OF COVERT TESTING FOR SELECTED OFFERINGS (GAO-20-634)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report.

HHS is committed to improving access to affordable health coverage. HHS' efforts to expand access to affordable coverage, such as short-term, limited-duration insurance, offer much-needed options, particularly for many middle-class Americans without employer-sponsored coverage who are not eligible for subsidies under the Patient Protection and Affordable Care Act (PPACA). Average benchmark Exchange premiums in states that used HealthCare.gov increased by 62 percent from 2016 to 2020 and, in response, millions of unsubsidized Americans have fled the PPACA-compliant individual market;¹ over one million unsubsidized people left the market in 2018 alone.² For Americans without access to subsidized PPACA-compliant plans, short-term, limited duration insurance can offer an affordable coverage option. It is important to note that in none of the covert calls in which GAO identified that potentially deceptive marketing practices took place did the sales representative actually offer or sell a short-term, limited duration insurance plan to the consumer.

States are responsible for overseeing the marketing and sale of PPACA-exempt health arrangements. As GAO noted, HHS does not have the authority to conduct oversight of PPACA-exempt plans. However, HHS staff work with state insurance commissioners to confirm that insurance sales representatives registered to work with the Exchange, which include those who sell both PPACA-compliant and PPACA-exempt plans, have an active state license to sell insurance. In addition, insurance sales representatives, often referred to as agents and brokers, are licensed and regulated by states rather than the federal government. Licensed agents and brokers working with the Federal Exchange must complete registration and training each year with HHS prior to enrolling consumers in Exchange plans. As part of the registration process, HHS verifies their identity and regularly validates their state health license to assist consumers. While the Exchange has no explicit agent and broker restrictions on enrolling consumers in short-term, limited-duration insurance plans or other types of coverage, when a consumer requests assistance via Help On Demand, HHS requires them to assist the consumer with either an Exchange plan or Medicaid/CHIP. The agreements signed by agents and brokers registered to work with the Exchange also include additional requirements, such as prohibiting the provision of misleading or false information to consumers or to the Exchange.

HHS takes consumer protection and program integrity very seriously. While GAO's report does not indicate whether any of the sales representatives contacted by covert callers were registered with HHS to work with the Federal Exchange, HHS plans to review any sales representatives who GAO identified as engaging in potentially deceptive marketing practices to determine if they are registered with the Exchange. If they are registered, HHS will take appropriate action within the scope of our authority.

¹ CMS, "Plan Year 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States," October 22, 2019. <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2020QHPPremiumsChoiceReport.pdf>

² CMS, "Trends in Subsidized and Unsubsidized Enrollment," August 12, 2019. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf>

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September 22, 2020

The Honorable Anna Eshoo
Chairwoman, House Energy and Commerce Health
Subcommittee
202 Cannon House Office Building
Washington, D.C. 20515

The Honorable Michael Burgess
Ranking Member, House Energy and Commerce
Health Subcommittee
2161 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee:

On behalf of National Taxpayers Union (NTU), the nation's oldest taxpayer advocacy organization, I thank you for this opportunity to submit a letter on the Subcommittee's September 23 hearing, "Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic."

As the voice of America's taxpayers, NTU takes an active role in shaping health policy on Capitol Hill, at federal agencies, and in the states. Sensible health policy that balances a number of competing interests can not only deliver savings for the taxpayers who fund federal and state health programs (like Medicare, Medicaid, and the Affordable Care Act exchanges), but can also encourage innovation and growth in America's private health care sector that benefits both patients and providers. Regulatory flexibility, for example, has not only been critical for the hospitals and medical professionals on the front lines of the fight against COVID-19; it has also contributed to extraordinary growth in the use of telehealth services that promise potential cost savings for patients and taxpayers in the long run.

It is with these goals in mind - delivering savings for taxpayers while encouraging innovation and growth in America's private health sector that benefits patients and providers - that NTU asks the Committee to consider a novel path forward for helping individuals and families who have lost health coverage due to the COVID-19 economic shock. We believe our **Pandemic Health Accounts (PHAs)** strike the appropriate balance between providing relief for families affected by a loss of employer-sponsored insurance (ESI) and properly tailoring a policy solution to the distinct problems at hand.

