

EXPLORING PATHWAYS TO AFFORDABLE, UNIVERSAL HEALTH COVERAGE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH,
EMPLOYMENT, LABOR, AND PENSIONS

OF THE

COMMITTEE ON EDUCATION AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

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EXPLORING PATHWAYS TO AFFORDABLE, UNIVERSAL HEALTH COVERAGE

Thursday, February 17, 2022

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND
PENSIONS,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The Subcommittee met, pursuant to notice, at 12 p.m., via Zoom, Hon. Mark DeSaulnier (Chairman of the Subcommittee) presiding. Present: Representatives DeSaulnier, Courtney, Norcross, Morelle, Wild, McBath, Stevens, Levin, Scott (Ex Officio), Allen, Walberg, Banks, Fitzgerald and Foxx (Ex Officio).

Also present: Representatives Jayapal and Cherfilus-McCormick. Staff present: Ilana Brunner, General Counsel; Daniel Foster, Health and Labor Counsel; Christian Haines, General Counsel; Rasheedah Hasan, Chief Clerk; Sheila Havenner, Director of Information Technology; Eli Hovland, Policy Associate; Carrie Hughes, Director of Health and Human Services; Ariel Jona, Policy Associate; Stephanie Lalle, Communications Director; Andre Lindsay, Policy Associate; Richard Miller, Director of Labor Policy; Max Moore, Staff Assistant; Kayla Pennebecker, Staff Assistant; Veronique Pluviose, Staff Director; Cyrus Artz, Minority Staff Director; Michael Davis, Minority Legislative Assistant; Mini Ganesh, Minority Staff Assistant; Taylor Hittle, Minority Professional Staff Member; John Martin, Minority Deputy Director of Workforce Policy/Counsel; Hannah Matesic, Minority Director of Member Services and Coalitions; Audra McGeorge, Minority Communications Director; Ethan Pann, Minority Press Assistant; Krystina Skurk, Minority Speechwriter

Chairman DESAULNIER. Good morning. The Subcommittee on Health, Employment, Labor, and Pensions will come to order please. Welcome, everyone. I will note for the record that a quorum is present. I note for the subcommittee that Congresswoman Jayapal of Washington and Congresswoman Cherfilus-McCormick of Florida are permitted to participate in today's hearing with the understanding that their questions will come only after all members of the subcommittee on both sides of the aisle who are present, have had an opportunity to question the witnesses.

The subcommittee is meeting today to hear testimony exploring pathways to affordable universal health care for Americans. This is an entirely remote hearing, and all microphones should be kept muted as a general rule to avoid unnecessary background noise.

Members and witnesses will be responsible for unmuting themselves when they are recognized to speak, or when they wish to seek recognition. I also ask that members please identify themselves before they speak. Members should keep their cameras—thank you, ranking member. Members should keep their cameras on while in the proceeding.

Members shall be considered present in the proceeding when they are visible on camera, and they shall be considered not present when they are not visible on camera. The only exception to this is if they are experiencing technical difficulty and inform committee staff of such difficulties. If any member experiences technical difficulty during the hearing, you should stay connected on the platform, make sure you are muted, and use your phone to immediately call the committee's IT director whose number was provided in advance.

Should the Chair experience technical difficulty, Mr. Courtney, or another majority member is hereby authorized to assume the gavel in the Chair's absence. This is an entirely remote hearing, once again and as such the committee's hearing room is officially closed.

Members who choose to sit with their individual devices in the hearing room must wear headphones to avoid feedback, echoes, and distortion resulting from more than one person on the software platform sitting in the same room. Members are also expected to adhere to social distancing and safe health care guidelines, including the use of masks, hand sanitizer, and wiping down the areas both before and after their presence in the hearing room.

In order to ensure the committee's 5-minute rule is adhered to; staff will be keeping track of time using the committee's digital timer which appears on its own thumbnail picture. Members and witnesses are asked to please wrap up promptly when their time has expired.

Pursuant to Committee Rule 8(c), opening statements are limited to the Chair and Ranking Member. This allows us to hear from our witnesses sooner and will provide all members with adequate time to ask questions. With that I will now recognize myself for the purpose of making an opening statement.

First of all, thank you all to all the members for attending, and for our visitors who are with us as well. Today we are meeting to explore pathways to help all Americans access high-quality, affordable health care. Over the past decade we've made significant progress toward expanding access to health care for Americans. Since President Obama signed the Affordable Care Act into law in 2010, more than 20 million Americans secured health coverage, and the uninsured rate has significantly declined.

The ACA has also ensured that 130 million individuals living with pre-existing conditions cannot be discriminated against or denied coverage—130 million. To expand American's access to health care during the pandemic we passed the American Rescue Plan, which has dramatically helped lower costs for families by providing enhanced upfront tax credits to low-income individuals to lower monthly health care costs, ensuring premium-free access to silver plans, and eliminating the subsidy cliff, so more low-and moderate-income individuals have access to affordable health care.

During the last open enrollment period, a record 14 and 1/2 million Americans enrolled in health care coverage through the ACA and state-based marketplaces. Simply put, the steps taken in the American Rescue Plan made coverage more obtainable for millions, and these reforms have saved lives.

While the U.S. has made progress in terms of coverage over the course of the past decade, millions of Americans remain uninsured, or underinsured. This is particularly true for Black, Latino, and low-income Americans, who are even more likely to be uninsured compared to their peers.

For more than a decade, some of our colleagues, particularly Republican State Attorney's General, have relentlessly worked to erode or eliminate the ACA entirely. While I think all open-minded people recognize that we can always improve on legislation, and look back at it, these attacks are unacceptable to the American public.

Far too many individuals also continue to be pushed toward low-quality, and unregulated junk health care plans. The ex-Trump administration actively promoted these plans, saddling many Americans with piles of debt. If Americans do not have high-quality coverage, they won't have the care they need.

Unfortunately, 12 of these Attorney General led states, Republican Attorney General led states, have also yet to expand eligibility for Medicaid, to help low-income individuals afford health care, which has left approximately 2.2 million Americans without insurance.

In comparison to our peers around the world, our health care system is underperforming. According to analysis by the Kaiser Family Foundation, the U.S. spent around 19 percent of its GDP on health care in 2020. Whereas the next highest comparable country, the United Kingdom, devoted 13 percent of its GDP. The same analysis by the Kaiser Foundation found that health care spending per person in the U.S. was almost \$12,000 in 2020, whereas the nearest comparable country Norway, in this case, spent less than \$7,000.

We know that these inflated costs are driven in part by excessive prices for prescription drugs and other health services. Not only does the United States underperform on access, but our peer nations also often have better outcomes, better quality care according to OECD data.

Our current health care system is broken, and Americans depends on us to fix it. The lesson we learned from the ACA and COVID-19 pandemic is that when we invest in expanding quality health care coverage, when we expect providers, insurance companies to perform and have outcomes in the performance, we can save lives. That is why Democrats are committed to ensuring all Americans have affordable, high-quality coverage, and I certainly hope that all of us in Congress feel the same way and will join our efforts.

As our witnesses will discuss today there are many approaches to expanding access to health care, and lots of good ideas about how to get there, such as expanding the Affordable Care Act, establishing a public option, or transitioning to a single-payer, Medicare for All system. Each of these options builds on the progress we

have made, and helps us achieve our shared goal of affordable, high-quality coverage for all.

I really hope that this conversation can also draw upon some of our own experiences back home as well in our districts. In California for example, we have taken a number of steps to improve coverage. I am proud of what we have done in California. I was proud to be very involved with it as Chair of the California State Senate Budget Committee for Health and Human Services, as well as being a member of the Policy Committee, and that body when we implemented the ACA. I am proud of the success that we have had, and we have had challenges.

In Contra Costa County here in San Francisco Bay area, we even have our own version of a public option, the Contra Costa Health Plan, which I am a proud member of, as a country retiree, and I can tell you I would not be here if it was not for them. They have saved my life. This public option competes with commercial insurers, and cooperates with commercial insurers. We cooperate with Kaiser, which is a dominant player started here in the East Bay. We have a collaborative effort that keeps prices low, and quality high for everyone in this area.

I think it is important that we learn from these and other examples as we discuss how best to deliver the quality health care coverage that Americans deserve. I look forward to hearing from our distinguished panel of witnesses, and I look forward to a robust conversation among my colleagues, where we have legitimate differences of opinion, but I really hope, and I hope our experience with pensions in the subcommittee, I want to thank Ranking Member Allen and Ranking Member Foxx for their support in those efforts.

For all our differences, there is work to be done, and I hope we can accomplish real improvements for Americans and health care. With that, I am happy to recognize the Ranking Member for his opening statement.

Mr. Allen.