There should be no doubt that people who lost ESI this year were quickly steered into other options, such as Medicaid and the Affordable Care Act (ACA) exchanges, due to provisions included in the ACA. NTU's purpose with this appeal is not to litigate or relitigate the effects of a decade-old health law. In the same vein, though, Subcommittee members who support the ACA should not use this hearing to gloss over glaring issues with the Medicaid and ACA programs that have been made worse by the pandemic. NTU has studied these issues at length, and it led us to the proposal we share with you today.

COVID-19 Coverage Losses: A Snapshot of the Present Situation

The early months of the COVID-19 pandemic and economic shock were filled with confusion as to just how many Americans lost employer-sponsored insurance (ESI). On April 3, 2020, Health Management Associates estimated that between 11.7 million and 35.0 million Americans would lose access to ESI and that, although a majority of these Americans would join Medicaid rolls after losing ESI, between 1.1 and 12.0 million people would either be uninsured or would need to turn to the ACA marketplace.¹ Then, in May, Kaiser Family Foundation (KFF) estimated that, between March 1 and May 2, 26.8 million lost ESI.² KFF also found that around half of these individuals (12.7 million) would be eligible for Medicaid, around a third (8.4 million) would be eligible for ACA premium tax credits (PTCs), and the remainder would be uninsured without access to PTCs.³

The picture on COVID-19 health coverage losses has become somewhat clearer in recent months. Avalere projected in September 2020 that roughly 12 million people will lose ESI in 2020.⁴ The Economic Policy Institute (EPI) also estimated in late August 2020 that close to “12 million people have been cut off from ESI coverage due to job losses in recent months.”⁵ Though policymakers cannot be absolutely sure just how many people at present have lost ESI due to COVID-19, several independent estimates are converging around a number of 12 million.

This is, of course, a challenge of unprecedented scale in the history of private health coverage: around 3.6 percent of Americans may have lost ESI in the last six months. Such a challenge requires bold solutions. While Medicaid and the ACA exchanges have presented options to some individuals losing access to ESI this spring and summer, there is little evidence to suggest that permanently expanding these programs is either the best or the most targeted solution for the millions of Americans experiencing a disruption in coverage.

Medicaid and the ACA Exchanges Are Inadequate Tools to Address Pandemic-Related Health Coverage Losses

Evidence suggests that state Medicaid programs around the country are absorbing the brunt of the health coverage shock Americans went through when government shutdowns started in March. As EPI put it:

A new government survey measuring the economic consequences of the COVID-19 shock in real time indicates that for every 100 workers who were covered by ESI before losing their job, about 85 retained access to some form of health insurance in the week after they lost their job.

¹ Health Management Associates. (April 3, 2020). “COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State.” Retrieved from:

<https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf> (Accessed September 18, 2020.)

² Garfield, Rachel; Claxton, Gary; Damico, Anthony; Levitt, Larry. “Eligibility for ACA Health Coverage Following Job Loss.” Kaiser Family Foundation, May 13, 2020. Retrieved from:

<https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/> (Accessed September 18, 2020.)

³ *Ibid.*

⁴ Sloan, Chris; Duddy-Tenbrunsel, Robin; Ferguson, Samantha; Valladares, Angel; Kornfield, Thomas. “COVID-19 Projected to Worsen Racial Disparities in Health Coverage.” Avalere, September 16, 2020. Retrieved from:

<https://avalere.com/press-releases/covid-19-projected-to-worsen-racial-disparities-in-health-coverage> (Accessed September 18, 2020.)

⁵ Bivens, Josh; Zipperer, Ben. “Health insurance and the COVID-19 shock.” Economic Policy Institute, August 26, 2020. Retrieved from: <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/> (Accessed September 18, 2020.)

...It is likely the case that Medicaid is the dominant alternative source of coverage when people have lost ESI in the COVID-19 shock, as Medicaid rolls have likely expanded by more than 4 million since the COVID-19 shock began.⁶

This kind of resilience in the health care system - that 85 percent of workers losing ESI can retain access to coverage after a job loss - is good news. That resilience, though, comes at a high cost.

Even after Congress passed a generous 6.2-percent FMAP increase for Medicaid in the Families First Coronavirus Response Act⁷ - and this FMAP increase will last through the end of the emergency period - and even though the federal government covers 90 percent of Medicaid expansion population costs,⁸ state budgets are buckling under the pressure of surging Medicaid rolls. According to *The Washington Post*:

That 13.5 percent increase [in Medicaid enrollment, from February through August] places Nevada among at least three states, along with Kentucky and Minnesota, where the cadre of people on Medicaid has spiked that much, including families, like the Chapins, who have never before asked for government help. But increases are widespread: Caseloads had risen on average 8.4 percent through July in 30 states for which researchers have enrollment information. And in 14 states with enrollment data through August, the average is 10 percent.⁹

The challenges are so great that even state leaders who strongly support Medicaid, such as Gov. Steve Sisolak (D-NV), have urged “steps to slow the program’s spending”:

With Nevada confronting a \$1.2 billion deficit and a requirement to balance its budget, the legislature has taken steps to slow the program’s spending — notably, curbing payments to doctors, hospitals and others who care for Medicaid patients to save \$53 million through next summer. That 6 percent rate cut is the largest so far in the nation.

...“But with the Nevada Department of Health and Human Services accounting for one-third of the state’s budget through next summer, and Medicaid the department’s biggest expense, the program was a target. To help carve \$233 million from the department, Sisolak urged lawmakers to eliminate a raft of services that Nevada has offered Medicaid patients, beyond what the federal government requires.”¹⁰

⁶ *Ibid.*

⁷ Families First Coronavirus Response Act, Sec. 6008, P.L. 116-127. (March 18, 2020).

⁸ Mitchell, Alison. “Medicaid’s Federal Medical Assistance Percentage (FMAP).” Congressional Research Service, Updated July 29, 2020. Retrieved from: <https://fas.org/srg/crs/misc/R43847.pdf> (Accessed September 18, 2020.)

⁹ Goldstein, Amy. “Medicaid rolls swell amid the pandemic’s historic job losses, straining state budgets.” *The Washington Post*, September 14, 2020. Retrieved from:

https://www.washingtonpost.com/health/covid-medicare-enrollment-increases/2020/09/14/84b6249a-e6f1-11ea-97e0-94d2e46e759b_story.html (Accessed September 18, 2020.)

¹⁰ *Ibid.*

This is the state of Medicaid *with* FMAP increases that will cost federal taxpayers \$165 billion - the plurality of federal aid provided to state and local governments since the COVID-19 crisis began.¹¹ What relative proportion states have to cover in normal times, from 23 percent of costs to 50 percent for traditional populations and just 10 percent for expansion populations,¹² still makes for one of the largest program area components of state budgets year to year - around 20.2 percent in fiscal year (FY) 2018.¹³

As states struggle with even a modest share of Medicaid costs, patients “face less generous benefit design, greater cost sharing, and more limited formularies” in Medicaid plans than on the individual market, according to Avalere’s Tom Kornfield.¹⁴ And, according to Avalere, “only 71% of physicians accept Medicaid payments for new patients, presenting further access barriers to patients shifting into Medicaid enrollment.”¹⁵

None of this is to say that Medicaid does not have a role to play in the American health care system, especially as a backstop for the nation’s most vulnerable families. Clearly, though, any federal proposals to expand Medicaid would have to rely almost exclusively on federal tax dollars for such expansion. Maybe that is the point for some proponents of Medicaid expansion today. Indeed, that was the point of the ACA’s Medicaid expansion in 2010. As explained by ACA architect Jonathan Gruber:

In recent research, we analyzed budget data from all 50 states from 2010 through 2018 to assess the impact of the ACA Medicaid expansion. As expected, we found that expansion states experienced a substantial increase in Medicaid spending since implementation of the expansion, with 24% higher growth than nonexpansion states between 2013 and 2018. Critically, when analyzing the source of funds, we found that this increase in Medicaid spending was subsidized entirely by increased federal funding to expansion states, with no significant changes in spending from state revenues associated with Medicaid expansion...¹⁶

States can barely afford Medicaid now, even with generous FMAP rates for the traditional and expansion populations. Some would argue that this is a reason to *further* expand the federal government’s role in Medicaid, but such an expansion would have to rely on ever-limited federal tax dollars. With the nation staring down a record \$26 trillion debt and an astonishing \$3 trillion deficit this fiscal year, targeted solutions are vital.

¹¹ Committee for a Responsible Federal Budget. (September 16, 2020). “COVID Relief Includes \$360 Billion of State and Local Aid.” Retrieved from: <http://www.crfb.org/blogs/covid-relief-includes-360-billion-state-and-local-aid> (Accessed September 18, 2020.)

¹² Kaiser Family Foundation. “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.” Retrieved from: <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22collid%22:%22location%22:%22sort%22:%22asc%22%7D> (Accessed September 18, 2020.)