[The statement of Chairman DeSaulnier follows:]



OPENING STATEMENT

House Committee on Education and Labor

Chairman Robert C. "Bobby" Scott

Opening Statement of Chair Mark DeSaulnier (CA-11)
 Subcommittee on Health, Employment, Labor, and Pensions
Exploring Pathways to Affordable, Universal Health Coverage
 Thursday, February 17, 2022, at 12:00 p.m. | Zoom

Today, we are meeting to explore pathways to help all Americans access high-quality, affordable health care.

Over the past decade, we have made significant progress toward expanding access to health care for Americans. Since President Obama signed the *Affordable Care Act* into law in 2010, more than 20 million Americans secured health coverage, and the uninsured rate has significantly declined. The ACA also ensured that the more than 130 million individuals living with pre-existing conditions cannot be discriminated against or denied coverage.

To expand Americans' access to health care during the pandemic, we passed the American Rescue Plan, which has dramatically helped lower costs for families by:

- Providing enhanced, up-front tax-credits to low-income individuals to lower monthly health care costs,
- Ensuring premium-free access to silver plans, and
- Eliminating the subsidy "cliff" so more low- and moderate-income individuals have access to affordable health care.

During the last Open Enrollment period, a record 14.5 million Americans enrolled in health care coverage through the ACA and State-Based Marketplaces. Simply put, the steps taken in the American Rescue Plan made coverage more attainable for millions – and these reforms have saved lives.

While the U.S. has made progress in terms of coverage over the course of the past decade, millions of Americans remain uninsured or underinsured. This is particularly true for Black, Latino, and low-income Americans who are even more likely to be uninsured compared to their peers.

For more than a decade, some of our colleagues – particularly Republican State Attorneys General – have relentlessly worked to erode or eliminate the ACA entirely.

While I think all open-minded people recognize that we can always improve on legislation and look back at it, these attacks are unacceptable to the American public.

Far too many individuals also continue to be pushed toward low-quality and unregulated "junk" health care plans. The ex-Trump Administration actively promoted these plans, saddling many Americans with piles of debt. And if Americans don't have high-quality coverage, they won't have the care they need.

Unfortunately, 12 of these Republican Attorneys General-led states also have yet to expand eligibility for Medicaid to help low-income individuals afford health care, which has left approximately 2.2 million Americans without insurance.

In comparison to our peers around the world, our health care system is underperforming. According to an analysis by the Kaiser Family Foundation, the U.S. spent around 19 percent of its GDP on health care in 2020, whereas the next-highest comparable country, the United Kingdom, devoted 13 percent of its GDP. The same analysis by the Kaiser Foundation found that health spending per person in the U.S. was almost \$12,000 in 2020, whereas the nearest comparable country, Norway in this case, spent less than \$7,000. We know that these inflated costs are driven, in part, by excessive prices for prescription drugs and other health services.

Not only does the United States underperform on access, but our peer nations also often offer better outcomes and better-quality care according to OECD data.

Our current health care system is broken, and Americans depend on us to fix it.

The lesson we learned from the ACA and the COVID-19 pandemic is that when we invest in expanding quality health care coverage and when we expect providers and insurance companies to perform and produce outcomes of that performance, we save lives. That's why Democrats are committed to ensuring all Americans have affordable, high-quality coverage and I certainly hope that all of us in Congress feel the same way and will join our efforts.

As our witnesses will discuss today, there are many approaches to expanding access to health care, and lots of good ideas about how to get there, such as:

1. Expanding on the *Affordable Care Act*,
2. Establishing a public option, or
3. Transitioning to a single payer "Medicare for All" system.

Each of these options builds on the progress we have made and helps us achieve our shared goal of affordable, high-quality coverage for all.

I really hope that this conversation can also draw upon some of our own experiences back home as well as in our districts. In California, for example, we have taken a number of steps to improve coverage. I'm proud of what we've done in California. I'm proud of being very involved with it as Chair of the California State Senate Budget Committee for Health and Human Services as well as being a member of the policy committee in that body when we implemented the ACA.

I am proud of the success that we have had, and we've had challenges. In Contra Costa County here in the San Francisco Bay Area, we even have our own version of public option—the Contra Costa Health Plan, which I am a proud member of as a county retiree. I can tell you I wouldn't be here if it wasn't for them; they saved my life. This public option competes with commercial insurers and cooperates with commercial insurers, and cooperates with Kaiser, which is a dominant player started here in the East Bay. We have a collaborative effort that keeps prices low and quality high for everyone in this area. I think it is important that we learn from these and other examples as we discuss how best to deliver the quality health coverage that Americans deserve.

I look forward to hearing from our distinguished panel of witnesses and I look forward to a robust conversation with my colleagues where we have legitimate differences of opinion. I really hope we reflect on our experience with pensions in this subcommittee, and I thank Ranking Member Allen and Ranking Member Foxx for their support in those efforts. For all our differences, there's work to be done and I hope we can accomplish real improvements for Americans in health care.

I now yield to the distinguished Ranking Member from Georgia, Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. Thank you to the witnesses here and for everyone participating in this important hearing today, employer sponsored health insurance, or ESI is the bedrock of America's healthcare system. We cover the majority of lives.

Despite this, the Biden administration has waged an assault on the coverage of the majority of Americans and their families rely on. As employers struggle to attract talent during the ongoing labor shortage due to the Biden administration's policies. They are increasingly bolstering health benefits to attract and retain talented workers.

We know that this recruiting tool works, in fact 75 percent of Americans say that coverage played a role in their decision to accept their current job. Further, a new poll released this week found that those with employer sponsored coverage ranked 19 percent more positively than those with coverage under Obama Care.

In an attempt to push more Americans into the Affordable Care Act exchanges, democrats are increasing Obama Care subsidies. If these subsidies get too high and create an unlevel playing field in our healthcare market, employer-sponsored health insurance plans will not be able to compete with Obama Care plans, which will ultimately lead to a public option.

As everyone knows a public option is simply a trojan horse for Medicare for All. Democrats radical Medicare for All in public opinion proposals would destroy most employer—in public opinion proposals, would destroy most employer-sponsored insurance plans, stripping America of their employer's-sponsored insurance, and dumping them into a government run healthcare, and that would be a major mistake.

It would worsen the current labor shortage and create a disincentive for work. The vast majority of the 155 million Americans who have employer-sponsored insurance are very happy with their plans. On average, employer-based plans provide richer and more comprehensive coverage, relative to ACA plans.

Further, when given the option 83 percent of employees in the U.S. choose to be on an employer-sponsored insurance plan. The Biden Administration's attempt to undermine these plans is a threat to the personal choice, and affordable healthcare, and it will cost taxpayers exponentially more.

We should be encouraging less dependence on government assistance, not more. We must resist democrat's attempt to expand broken, unaffordable programs. The so-called Build Back Better Act would drastically expand ACA, and Medicaid eligibility. Obama Care has been breaking promises for over a decade, and throwing more money after bad will not fix this problem. Additionally, these proposed expansions to the ACA would overwhelmingly help wealthy households and exacerbate healthcare inflation.

These expansions also will not increase the number of people insured, but they will primarily go to those who already have health insurance. President Biden's socialist tax and spending bill would also allow the Secretary of Health and Human Services to negotiate, if not dictate, the prices of prescription medications. These price controls would reduce the incentive for companies to participate in medical innovation, and severely cut back on new life saving drugs and their development.

Companies who do not abide by the negotiated price will face such steep penalties that they would likely be driven out of the market. This will give Americans less freedom and less choice in healthcare. More government intervention will decrease the cost of healthcare. The best way to make healthcare affordable would be to increase the use of association health plans.

These plans have the power to save Americans up to 50 percent on healthcare cost by allowing small businesses to band together to offer lower cost health insurance. While democrats want to monopolize healthcare with inefficient government run plans, associated health plans focus on expanding real healthcare options to Americans who do not currently have affordable coverage.

Simply put, more Federal control is the biggest threat to our healthcare system. Socializing healthcare would increase inflation, exacerbate the Federal debt, grossly diminish the quality of healthcare and put Washington bureaucrats in charge of making the healthcare decisions for millions of Americans.

Expanding Washington control will not improve our country's healthcare system, it will make it exponentially worse, and with that I yield back.

[The statement of Ranking Member Allen follows:]

2.17.22 - HELP Subcommittee Hearing: Exploring Pathways to Affordable, Universal Health Coverage

Opening Remarks from HELP Ranking Member, Rep. Rick Allen

“Employer-sponsored health insurance, or ESI, is the bedrock of America’s health care system. Despite this, the Biden Administration has waged an assault on the coverage that a majority of Americans and their families rely on.

“As employers struggle to attract talent during the ongoing labor shortage due to the Biden Administration’s policies, they are increasingly bolstering health benefits to attract and retain talented workers. And we know that this recruiting tool works. In fact, 75 percent of Americans say that coverage played a role in their decision to accept their current job. Further, a new poll released this week found that those with employer-sponsored coverage rate their care 19 percent more positively than those with coverage under Obamacare.