¹³ Schneider, Andy. “Medicaid and State Budgets: Checking the Facts (Yet Again).” Georgetown University Health Policy Institute Center for Children and Families. February 28, 2019. Retrieved from: <https://ccf.georgetown.edu/2019/02/28/medicaid-and-state-budgets-checking-the-facts-yet-again/#:~:text=IP%20you%20want%20to%20know,all%20state%20general%20fund%20dollars>. (Accessed September 18, 2020.)

¹⁴ Owens, Caitlin. “Racial disparities during pandemic extend to health coverage losses.” *Axios*, September 17, 2020. Retrieved from: <https://www.axios.com/health-coverage-losses-race-coronavirus-0ca93cd5-ec34-4c6e-8ab8-4784b1b3f3f3.html> (Accessed September 18, 2020.)

¹⁵ Sloan, Chris; Duddy-Tenbrunsel, Robin; Ferguson, Samantha; Valladares, Angel; Kornfield, Thomas. “COVID-19 Projected to Worsen Racial Disparities in Health Coverage.” Avalere, September 16, 2020. Retrieved from: <https://avalere.com/press-releases/covid-19-projected-to-worsen-racial-disparities-in-health-coverage> (Accessed September 18, 2020.)

¹⁶ Gruber, Jonathan, and Sommers, Benjamin D. “Paying for Medicaid — State Budgets and the Case for Expansion in the Time of Coronavirus.” *New England Journal of Medicine*, June 11, 2020. Retrieved from: <https://www.nejm.org/doi/full/10.1056/NEJMp2007124> (Accessed September 18, 2020.)

More importantly, perhaps, the majority of Americans do not want an aggressive expansion of government-provided coverage. In a national survey of 4,000 voters, 65 percent of Americans said it is more important to “[build] on our current health insurance system” than to “[create] a public option,” with majority support from Republicans, Democrats, and “swing” voters.¹⁷ Nearly two-thirds of Americans (66 percent) said they would rather keep their current coverage *than pay the same amount* for equivalent public option coverage.¹⁸

Efforts to permanently expand the ACA are distinct from Medicaid expansion efforts, especially since the ACA marketplaces host privately sponsored plans. However, bills like H.R. 1425, recently passed by House Democrats, are also poorly targeted at the current crises. As we wrote in June:

Title I of the bill features two permanent, major expansions of the Affordable Care Act’s (ACA) PTCs. First, the legislation would make the values of PTCs more generous by lowering the share of income that households contribute to their ACA premiums. Second, the bill would make PTCs eligible for households beyond 400 percent of the federal poverty line (FPL), which in 2020 is \$104,800 in annual income for a family of four. There are three major issues accompanying the expansion of PTCs: 1) expansion is expensive (with a \$212 billion deficit impact), 2) targeting generous PTCs to households making six figures or more is a poor use of limited taxpayer dollars, and 3) PTCs are not designed to bend the cost curve for private health coverage, and will only increase in cost as premium hikes outpace wage increases.¹⁹

A different kind of solution is needed, one that: 1) responsibly reduces the budget burdens Medicaid places on state and federal taxpayers, 2) offers displaced workers and their families the maximum amount of plan choice and flexibility, including access to plans on the ACA marketplace, and 3) is targeted and temporary, so that the federal government can maximize limited tax dollars and put them to use solving a number of problems facing Americans during the COVID-19 pandemic and economic shock. We believe our **PHA proposal**, outlined below, meets the challenge.

Pandemic Health Accounts (PHAs) Strike the Proper Balance Between Coverage and Choice

NTU introduced our concept for Pandemic Health Accounts (PHAs) in April, when Congress had passed the CARES Act and the COVID-19 public health and economic crises were just beginning. The concept is simple:

We propose creating for every household that loses access to ESI - and does not have access an adequate insurance option - a Pandemic Health Account (PHA).

These accounts, which share many similarities with Health Savings Accounts (HSAs), would serve as a bridge between a household’s loss of ESI and the start of their next job with ESI benefits. For that reason, we propose a federal credit designed to help a displaced worker (and, if applicable, their family) afford and choose the health insurance option that best suits their own needs. This credit could be

¹⁷ Locust Street Group. (September 2020). “Voter Vitals: A Health Care Tracking Poll Edition IV.” Retrieved from: <https://americashealthcarefuture.org/wp-content/uploads/2020/09/PAHCF-Voter-Vitals-IV-Survey-Analysis.pdf> (Accessed September 18, 2020.)