“In an attempt to push more Americans onto Affordable Care Act (ACA) exchanges, Democrats are increasing Obamacare subsidies. If these subsidies get too high and create an unlevel playing field in the healthcare market, employer-sponsored health insurance plans won’t be able to compete with Obamacare plans, which will ultimately lead to a public option. And as everyone knows, a public option is simply a trojan horse for Medicare-for-All.

“Democrats’ radical Medicare-for-All and public option proposals would destroy most employer-sponsored insurance plans. Stripping Americans of their employer-sponsored insurance and dumping them into government-run health care would be a major mistake. It would worsen the current labor shortage and create a disincentive for work.

“The vast majority of the 155 million Americans who have employer-sponsored insurance are very happy with their plans. On average, employer-based plans provide richer and more comprehensive coverage relative to ACA plans. Further, when given the option, 83 percent of employees in the U.S. choose to be on an employer-sponsored insurance plan.

“The Biden Administration’s attempt to undermine these plans is a threat to personal choice and affordable health care, and it will cost taxpayers exponentially more. We should be encouraging less dependence on government assistance, not more.

“We must resist Democrats’ attempt to expand broken, unaffordable programs. The so-called Build Back Better Act would drastically expand ACA and Medicaid eligibility. Obamacare has been breaking promises for over a decade, and pouring more money after bad will not fix this program.

“Additionally, these proposed expansions to the ACA would overwhelmingly help wealthy households and exacerbate health care inflation. These expansions also won’t increase the number of people insured, but they will primarily go to those who already have health insurance.

“President Biden’s socialist tax-and-spending bill would also allow the Secretary of Health and Human Services to negotiate—if not dictate—the prices of prescription medications. These price

controls would reduce the incentive for companies to participate in medical innovation and severely cut back on new life-saving drugs and their development. Companies who don't abide by the negotiated price will face such steep penalties that they would likely be driven out of the market. This will give Americans less freedom and less choice in health care.

"More government intervention won't decrease the cost of health care. The best way to make health care affordable would be to increase the use of Association Health Plans (AHPs). These plans have the power to save Americans up to 50 percent on health care costs by allowing small businesses to band together to offer lower-cost health insurance.

"While Democrats want to monopolize health care with inefficient government-run plans, Associated Health Plans focus on expanding real health care options to Americans who do not currently have affordable coverage.

"Simply put, more federal control is the biggest threat to our health care system. Socializing health care would increase inflation, exacerbate the federal debt, grossly diminish the quality of health care, and put Washington bureaucrats in charge of making the health care decisions for millions of Americans. Expanding Washington control will not improve our country's health care system—it will make it exponentially worse."

Chairman DESAULNIER. Thank you, Mr. Allen. It is now my pleasure to introduce our witnesses, and we will start with a friend, Secretary Robert B. Reich. He is Chancellor's Professor of Public Policy at the University of California Berkeley and I will show you the cup I am drinking from, Go Bears. Welcome, Mr. Secretary.

He is previously served in a number of key positions in the Federal Government, including as Secretary of Labor under President Bill Clinton, for which Time Magazine named him one of the ten most effective cabinet secretaries of the 20th Century. Mr. Secretary welcome, please go ahead.

STATEMENT OF HON. ROBERT B. REICH, CHANCELLORS PROFESSOR OF PUBLIC POLICY, UNIVERSITY OF CALIFORNIA AT BERKELEY

Mr. REICH. Well thank you very much Mr. Chairman, members of the committee and the subcommittee. My name is Robert Reich, Chancellor's Professor of Public Policy at the University of California, Berkeley. Thank you for giving me this opportunity to testify before the subcommittee.

Let me just begin by saying it would be hard to invent a more expensive, and less effective health care system than we have here in the United States. Even before the pandemic the typical American family was spending more than \$6,000 a year on health insurance premiums.

If you add in copayments and deductibles, the doctors, hospitals and drug companies also charge, that sum increases to \$6,400. Add in typical out of pocket expenses for pharmaceuticals, and it is at least \$6,800. That is not all, because some of the taxes that a typical family pays are for health care too for Medicare and Medicaid and the Affordable Care Act.

Add them in, and the typical household pays \$8,975 a year for health insurance. This number does not include what typical worker's employers spend on their health insurance, which might otherwise go to their wages. Americans spending on health care per person is more than twice the average in the world's other 35 advanced nations.

Here's where we come to ineffectiveness. The United States ranks near the bottom among advanced nations for lifespan and infant mortality. Americans are sicker, our lives are shorter, and we have more chronic illnesses. Canadians for example, can expect to live an average of almost four and a half years longer than Americans, even though health care spending per person in Canada is only half as high as in the United States.

The connection between the high cost and ineffectiveness of our system is clear because health care is so expensive, many Americans put off seeing a doctor until their health has seriously deteriorated. Even with the Affordable Care Act, there are tens of millions of Americans who have no health insurance coverage at all.

One major reason for the extraordinary cost is the administrative costs involved in private for-profit insurance. About a third of what the typical American pays for health insurance goes to the people who oversee billing and collections. Then of course there are marketing and advertising expenses, and the profits that go to shareholders or private equity managers.

Replacing private, for-profit health insurance with Medicare, Medicare for All would lead to far lower total costs, and I am including premiums, copayments, deductibles and taxes. It would cover all Americans. People could keep their same doctor, or other health care provider, and could buy private insurance to supplement it just as some people now buy private insurance to supplement Medicare and social security.

Finally, if the pandemic has taught us anything, it is that we need to decouple health insurance from employment. Losing a job should not mean a loss of the family's lifeline to health care. The Affordable Care Act was a good start at reform, but as Medicare and Social Security have demonstrated, we should not have to pay private for-profit insurers, boatloads of money to get the insurance we need.

Now I have no illusions this is going to happen soon, but the road we are now on is unsustainable economically, politically and socially. Eventually we are going to have to have some version of Medicare for All. The question is how much unnecessary cost and hardship we must bear before we do. Thank you.

[The prepared statement of Robert B. Reich follows:]

Exploring Pathways to Affordable, Universal Coverage

United States House of Representatives

Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions

February 17, 2022

Mr. Chairman and members of the Committee,

My name is Robert Reich. I am Chancellor's Professor of Public Policy at the University of California at Berkeley. Thank you for giving me this opportunity to testify before the Committee on how we move to affordable and universal healthcare coverage.

The typical American family spends¹ more than \$6,000 a year² on health insurance premiums. Add in the copayments and deductibles that doctors, hospitals, and drug companies also charge, and that sum rises to \$6,400.³ Add in the typical out-of-pocket expenses for pharmaceuticals, and it's at least \$6,800.

But that's not all, because some of the taxes the typical family pays are for health insurance, too — for Medicare and Medicaid and for the Affordable Care Act. Add *them* in, and the typical household pays a whopping \$8,975⁴ a year for health insurance. And this number is expected to rise⁵ in the coming years. Oh, and this number doesn't even include what typical workers' *employers* spend on their health insurance — which might otherwise go to their wages.

¹ In order that data are not distorted by unique health needs and challenges during the pandemic, all data on private and public health expenditures predate the pandemic.

² <https://www.bloomberg.com/news/articles/2019-09-25/why-is-health-insurance-so-expensive-20-000-a-year-for-coverage?sref=OKUfhQHv>

³ <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/how-much-us-households-employer-insurance-spend-premiums-out-of-pocket>

⁴ <https://www.fool.com/taxes/2018/04/22/how-much-does-the-average-american-pay-in-taxes.aspx>

⁵ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>

Not a pretty picture. If you're a typical American, you're paying far more for health insurance than people in any other advanced country ⁶

And you're not getting your money's worth. American spending on healthcare per person is more than *twice* the average in the world's thirty-five advanced economies. (See Charts 2 through 4 below). Yet the United States ranks near the bottom among those advanced economies for life span and infant mortality. (See Chart 1, below). Americans are sicker, our lives are shorter, and we have more chronic illnesses than in any other advanced nation. Canadians, for example, can expect to live on average almost four and a half years longer ⁷ than Americans, even though health care spending per person is only about half ⁸ as high as in the U.S.

That's largely because medical care is so expensive for the typical American that many put off seeing a doctor until their health has seriously deteriorated. Some 30 million Americans have no health insurance coverage at all.⁹

The Affordable Care Act is not perfect, but it has proven to be a major step in the right direction. Over 20 million¹⁰ Americans have gained coverage because of it. The Biden administration has strengthened it by increasing outreach ¹¹ to potential enrollees, and the American Rescue Plan expanded subsidies for Americans buying insurance on health care exchanges. But the Rescue Plan provided only two years of enhanced subsidies; unless Congress passes an extension, the subsidies will soon be gone.

Congress's first priority should be to strengthen the Affordable Care Act. The next should be to move toward universal health insurance.

A big reason Americans pay so much for health insurance are the administrative costs involved in private for-profit insurance.¹²

About a third of what the typical American pays for health insurance goes to the people who oversee billing and collections. ¹³ And then of course there are the marketing and advertising expenses, ¹⁴ and the profits that go to shareholders or private-equity managers.¹⁵

⁶ <https://jamanetwork.com/journals/jama/article-abstract/2674671>

⁷ <https://data.oecd.org/healthstat/life-expectancy-at-birth.htm>

⁸ <https://data.oecd.org/healthres/health-spending.htm>

⁹ <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>

¹⁰ https://archive-it.org/collections/3926?fc=meta_Date:2016

¹¹ <https://www.cnbc.com/2022/01/18/obamacare-enrollment-hits-record-high-after-biden-makes-changes.html>

¹² <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1327>

¹³ <https://www.nejm.org/doi/full/10.1056/nejmsa022033>

¹⁴ <https://www.reuters.com/article/us-health-medical-marketing/us-health-care-industry-spends-30-billion-a-year-on-marketing-idUSKCN1P22GG>

¹⁵ <https://www.ibtimes.com/obamacare-effect-top-us-insurers-reward-shareholders-healthcare-costs-climb-2032391>

With a limited version of Medicare for All that kept private insurance, the insurance costs would of course remain the same (it's the same private insurers and the same co-payments and deductibles). But more of it would be paid through peoples' taxes rather than by individuals directly, because the government would reimburse the insurance companies.

This could help bring down costs by giving the government more bargaining leverage to get better prices.

A more ambitious version of Medicare for All would replace private for-profit health insurance. This would lead to far lower total costs — including premiums, co-payments, deductibles, *and* taxes.

The main reason this option is far cheaper is because it wouldn't have all the administrative expenses.¹⁶ Public insurance that reimburses hospitals, doctors, and pharmaceutical companies directly eliminates the bloat of private insurance companies.

Economists at the University of Massachusetts-Amherst¹⁷ have calculated that Medicare for All -- which replaced private for-profit insurance -- would reduce costs by about 10 percent, mostly from lower administrative and drug costs. The Urban Institute¹⁸ estimates that households and businesses would save about \$21.9 trillion over ten years, and state and local governments would save \$4.1 trillion.

Even though individuals would still be paying for it — through a combination of premiums, fees, and taxes — their *overall* expenses would go way down. So they would come out ahead. And everyone would be covered.

They'd keep your same doctor or other health-care provider. And they could still buy private insurance to supplement Medicare for All, just like how some people now buy private insurance to supplement Medicare and Social Security. The only thing that would change is they would no longer be paying private for-profit insurers.

Like Medicare and Social Security, this system would be based on the simple and proven idea that we shouldn't be paying private for-profit insurers boatloads of money to get the insurance we need.

I have no illusions that we will move anytime soon to this form of Medicare for All, but I believe it should be our aspiration. The costs of private for-profit health insurance, along with copayments and deductibles, are rising too quickly, and the nation's overall health is too poor. This is not sustainable over the long term.

¹⁶ <https://www.nytimes.com/2018/10/15/upshot/is-medicare-for-all-the-answer-to-sky-high-administrative-costs.html#targetText=Putting%20them%20together%20for%20the,11%20percent%20of%20their%20spending>.

¹⁷ https://peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all?mod=article_inline

¹⁸ <https://www.urban.org/sites/default/files/publication/80486/200785-The-Sanders-Single-Payer-Health-Care-Plan.pdf>

The Affordable Care Act has taken the United States closer to universal coverage than ever before, and has functioned well -- but it has still left millions uninsured. Americans continue to pay more for health insurance than the citizens of any other advanced country. And Americans have the worst health.

Surely, we can do better.

CHART 1

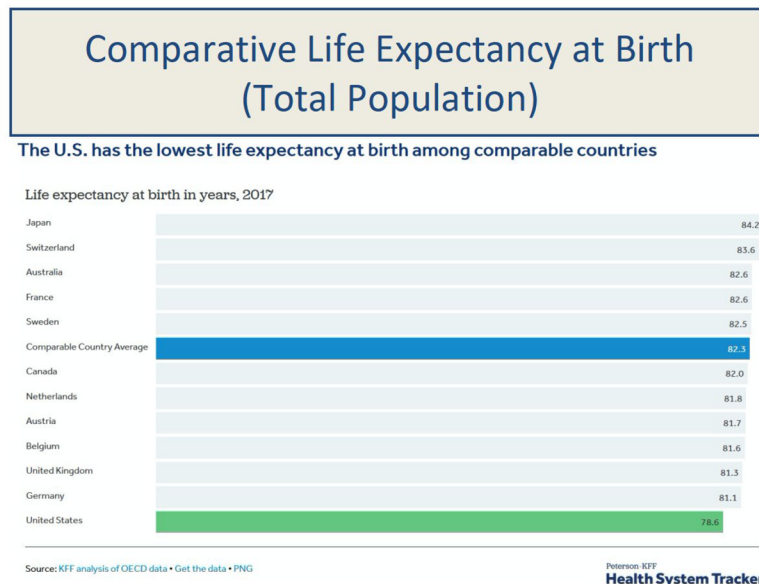
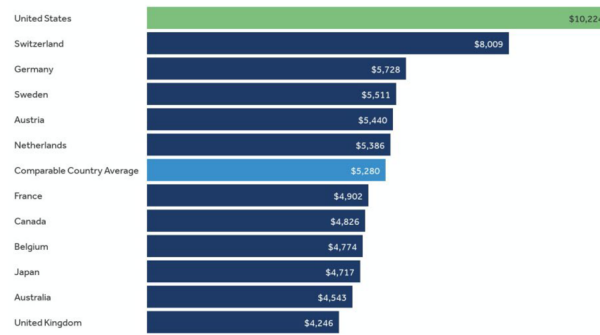


CHART 2

Comparative Health Spending, per capita

Health consumption expenditures per capita, U.S. dollars, PPP adjusted, 2017



Notes: U.S. value obtained from National Health Expenditure data. Health consumption does not include investments in structures, equipment, or research.

Source: KFF analysis of OECD and National Health Expenditure (NHE) data • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

CHART 3

U.S. comparative health care spending over time, as percentage of GDP

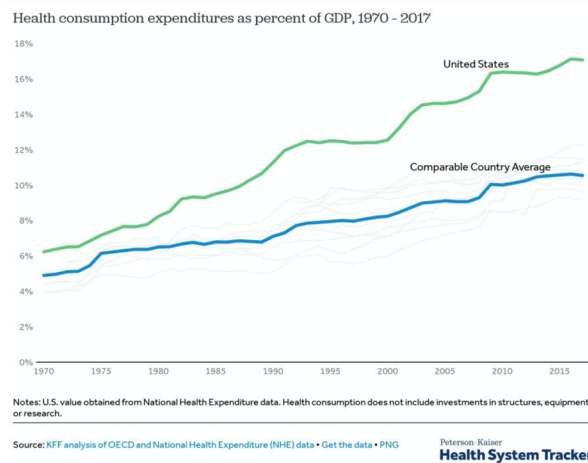
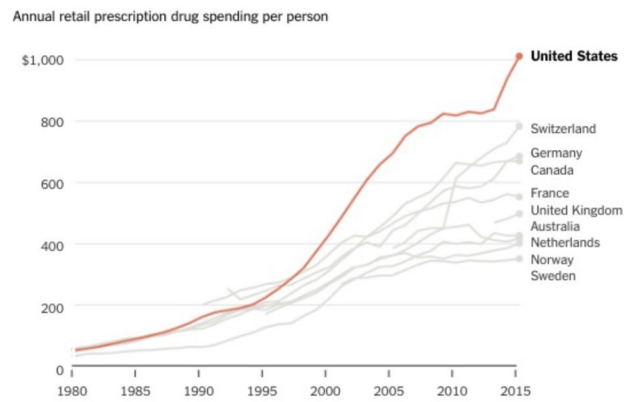


CHART 4

Retail prescription drug spending per-capita, by country



Source: The Commonwealth Fund. Graphics by NY Times

Chairman DESAULNIER. It is the joy of aging and finding the cursor Bannon. I talked to those people in Silicon Valley about that. Thank you. I apologize. Now we are going to hear from Dr. Georges Benjamin. He is the Executive Director of the American Public Health Association.

He is also Board certified in internal medicine, a Master of the American College of Physicians, a Fellow of the National Academy of Public Administration, Fellow Emeritus of the American College of Emergency Physicians, and a member of the National Academy of Medicine. Dr. Benjamin the floor is yours.

STATEMENT OF GEORGES C. BENJAMIN, M.D., EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. BENJAMIN. Mr. Chairman and members of the committee thank you very, very much. I have had the privilege of practicing medicine for many years, and in many, many settings, and interestingly enough the one thing that I have learned through all of my experiences is that coverage matters.

Now our Nation has been trying to get this right for over 100 years. We have not yet achieved that. There is no question that we can do better. I am going to spend my time basically just expounding on my written testimony that you have, and just talk about what coverage matters.