¹⁸ *Ibid.*

¹⁹ Lautz, Andrew. “NTU Urges Representatives to Oppose Expensive, Partisan Health Care Bill.” National Taxpayers Union, June 25, 2020. Retrieved from: <https://www.ntu.org/publications/detail/ntu-urges-representatives-to-oppose-expensive-partisan-health-care-bill> (Accessed September 18, 2020.)

applied to COBRA premiums, an ACA marketplace plan, or a short-term limited duration (STLDI) plan for around four months. Congress may elect to extend that benefit, depending on the duration of the economic crisis.

...we propose a PHA benefit amount of roughly \$2,000 for individuals and \$6,000 for joint or family accounts. (This comes out to \$500 per month for individuals and \$1,500 per month for families.)²⁰

Though PHAs would operate *like* HSAs, they would be unshackled from some of the requirements that we believe do not make sense for either PHAs or HSAs, such as the high-deductible health plan (HDHP) requirement and the limitation on using HSA dollars for insurance premiums.

The fundamental benefit of PHAs over either Medicaid, COBRA coverage, or even the ACA marketplaces is *choice* and *flexibility* for the account holder. We envision, for example, that someone receiving a PHA could use the funds to subsidize their COBRA coverage for several months. Unlike a COBRA subsidy, though, the PHA holder could also decline their COBRA coverage and turn to the ACA marketplace.²¹ If the PHA holder is unsatisfied with ACA marketplace options, they could turn to off-marketplace options for coverage that costs less such as a short-term limited duration insurance (STLDI) plan. While such plans are not for everyone, they were designed for precisely the types of brief coverage gaps we expect many Americans will have this year due to COVID-19.

PHAs are better for the taxpayer, too - using KFF's earlier estimates of coverage loss (nearly 27 million), we estimated PHAs could cost between \$56 billion and \$67 billion - significantly less than the \$98 billion cost for nine months of a 100-percent COBRA subsidy.²² Though policymakers could benefit from an updated estimate on the cost of a COBRA subsidy, since the last Joint Committee on Taxation (JCT) estimate was in May, we believe that if 12 million individuals were to benefit from a PHA (instead of 27 million) then the cost would range from between \$24 billion and \$36 billion. This figure would likely still be less expensive than a 100-percent COBRA subsidy, and is also significantly less costly than the cost of permanent ACA expansion (\$212 billion over 10 years).²³ It's also important to note that if policymakers were to allow people who *have* joined Medicaid since losing ESI to *opt in* to taking a PHA instead, then Congress could reduce state fiscal burdens at a perilous time for many states and their Medicaid programs.

²⁰ Lautz, Andrew. "Pandemic Health Accounts (PHAs): How Congress Can Best Help Millions of Americans Who May Soon Be Uninsured." National Taxpayers Union, April 8, 2020. Retrieved from: <https://www.ntu.org/publications/detail/pandemic-health-accounts-phas-how-congress-can-best-help-millions-of-americans-who-may-soon-be-uninsured> (Accessed September 21, 2020.)

²¹ We do not envision allowing a PHA holder to access premium tax credits (PTCs) in the marketplace as long as they have federal funds remaining in their PHA; however, we believe that the PHA subsidy combined with unemployment insurance (UI) support for a displaced worker would be enough to help most Americans through the designated four-month period. Should an account holder run low or out of PHA funds while on an ACA exchange plan and still require the ACA plan as a bridge to ESI, we believe lawmakers could explore allowing an account holder to then receive PTCs.

²² The Joint Committee on Taxation. (May 28, 2020). "Estimated Budget Effects Of The Revenue Provisions Contained In H.R. 6800, The "Health And Economic Recovery Omnibus Emergency Solutions (HEROES) Act," As Passed By The House Of Representatives On May 15, 2020." Retrieved from: <https://www.jct.gov/publications.html?func=standown&id=5261> (Accessed September 21, 2020.)

²³ Congressional Budget Office. (June 26, 2020). "Estimated Effect on the Deficit of Rules Committee Print 116-56, the Patient Protection and Affordable Care Enhancement Act, as Amended by Amendment Number 6 (Pallone, Neal, Scott) on June 25, 2020." Retrieved from: <https://www.cbo.gov/system/files/2020-06/Combined%20Tables.pdf> (Accessed September 21, 2020.)