There is no question that having an insurance card is your entry fee into getting high-quality affordable health care. You know numerous studies have demonstrated that fact. You go back to 2002 when the Institute of Medicine found that uninsured adults had fewer preventive screens, worse clinical outcomes from cancer, cardiovascular disease, HIV, mental illness, and end-stage renal disease.

When they did their study, they estimated that about 18,000 premature deaths occurred simply because people did not have health insurance coverage. There have been many other studies. One that I am aware of because it was published in the American Journal of Public Health, which is the Journal that my association sponsors, which went to almost 44,000 deaths per year because people were not covered.

We also know that since the passage of the Affordable Care Act, and when the Supreme Court decision made Medicaid coverage optional for the states, we in effect have had a natural experiment occurring in our country. We have had states that have not been covered with Medicaid and did not expand in other states.

We know that for example having a personal doctor, which of course is known to be an important determinant of access to care, the individuals in those states that were covered they were much more likely to have a relationship with a particular physician.

In addition, in a series of studies that found Medicaid coverage facilitated more people having a regular source of care, better access to preventive services, better access to well-child visits, better access to early diagnosis and treatment, and improved access to behavioral health, and treatment for things like substance use disorders.

We also know that all-cause mortality, was reduced in states like Massachusetts when Massachusetts expanded coverage overall

their mortality dramatically fell. We know that a national goal also was to reduce utilization of hospital emergency departments for non-urgent care.

There have been many studies that have shown that we reduced the utilization of emergency departments when we've expanded coverage. We also know that universal health care coverage can reduce health inequities and disparities in health. When we expanded CHIP, the Children's Health Insurance Program, which was of course expanded for low-income families who did not qualify for Medicaid.

It was associated with increased access to care and reduced racial disparities. We also know that similarly differences in diabetes and cardiovascular disease outcomes by race, ethnicity, and socioeconomic status declined among previously uninsured adults once they became eligible for Medicare coverage.

We also know that as we think about these disparities universal access to care goes a long way to improving health, but the social determinant of health is actually a bigger determinant in many ways, particularly around health care disparities. Access is actually an essential component of that. We know also that health insurance coverage can improve the economic well-being of communities, it can create jobs as well.

If there is anything that we have not missed, the COVID outbreak has demonstrated the importance of universal health care coverage more than anything else. As you know we've got over 78 million people that were exposed to this disease who got it.

Peak hospitalizations—over 150,000 per day, and almost a million deaths so far, and so there is an absolute need for universal health care coverage. When it is time I will be happy to take questions on any of these issues. Thank you very, very much.

[The prepared statement of Dr. Benjamin follows.]



**Testimony of Georges C. Benjamin, MD, MACP, FACEP(E), FNAPA
Executive Director
American Public Health Association
Exploring Pathways to Affordable Universal Coverage
Committee on Education and Labor
Subcommittee on Health, Employment, Labor and Pensions
U.S House of Representatives
February 17, 2022**

Chairman DeSaulnier, Ranking Member Allen, Chairman Scott, and members of the subcommittee, thank you for giving me the opportunity to address you today on the need for universal health care coverage.

I am Georges C. Benjamin, MD, executive director of the American Public Health Association. APHA is our nation's professional society that champions the health of all people and all communities. We are celebrating our 150th anniversary as an association this year and are celebrating our work to improve the health and well-being of our nation and the world.

I am a physician who is trained and certified in internal medicine. I spent the first half of my career as a clinician, practicing and teaching emergency medicine both in the private sector and in the military. I have also had the opportunity to serve my community in a variety of executive management positions to include: Chief of Emergency Medicine at the Walter Reed Army Medical Center; Chairman of the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital; Acting Commissioner for Public Health for Washington, D.C.; Interim Director of the Emergency Ambulance Bureau of the D.C. Fire and EMS Department; and Health Secretary for the State of Maryland. I have served as the executive director of APHA for the last 19 1/2 years. I share my professional background with you here today to point out I have practiced and managed in almost every patient care component of our health and public health system. During my professional career, I have learned one thing: To receive quality, affordable health care, coverage matters.

The State of Coverage

Efforts around universal health care in the United States started in the early 1900s and have resurfaced on a regular basis.¹ President Franklin D. Roosevelt attempted twice in the 1940s to establish universal health care and was unsuccessful.¹ The U.S. Congress passed Medicare and Medicaid in the 1960s, and when the programs were signed into law, we expanded coverage for most seniors and some low-income individuals and families. The movement toward universal health care coverage was further advanced after the Patient Protection and Affordable Care Act was signed into law.² Expanding health insurance coverage has been surprisingly difficult. There also have been decades of political animosity toward health care reform in the United States, with failed attempts during the Nixon and Clinton administrations and numerous failed attempts to repeal and challenge the ACA. Today, the U.S. government remains the largest payer of health care in the United States, covering nearly 90 million Americans through Medicare, Medicaid, TRICARE, and the Children's Health Insurance Program.³ However, this coverage is not universal, and many Americans remain uninsured³ or underinsured.^{4,5}

Health insurance is your membership card to our nation's health care system. While we do have a very large safety net system that includes public and private clinics, community health centers and emergency departments, health insurance coverage remains your best ticket to equitable care. Today, 90% of the civilian noninstitutionalized U.S. population has health insurance coverage.⁴ Sixty-one percent have coverage through private coverage, and 38% through public coverage. This means that 9.7% of the population is uninsured. The percentage of individuals lacking insurance coverage is highly variable across states, with Texas being the highest at 17.7% to Massachusetts the lowest at 2.8%.⁶ The lack of insurance coverage is also variable across race and ethnicity:

- of non-Hispanic Whites, being 7.8% lack coverage;
- of Asians 7.2% lack coverage;
- of non-Hispanic Blacks, 11.4% lack coverage;
- of Hispanics, 20% lack coverage;
- of American Indian/Alaska Natives, 21.7% lack coverage; and
- of Native Hawaiian/Pacific Islanders, 12.7% lack coverage.⁷

We know coverage disparities contribute to worse health outcomes. It is clear that until we achieve a health system with everyone in and no one out, we will continue to struggle to achieve

the best health for our population. In the United States today, the key to such a health system is affordable health insurance coverage.

The United States spends more on health care (\$4.1 trillion, or 19.7% of GDP in 2020) than any other industrialized country yet has worse health outcomes.^{3,8} Tragically, we have the most preventable deaths of any high-income nation but spend just 2.9% of that \$4.1 trillion on public health.⁸

Our lack of universal coverage has been found to be one of the four factors that has contributed to the U.S. ranking last in health system performance when compared to 11 other high-income countries. One study found that there were four features that distinguished top performing countries from the United States: “1) they provide for universal coverage and remove cost barriers; 2) they invest in primary care systems to ensure that high-value services are equitably available in all communities to all people; 3) they reduce administrative burdens that divert time, efforts, and spending from health improvement efforts; and 4) they invest in social services, especially for children and working-age adults.”⁹

Coverage Improves Health

Health insurance coverage impacts many things including access to health care, morbidity, mortality, the quality of care received, equity, and both individual and system economics.

Numerous studies have demonstrated the value of coverage. Since the passage of the Affordable Care Act and the 2012 Supreme Court decision *National Federation of Independent Business et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al.*, which made Medicaid coverage optional for the states, the nation has undergone a natural experiment that has demonstrated the value of health insurance coverage. For example, having a personal doctor is known to be an important determinant of good access to care. More individuals in states that have expanded the Medicaid program have a personal physician than in states that have not expanded.¹⁰ In addition, a series of studies found Medicaid coverage facilitated more people having a regular source of care; better access to preventative services, well child visits and early diagnosis and treatment; and improved access to behavioral health and treatment for substance use disorders.^{11,12,13,14,15,16,17} All-cause mortality was reduced in the state of Massachusetts when

they expanded coverage.¹⁸ In states that expanded Medicaid following the ACA's passage, several studies have shown that mortality increased specifically with cardiovascular disease.¹⁹

Another national goal has been to optimize the utilization of care to the appropriate clinical setting. Coverage has been shown to reduce the utilization of emergency departments for non-emergent care.^{20,21,22,23} If cost is a concern, which of course it is, keeping people out of emergency rooms except for emergency care is a major reason to provide universal coverage.

Universal health care can help increase access to care while decreasing disparities in health. Several factors point to decreased racial and ethnic disparities under a universal health care model. CHIP's creation in 1997 covered children in low-income families who did not qualify for Medicaid; this coverage is associated with increased access to care and reduced racial disparities.²⁴ Similarly, differences in diabetes and cardiovascular disease outcomes by race, ethnicity, and socioeconomic status decline among previously uninsured adults once they become eligible for Medicare coverage.²⁵ While universal access to medical care can reduce health disparities, it does not eliminate them; health inequity is a much larger systemic issue that society needs to address.

Still, universal health care better supports the needs of vulnerable groups. The estimated lifetime risk of need for long-term care and support services is about 52% among Americans 65 years or older.²⁶ Activities of daily living programs are not considered "medical care" and are not covered by Medicare or health plans. Medicaid buy-in programs for workers with disabilities exist in many states but have varying benefit levels and eligibility restrictions.²⁶ The United States can adopt strategies from existing models in other countries with long-term care policies already in place. For example, Germany offers mandatory long-term disability and illness coverage as part of its national social insurance system, operated since 2014 by 131 nonprofit sickness funds.²⁷ German citizens can receive an array of subsidized long-term care services without age restrictions.²⁷ In France, citizens 60 years and older receive long-term care support through an income-adjusted universal program.²⁸

Universal health care can also decrease health disparities among individuals with mental illness. For instance, the ACA Medicaid expansion helped individuals with mental health concerns by improving access to care and effective mental health treatment.^{29,30,31}

Health insurance coverage has been understood to improve the economic well-being of individuals, families, and health systems. Coverage reduces out of pocket costs as well as serves

as a buffer from catastrophic costs should an individual require a costly medical care.³⁰ In addition, the economic well-being of hospitals, particularly in rural communities, has been shown to be enhanced.^{31,32}

Other societal benefits from Medicaid coverage have been job creation. In Montana, for example, Medicaid expansion has been credited with the expansion of 5,000 jobs between 2018 and 2020, and in Ohio expansion is linked to improving the ability to seek and maintain work.^{31,34}

COVID-19 Pandemic Exposes Health System Shortfalls

The COVID-19 pandemic exacerbated underlying vulnerabilities in our current health care system and highlighted the urgent need for universal health care for all Americans.

Health care is inaccessible for many individuals in the United States. For many Americans, accessing health care remains cost prohibitive.³⁵ Coverage under employer-based insurance is vulnerable to fluctuations in the economy. Due to the COVID-19 pandemic, an estimated 20 million Americans had lost their employer-sponsored health insurance by September 2021 as a result of job loss.³⁶ Job losses were not distributed evenly and particularly affected those in low-paying, service-sector positions, thereby disproportionately affecting individuals of lower socioeconomic status.^{37,38} When uninsured or underinsured people refrain from seeking care, this may lead to delayed diagnosis and treatment. These delays can promote the spread of an infectious pathogen, reduce overall health, and, therefore, increase overall health care costs.

The ACA reformed health care by eliminating exclusions for preexisting conditions, requiring coverage of 10 standardized essential health care services, capping out-of-pocket expenses, and significantly increasing the number of insured Americans. However, many health services remain uncovered, and out-of-pocket costs can vary considerably. Those living with a disability or chronic illness are likely to use more health services and pay more. A recent survey conducted during the COVID-19 pandemic revealed that 38.2% of working adults and 59.6% of adults receiving unemployment benefits from the Coronavirus Aid, Relief, and Economic Security (CARES) Act could not afford a \$400 expense, highlighting that the COVID-19 pandemic exacerbated lack of access to health care because of high out-of-pocket expenses.³⁷ In addition, the ACA did not cover optometry or dental services for adults, thereby limiting access to care even among the insured population.³⁹

A 2019 study by the Commonwealth Fund⁵ showed that after 10 years of implementation, 45% of adults ages 19 to 64 enrolled in the ACA were underinsured, defined as having out-of-pocket health care expenses of 10% or more of one's income (or 5% or more for those up to 200% above the federal poverty limit).

Our current health care system remains significantly stressed in its response to the COVID-19 pandemic to supply the level and quality of care our population expects and is entitled to. For the first time in our history, we implemented crisis standards of care on a broad basis, thereby triaging care for many individuals. The pandemic also reminded our nation of the vital role of the governmental public health system. The lack of an adequately structured and resourced federal, state, and local public health system is one major reason our nation performed as poorly as it did in responding to the COVID-19 pandemic.^{40,41}

The U.S. public health system has a fragmented and antiquated data collection and disease surveillance systems. The COVID-19 pandemic response was plagued by inconsistent utilization of science-based public health strategies to mitigate the contagion, such as isolation, quarantine, masking, testing, and vaccination. Our system has been doubly challenged by historic under-investments in public health infrastructure and an inability to mount a coordinated national response linking our medical and public health data systems, messaging, and outreach.⁴⁰

As in other economic downturns wherein people lost their employer-based insurance, more people enrolled in Medicaid during the pandemic. States' efforts to cover their population, such as expanding eligibility, allowing self-attestation of eligibility criteria, and simplifying the application process, also increased Medicaid enrollment numbers.⁴¹ The federal "maintenance of eligibility" requirements further increased the number of people on Medicaid by postponing eligibility redeterminations. Resuming eligibility redeterminations will cause some to lose coverage. There is significant concern that when the public health emergency ends as many as 15 million people will be at risk of losing their coverage if their incomes are above traditional Medicaid thresholds.^{42, 43}

An urgent need for coverage during the pandemic persists. Virginia's enrollment has increased by more than 40% since March 2020.⁴⁴ In Arizona, 78,000 people enrolled in Medicaid and CHIP in two months.⁴⁴ In New Mexico, where 42% of the population was already enrolled in Medicaid, 10,000 more people signed up in the first two weeks of April than expected before the pandemic.⁴⁵ Nearly 24 million people who lost their jobs during the pandemic could

be eligible for Medicaid.⁴⁵ Even in September 2021, the leisure and hospitality sector had a job shortfall of nearly 1.6 million relative to February 2020. The number of long-term unemployed (those jobless for 27 weeks or more) decreased by 496,000 in September to 2.7 million but was 1.6 million higher than in February 2020.⁴⁶

While increasing Medicaid enrollment can cover individuals who otherwise cannot afford care, it further strains state budgets.⁴⁴ Medicaid spending represents a significant portion of states' budgets, making it a prime target for cuts. Ohio announced \$210 million in cuts to Medicaid, a significant part of Colorado's \$229 million in spending cuts came from Medicaid, Alaska cut \$31 million in Medicaid, and Georgia anticipates 14% reductions overall in 2020. These cuts were in response to reduce revenues related to the pandemic.⁴⁴

While Congress authorized a 6.2% increase in federal Medicaid matching during the pandemic, this increase was not permanently expanded (through 2021)⁴⁷ and is unlikely to sufficiently make up the gap caused by increased state spending and decreased revenue.⁴² Given the severity and projected longevity of the pandemic's economic consequences, many people will remain enrolled in Medicaid throughout state and federal funding cuts. This piecemeal funding strategy is unsustainable and will strain Medicaid, making accessibility even more difficult for patients.

One way to expand health insurance coverage is to continue to build upon the Affordable Care Act. The House-passed Build Back Better Act includes significant investments for expanding and improving health coverage in the nation, moving us closer to the goal of achieving universal health coverage for all. The bill would close the current Medicaid coverage gap through 2025 by providing premium tax credits and cost-sharing subsidies for more than 2 million uninsured individuals who live below the poverty line. Importantly, the bill would also expand Medicare benefits by adding coverage for hearing services for millions of our nation's seniors. The bill would also extend the American Rescue Plan Act's enhanced premium tax credits for purchasing Affordable Care Act plans in the federal marketplace through 2025.

In addition, the measures in the legislation would provide important new investments to improve the health of our nation's children and their families. The bill would require 12 months of continuous Medicaid and the CHIP eligibility to postpartum women, implement interventions and research to address the nation's maternal mortality crisis, require 12 months of continuous

eligibility for children enrolled in Medicaid and CHIP and authorize permanent funding for CHIP.⁴⁸

The pandemic continues to highlight the difficult truth that health disparities remain a significant problem in our current health system. Four reasons that have historically been thought to contribute to health inequities:

1. unequal access to health care, including, health insurance coverage;
2. differences in the quality of care received in the system;
3. differences in health seeking behavior; and
4. differences in access to goods and services communally known as the social determinants of health. These social determinants include structural racism and discrimination. During COVID-19 many of these factors became evident in the higher prevalence in COVID-19 hospitalizations and deaths in communities of color.⁴⁹

The 1964 Civil Rights Act outlawed segregation of health care facilities receiving federal funding, and beginning in 2010, the ACA significantly benefited people of color. Yet racial and sexual minority disparities persist today in our health care system. For example, under a distribution formula set by the U.S. Department of Health and Human Services, hospitals reimbursed mostly by Medicaid and Medicare received far less federal funding from the March 2020 CARES Act and the Paycheck Protection Program and Health Care Enhancement Act than hospitals mostly reimbursed by private insurance.⁵⁰ Hospitals in the bottom 10% based on private insurance revenue received less than half of what hospitals in the top 10% received. Medicare reimburses hospitals, on average, at half the rate of private insurers. Therefore, hospitals that primarily serve low-income patients received a disproportionately smaller share of total federal funding.⁵⁰