We left several design and implementation questions open to lawmakers, believing that their expertise is best suited to settling these questions. However, NTU stands ready to work with *any and all* lawmakers interested in this novel option to support Americans that have lost ESI this year. We believe that this plan offers the financial support for ESI that many congressional Democrats have asked Congress to consider during the crisis, while offering the plan choice, flexibility, and fiscal restraint stressed by many Congressional Republicans. I stand ready to answer any of your questions, and thank you for your consideration ahead of the Committee's hearing.

Sincerely,

Andrew Lautz
Policy and Government Affairs Manager

CC: The Honorable Frank Pallone, Chairman, House Energy and Commerce Committee
The Honorable Greg Walden, Ranking Member, House Energy and Commerce Committee
The Honorable Eliot Engel
The Honorable G. K. Butterfield
The Honorable Doris Matsui
The Honorable Kathy Castor
The Honorable John Sarbanes
The Honorable Ben Ray Lujan
The Honorable Kurt Schrader
The Honorable Joseph P. Kennedy
The Honorable Tony Cardenas
The Honorable Peter Welch
The Honorable Raul Ruiz
The Honorable Debbie Dingell
The Honorable Ann M. Kuster
The Honorable Robin L. Kelly
The Honorable Nanette Diaz Barragan
The Honorable Lisa Blunt Rochester
The Honorable Bobby L. Rush
The Honorable Fred Upton
The Honorable John Shimkus
The Honorable Brett Guthrie
The Honorable H. Morgan Griffith
The Honorable Gus M. Bilirakis
The Honorable Billy Long
The Honorable Larry Bucshon
The Honorable Susan W. Brooks
The Honorable Markwayne Mullin
The Honorable Richard Hudson
The Honorable Earl L. "Buddy" Carter
The Honorable Greg Gianforte



Statement of Community Catalyst on Hearing on “Health Care Lifeline: The Affordable Care Act and The COVID-19 Pandemic”

Submitted to House Committee on Energy and Commerce for hearing of September 23, 2020

Community Catalyst respectfully submits the following statement on the House Energy and Commerce Committee’s hearing on “Health Care Lifeline: The Affordable Care Act and The COVID-19 Pandemic.”

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health care system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers and foundations, providing leadership and support to change the health care system so it serves everyone—especially vulnerable members of society.

The Affordable Care Act (ACA) is a fundamental part of the fabric of the American health care system. It is inextricably intertwined with Medicare and Medicaid and works with and through those programs to provide care to millions of people across the country when they need it most. It has also resulted in the largest reduction in health inequities for communities of color since the creation of Medicaid in 1965. Thanks to the ACA, millions of people have gained access to the health care they need to lead productive and healthy lives.

Protecting and building on the ACA has been a primary goal for health advocates since its inception. The COVID-19 crisis has added even more urgency to the work of safeguarding the ACA, including its Medicaid expansion provisions, which have played a vital role in protecting family economic security and ensuring health care access as the pandemic and economic crisis have worsened. COVID-19 has caused broad shutdowns of economic activity, resulting in shrinking state revenues that are destabilizing state budgets. Further, close to 30 million people have lost their jobs and private health insurance, many of whom are people of color. The ACA, along with the broader Medicaid program, is a lifeline for these individuals, their families, and our economies.

However, despite the clear benefits of the ACA to our overall health and financial stability, the Trump administration has spent the last four years actively working to weaken the health care infrastructure by chipping away at coverage gains and consumer protections afforded by the ACA. Even during a pandemic, when so many lives are at risk, the Trump administration has continued its attacks on the ACA, specifically and health coverage in general, by refusing to

open enrollment for people newly unemployed and uninsured due to the economic crisis, rolling back anti-discrimination protections, and by joining in the *California v. Texas* lawsuit—now before the Supreme Court—aimed at invalidating the entire ACA.

The ACA provides a safety net for millions of people before and during the COVID-19 pandemic

Thanks to the ACA, roughly **20 million people have gained coverage**. The uninsured rate fell by almost half, from 20.4 percent to 12.4 percent, between 2013 and 2018, as the result of ACA marketplaces and Medicaid expansion. Thanks to these coverage gains, most notably in states that expanded Medicaid, inequities in health care access for Black and brown communities has increased significantly.