Additional barriers for these communities include fewer and more distant testing sites, longer wait times,⁵¹ prohibitive costs, and lack of a usual source of care.⁵² Black Americans diagnosed with COVID-19 are more likely than their White counterparts to live in lower-income zip codes, to receive tests in the emergency department or as inpatients, and to be hospitalized and require care in an intensive care unit.⁵³ Nationally, only 20% of U.S. counties are disproportionately Black, but these counties account for 52% of COVID-19 diagnoses and 58% of deaths.⁵⁴ The pre-pandemic racial gaps in health care catalyzed pandemic disparities and will

continue to widen them in the future. As of February 2022, disparities in COVID-19 vaccination rates among Hispanic, Black, Native American, and Asian/Pacific Islander individuals have improved substantially but remain below the rate among their White counterparts.⁵⁵

Summary

The COVID-19 pandemic has brought a new urgency to the need for universal health care coverage in the United States. This is an unprecedented time, and indeed the pandemic has exacerbated many of the existing problems in our current patchwork health system. The COVID-19 pandemic represents a watershed moment where we can reconstruct a fractured health insurance system into a system of universal health care. As new data emerge about those most impacted by the pandemic, this is also a unique opportunity to expand benefits to address the needs of the underserved, the most vulnerable, and those historically denied or left out of health services. If we can drive to homebound people's houses to vaccinate them, we can reimagine boundaries to make home- and community-based disability services, dental care, vision services, prescription drugs, chiropractic care, mental health care, and telemedicine standard practice. We also recognize the essential role of ensuring that public health remains an integral part of any universal health system in order to advance population health.

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Chairman DESAULNIER. Thank you, Doctor. Next, we have Dr. Brian Blase. He is the President of Paragon Health Institute. He was previously Special Assistant to the President for Economic Policy at the White House's National Economic Council from 2017 to 2019. He also serves as a Senior Fellow at the Galen Institute, and a visiting fellow at the Foundation for Government Accountability. Doctor Blase, the floor is yours.

**STATEMENT OF BRIAN BLASE, PH.D., PRESIDENT, PARAGON
HEALTH INSTITUTE**

Dr. BLASE. Thank you, Mr. Chairman, Ranking Member Allen, and members of the committee. It is a privilege to testify before you today, particularly since I was once a House staffer. I am the Founder and President of a new think tank, the Paragon Health Institute, and my testimony today represents my own views.

I will focus on how to achieve more affordable and higher quality healthcare and coverage. For too many people healthcare and coverage are not affordable, for which government bears some responsibility. For example, individual market premiums more than doubled in the first 4 years of the Affordable Care Act yet plans covered fewer doctors and hospitals.

In 2021, the average ACA plan premium plus deductible for a family of four was \$25,000.00. Since coverage is cost prohibitive, most enrollees need large subsidies to afford these plans. At the outset, it is important to acknowledge some basic truths. The U.S. does not have a free market for health care. Half of U.S. healthcare spending is by government, most of the rest is impacted by government policy.

As government's role in healthcare has expanded, prices have soared. By contrast, in industries where government's role is minimal, inflation adjusted prices typically decline while quality improves. High healthcare prices and spending that correspond to meaningful health and longevity gains have justification. Some areas of U.S. healthcare, like our cancer survival rates are exceptional compared to other developed nations.

Too often however, high prices and spending do not correspond to high value and improved health. This is a key problem to confront in health policy. For example, if the ACA expanded coverage, and significantly increased Federal health spending, primarily through Medicaid, but American life expectancy declined for three straight years after the ACA's covered provisions took effect.

In fact, American's life expectancy was lower in 2019 than in 2013. There is too much government bureaucracy in healthcare. Different Government rules despite good intentions, often restrict options for coverage and care, stymie innovation, and prevent providers from being able to best meet their patient needs.

Government also mismanages programs to an epic degree. Last year CMS reported annual Federal improper payments in Medicaid were 100 billion dollars. There is too much insurance bureaucracy in healthcare. Insurance is important, but having insurance pay for routine and shoppable services leads to over consumption and waste. People often secure better prices by not using the health insurance.

One study estimated the cash prices are 40 percent cheaper, than prices with insurance. For healthcare services where a third-party payment is limited, such as cosmetic surgery and Lasik, real prices have declined while quality has improved. Moving forward you should keep a few principles in mind.

First, policy changes always have unintended consequences. We should evaluate outcomes, not the intentions behind those policies. For example, many ACA proponents said it would reduce ER visits because patients could find a usual source of care, but the exact opposite happened. ER use surged, often for non-emergent care.

Second, when government subsidizes something, it becomes more expensive. Subsidies increase demand, raise prices, and increase total spending, and must be funded by taxpayers. The American Rescue Plan Act expanded the ACA's already substantial subsidies, and in doing so increased coverage, but most of the benefit went to people already insured, so it was a highly inefficient way to increase coverage.

According to CBO estimates, the subsidy expansion cost about \$17,000.00 each year per newly insured person. These subsidies are also inflationary, allowing insurers to raise premiums at taxpayer's expense.

Finally, some recommendations. Congress should codify four of the previous administration's policies that expanded options without new Federal spending—association health plans will allow more small employers the ability to offer coverage to workers. Short term plans help many Americans who could not otherwise afford coverage.

Individual coverage HRA's enable employers another way to offer health insurance through tax deferred contributions that the workers use to buy coverage in the individual market. Price transparency rules empower patients and employers to know prices before purchasing services.

Congress should also reorient this government spending to maximize patient choice, and reward value conscious decisions. Americans should have the freedom to spend their own money on the healthcare and coverage they choose. These policies provide a good start. I thank you again for the opportunity to testify today, and I look forward to your questions.

[The prepared statement of Dr. Blase follows:]

Testimony of Brian C. Blase, PhD before the House Committee on Education and Labor
 Subcommittee on Health, Employment, Labor, and Pensions
 “Exploring Pathways to Affordable, Universal Health Coverage”
 February 17, 2022

Chairman DeSaulnier, Ranking Member Allen, and members of the Subcommittee, my name is Brian Blase, and I was privileged to work for the House Committee on Oversight and Government Reform from 2011 through 2014. You have vital jobs serving the American people, and it is an honor to testify before this Committee today on this important topic.

I am the founder and president of a new health policy think tank—Paragon Health Institute. My testimony today represents my views and not those of Paragon. I am also a senior research fellow at the Galen Institute and a visiting fellow at the Foundation for Government Accountability. From 2017 through 2019, I served as a Special Assistant to the President for Economic Policy at the White House’s National Economic Council. In that capacity, I led policy and regulatory work on several areas that I am testifying about today, including Association Health Plans, short-term limited-duration health plans, individual coverage health reimbursement arrangements, and price transparency rules.

The title of today’s hearing is “Exploring Pathways to Affordable, Universal Health Coverage.” I’m here to discuss how we can achieve more affordable, higher quality health care—a worthy goal that nearly everyone supports. The goal of achieving universal health coverage can only be achieved if both health care and health coverage are affordable—and for too many people today, they are not. I will focus my testimony on how to achieve more affordable and higher-quality health care which will lead to millions more people having health coverage.

In many areas of the economy, products and services have become higher in quality over time while real prices, after accounting for inflation, have declined (Figure below: “Price Changes”).¹ Unfortunately, this has not been the case for most health care products and services.² As the following figure shows, prices for hospital services—the largest component of health care expenditures—have increased more than three times faster than general inflation over the past two decades.³ As health costs have risen, insurance premiums have correspondingly soared, even as plan deductibles have risen dramatically. In 2020, health care spending was 19.7 percent of U.S. Gross Domestic Product, a 6.4 percentage point increase and 48 percent increase from the 13.3 percent of U.S. GDP expended on health care in 2000.⁴ Importantly, over the past few decades, there have been some noticeable advances in health, such as a decline in cardiac mortality, improvement in cancer survival rates, a cure for Hepatitis C, and new AIDS treatments. However, there is also significant waste in the health sector and health outcomes