[Research](#) shows that the ACA has led to historic reductions in racial disparities in access to health care. Between 2013 and 2018, the uninsured rate dropped 4.1 percentage points between Blacks and whites and 9.4 percentage points between Latinos and whites. These coverage gains under the ACA have [made it easier](#) for people to access the health care services they need. Though more is needed to improve affordability, most low-income individuals and families have benefited from the law's insurance subsidies, out-of-pocket cost protections and Medicaid expansion. For instance, Medicaid expansion [has improved health outcomes](#) for many Black adults. For example, in addition to having better access to care—better access to care—such as having a consistent primary care doctor or having a central localized location for medical check-ups—Black adults with cancer living in states that expanded Medicaid are more likely to be diagnosed at early stages and receive timely treatment, and thus, have better chances of surviving cancer than those living in non-expansion states.

Unfortunately, this progress has stalled, and in some cases eroded, since 2017 as **the Trump administration has taken numerous steps to undermine the ACA**. For instance, [funding for the Navigator program](#) has been cut by about 84 percent, resulting in fewer trusted community connections to turn to for help enrolling in coverage. The administration has also pushed policies, such as the Department of Homeland Security's Public Charge regulation, that discourage immigrant families from obtaining coverage and seeking necessary care. The public charge rule [could lead](#) to between 2 and 4.7 million people disenrolling from CHIP and Medicaid.

In terms of the ongoing COVID-19 crisis, more than 6.8 million people across the country have tested positive for the virus and there have been over 205,000 deaths to date. The pandemic has caused broad shutdowns of economic activity, resulting in [nearly 30 million people](#) losing their jobs and employer-sponsored health insurance coverage. Data shows [workers of color](#) are most vulnerable for potential layoffs during a downturn, as they are overrepresented in low-wage, service industry jobs. The Center on Budget and Policy Priorities [projected](#) that nearly 1 in 10 Blacks and 1 in 10 Latinos are projected to lose coverage, compared to 1 in 6 whites, as a result of economic decline. The ACA is and will continue to be a lifeline for those who lose their employer-sponsored health insurance. According to the [Kaiser Family Foundation](#), half of those who become uninsured after job loss are eligible for Medicaid, and an additional 8.4 million people are eligible for marketplace subsidies.

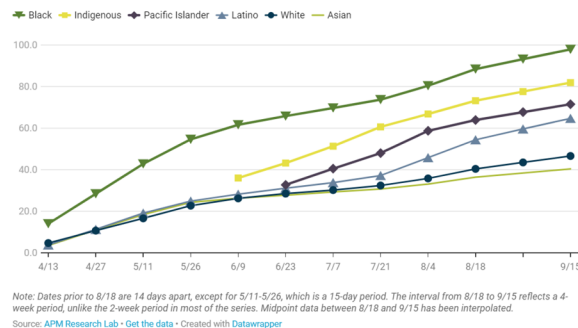
As the country confronts both the short-term and long-term threats posed by the COVID-19 pandemic, it is more important than ever to retain and expand pathways to coverage. The ACA ensures that millions of people can get the testing, treatment and care they need to keep communities safe and promote financial security.

Without the ACA, our fight against the COVID-19 pandemic will be harder

While the COVID-19 crisis has brought to light many faults in national, state and local infrastructures, the ever-present truth threaded throughout the unfolding narrative is that pervasive health and economic inequities are resulting in dramatically disproportionate impacts. The virus does not discriminate, but some populations are being hit especially hard—especially [people of color](#). According to the AMP Research Lab, [Blacks and Tribal members](#) experience highest death tolls from COVID-19.

Black & Indigenous Americans experience highest death tolls from COVID-19

Cumulative actual COVID-19 mortality rates per 100,000, by race and ethnicity, April 13–Sept. 15, 2020



It is impossible to deny the [devastating effect](#) the pandemic is having on Black people. A national study conducted in May found that disproportionately [Black counties](#) account for over half of coronavirus cases in the U.S. and nearly 6 percent of deaths. There are several factors contributing to the disproportionate impact on Black communities. First, Black people in the U.S. are more likely to be exposed to the virus through their work in occupations that are considered essential and/or in which they cannot physically distance themselves from others or work from home. Second, power structures built on structural racism continue to [segregate neighborhoods](#) and inhibit [equitable access to preventive health care](#), forcing many Black people to live in places that negatively affect their health. Thus, Black people [have higher rates of underlying health conditions](#) such as asthma, diabetes, heart disease and obesity, as compared to white people. Research also shows stress from constantly enduring racism and its consequences can exacerbate these health conditions. This puts Black people at a [greater risk](#) of becoming severely ill if infected by COVID-19.

One of the cornerstones of the ACA is the protections it provides for people with pre-existing health conditions. Since the ACA's implementation, at least 133 million people with pre-existing conditions have been protected from being charged more or locked out of coverage by private insurers. COVID-19 has created a number of cascading health care and health care coverage crises that need to be accounted for in our efforts to keep the ACA intact including impacting people with pre-existing conditions more frequently and with greater consequence. The virus itself will also be defined by insurers as a new pre-existing condition for those who have been infected and could produce long-term, cascading health impacts on the respiratory, renal, and other vital systems of those who have "recovered."

In addition to pre-existing condition protections, the ACA also builds on existing federal civil rights protections to ban health care and health insurance discrimination based on race, color, national origin, sex, age and disability. Without the ACA, [25 million individuals with limited English proficiency](#) (LEP)—[most of whom are Latinos and Asians](#)—would not be able to have meaningful access to language assistance (i.e. translation and interpretation services) for health related services. The Trump administration's sabotage efforts have particularly focused on limiting the ACA's protections in this realm and these efforts have already had alarming consequences. [Growing evidence](#) shows many LEP people have been misinformed about the COVID-19 pandemic's spread and treatment. For example, people with limited English proficiency in Greenville, South Carolina, [voiced concerns](#) of not being well informed COVID-19. The same is true in Boise, Idaho, where there are few news sources in languages other than English from which community members could access information about the virus. Instead, these communities rely on health care providers for their information about how to prevent infection and where and when to seek treatment. Without language assistance, LEP people would be more at risk of contracting the virus than their English-speaking neighbors.

Conclusion

After more than 10 years since the passage of the ACA, nearly 20 million people gained coverage. The law has provided protections for more than 133 million people with pre-existing conditions. During the COVID-19 pandemic, the ACA serves as a lifeline for 30 million people without insurance coverage as a result of widespread job losses. Protecting the ACA and building on its successes must be the top priorities for Congress. The [Patient Protection and Affordable Care Enhancement Act \(H.R. 1425\)](#), passed by the House in June, and the [Health and Economic Recovery Omnibus Emergency Solutions Act or the HEROES Act \(H.R. 6800\)](#), passed by the House in May, are steps in the right direction to strengthen coverage and improve affordability for millions of low-income people, people of color, immigrants, older adults, people with disabilities, women, LGBTQ+ people and people in rural communities who have long been left out of traditional coverage mechanisms or specifically discriminated against in accessing care and services. It also provides immediate relief to families that have been hit hardest by the pandemic and must be a priority for Congress and the administration if we are ever to find a way out of this crisis.

Appendix A

Additional information on impacts of ACA repeal on specific populations

- The Affordable Care Act's Impact on Communities of Color: What's at Stake for Black People if it Goes Away? <https://www.communitycatalyst.org/resources/2020-covid/ACA-COVID-BlackPOC.pdf>
- The Affordable Care Act's Impact on Communities of Color: What's at Stake for Asian Americans, Native Hawaiians and Pacific Islanders if it Goes Away? <https://www.communitycatalyst.org/resources/2020-covid/ACA-COVID-AAPI.pdf>
- The Affordable Care Act's Impact on Communities of Color: What's at Stake for American Indians and Alaska Natives? <https://www.communitycatalyst.org/resources/2020-covid/ACA-COVID-AIAN.pdf>
- Affordable Care Act Threatened: What's at Stake for Latinos <http://publications.unidosus.org/handle/123456789/2061>

For Community Catalyst's recommendations on how Congress can take steps to address racial and ethnic health disparities during the COVID-19 pandemic

- Statement of Community Catalyst on Hearing on the Disproportionate Impact of COVID-19 on Communities of Color https://www.communitycatalyst.org/resources/2020-covid/CC-Statement-Ways-and-Means_05_27_2020.pdf

Attachment—Additional Questions for the Record

**Subcommittee on Health
Hearing on
“Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic”
September 23, 2020**

Douglas Holtz-Eakin, Ph.D.
President
American Action Forum

The Honorable Greg Walden (R-OR):

1. The U.S. Government Accountability Office (GAO) recently released a study examining the marketing practices of certain Affordable Care Act-exempt plans. Of the violations discovered by GAO, how many were committed by plans that were affected by the Trump Administration’s rule on short-term limited-duration (STLD) plans?