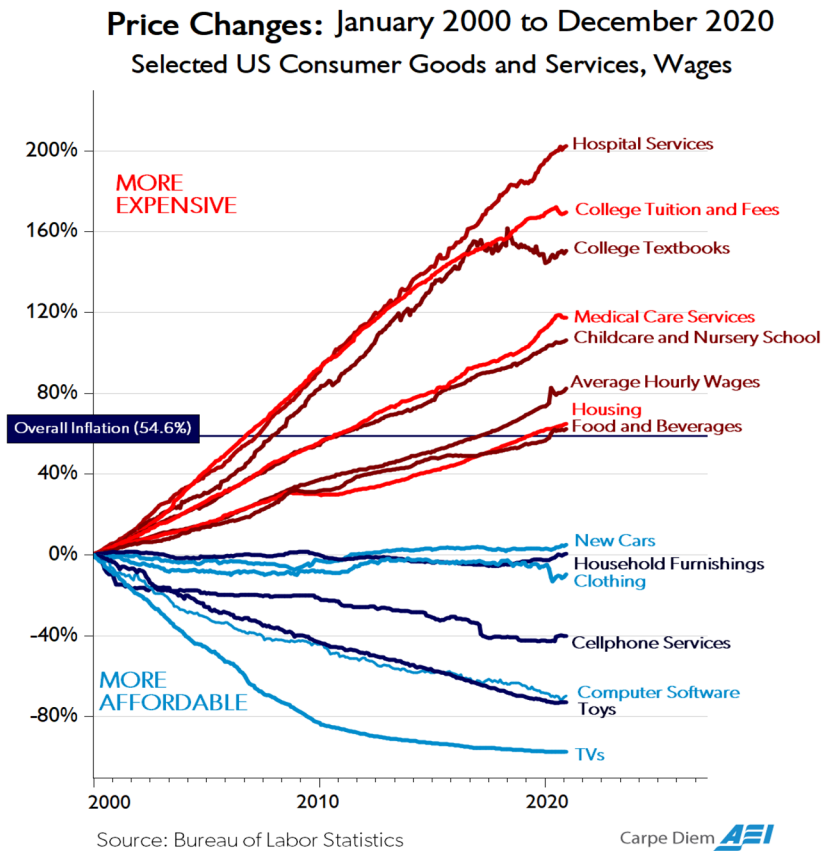
¹ Mark Perry, “Chart of the day . . . or century?” Carpe Diem, American Enterprise Institute, January 19, 2022, <https://www.aei.org/carpe-diem/chart-of-the-day-or-century-7/>.

² Id.

³ Id.

⁴ In 2019, the year before the pandemic, health care spending amounted to 17.6 percent of GDP. The increase in the percentage of GDP expended on health care increased in 2020 as health spending increased and GDP contracted. As the economy improves, health care spending as a percentage of GDP will likely decline. “National Health Expenditures 2020 Highlights,” Centers for Medicare and Medicaid Services (CMS), <https://www.cms.gov/files/document/highlights.pdf>.

have recently stagnated despite the Affordable Care Act's (ACA) new spending and the significant expansion of Medicaid. American life expectancy was lower in 2019 than it was in 2013, before the ACA's coverage and spending provisions took effect.⁵



⁵ "U.S. Life Expectancy 1950-2022," MacroTrends, <https://www.macrotrends.net/countries/USA/united-states/life-expectancy>, retrieved February 13, 2022.

Government Impact on Rising Health Care Prices and Costs

Current Policies

There are many policies—at both the federal and state levels—that raise health care prices and costs. Generally, high prices convey high value. But in health care because of government’s involvement, excessive third-party payment, and generally consolidated markets—high prices are often not a reflection of high value. A major consideration for policymakers in addressing high prices for medical care should be examining how existing government policies contribute to the problem and then focusing on reform.

A primary way that government inflates health care prices and costs is through tax and spending policies. In 2020, government health care spending—including both state and local government spending—was half of total U.S. health care expenditures.⁶ Federal policy also has a major influence over private sector health care spending, particularly through the tax exclusion for employer-sponsored health insurance. The Tax Policy Center estimated that this tax exclusion reduced federal revenue—both income and payroll tax collections—by \$273 billion in 2019.⁷

The key economic reality is that when government subsidizes something, that thing becomes more expensive. Subsidies increase demand, raise prices, and thus increase total spending in that area. For complete economic analysis, the taxpayer share of the total cost must be considered. For households to receive subsidies, other households must finance those subsidies. This financing can occur through higher taxes or through greater debt. More debt represents higher taxes in the future, either through direct taxes or higher inflation.

Reforming government health care subsidies is crucial to making health care more affordable for families, businesses, and taxpayers. While such reform is critical to reducing health care cost pressures on family and government budgets, I am generally limiting my testimony on federal health care subsidies to current proposals that would make the existing problems even worse.

Health Subsidy Design Flaws

Although the magnitude of government subsidies for health care increases prices and spending, the design of the subsidies is also problematic. Historically, government programs and tax policy have encouraged third-party payment of health services. Thus, for the vast majority of health care transactions, individuals do not directly spend their own money but instead rely on a government program or their insurance plan. Insurance should play a significant role in financing catastrophic and expensive care but having insurance pay for routine and shoppable services rather than relying on markets for these services distorts decision-making and leads to overconsumption and waste. While inflation in health care services has been substantial, health care services where third-party payment is limited—such as cosmetic surgery and Lasik-eye

⁶ “National Health Expenditures 2020 Highlights,” CMS.

⁷ *Tax Policy Center Briefing Book*, “Key Elements of the U.S. Tax System: How does the tax exclusion for employer-sponsored health insurance work?” 2021, <https://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work>.

surgery—have had real price declines as quality has significantly improved.⁸ Also, a number of physician practices and medical centers, such as the Oklahoma Surgery Center, do not accept insurance and have much lower average prices.⁹

As I discuss below, the ACA made individual market health insurance less affordable and introduced a generally inefficient set of subsidies. The ACA expanded coverage in two ways—with a large Medicaid expansion funded almost entirely by federal dollars and with new premium subsidies to help people afford individual and small group insurance that was made much more expensive because of the ACA's extensive new federal regulation.

Nearly the entire net coverage gains from the ACA occurred through Medicaid expansion, although many people who gained coverage through Medicaid were, in fact, not eligible for the program.¹⁰ Enrollment in individual market changes through the exchanges has largely been disappointing, falling far below original projections. From 2015-2020, exchange enrollment averaged about 10-11 million people¹¹—about 60 percent below what the Congressional Budget Office projected in May 2013 in its last analysis before the ACA's provisions took effect.¹²

Low exchange enrollment may be explained by the individual market premiums increasing 105 percent from 2013 to 2017.¹³ The vast majority of enrollees receive large subsidies as the premium increases have largely priced unsubsidized individuals out of the market.

For the unsubsidized in 2021, the average exchange plan annual premium plus deductible for a family of four was about \$25,000—meaning that a family needed to spend about \$25,000 before they received any real meaningful financial benefit from their insurance.¹⁴ In addition to the high cost, ACA plans tend to have narrow networks, excluding the best hospitals and doctors in local regions. For example, in Texas, not a single ACA plan covers Houston's world-renowned MD Anderson Cancer Center.

⁸ Mark Perry, "What economic lessons about health care costs can we learn from the competitive market for cosmetic procedures?" American Enterprise Institute, April 25, 2019, <https://www.aei.org/carpe-diem/what-economic-lessons-about-health-care-costs-can-we-learn-from-the-competitive-market-for-cosmetic-procedures-2/>.

⁹ For a discussion of the Oklahoma Surgery Center: Russ Roberts and Keith Smith, "Keith Smith on Free Market Health Care," EconTalk, November 18, 2019, <https://www.econtalk.org/keith-smith-on-free-market-health-care/>.

¹⁰ Brian Blase and Aaron Yelowitz, "The ACA's Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments," Mercatus Center, November 25, 2019, <https://www.mercatus.org/system/files/blase-medicaid-expansion-mercatus-research-v1.pdf>.

¹¹ The average number of enrollees over the course of the year accounts for the fact that some people who choose coverage during open enrollment fail to pay any premium and net attrition in enrollment over the course of the year. Typically, about 12 million people would enroll initially, but by the end of the year enrollment would be closer to 9 million.

¹² "CBO's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," Congressional Budget Office, May 2013, <https://www.cbo.gov/sites/default/files/recurringdata/51298-2013-05-aca.pdf>.

¹³ ASPE Data Point, "Individual Market Premium Changes: 2013-2017," Assistant Secretary for Planning and Evaluation, May 23, 2017, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/174771/IndividualMarketPremiumChanges.pdf.

¹⁴ Davalon, "How Much Does Health Insurance Cost Without a Subsidy?" eHealth, January 21, 2022, <https://www.ehealthinsurance.com/resources/affordable-care-act/much-health-insurance-cost-without-subsidy>.

Rather than addressing underlying problems with the ACA that caused high premiums and deductibles and narrow plan networks, the American Rescue Plan Act (ARPA) further increased subsidies for this coverage. These subsidies have multiple problems, including being inflationary and inefficient. They push up prices and premiums, and they are a poor use of taxpayer dollars since much of the benefit accrues to higher-income people who are already insured. I further detail the subsidies' problems below.

Due to these problems, the projected subsidy expansion in ARPA equates to about \$17,000 each year per newly insured individual. The expanded subsidies will increase exchange enrollment but will do so by shifting more cost to the taxpayer. For example, an individual who faced a \$600 monthly premium and qualified for a \$500 subsidy and refused to purchase ACA coverage would likely enroll if an expanded subsidy covered the entire cost of the premium. HHS reported that 14.5 million people enrolled in coverage or were automatically re-enrolled in coverage for the 2022 plan year through January 15, 2022—a 21 percent increase from the previous year before the ARPA's increase in taxpayer subsidies.¹⁵

Increasing Affordable Health Coverage Without New Federal Spending

There are ways to increase affordable health coverage without new federal spending. Many policies implemented by the previous administration expanded affordable coverage options for families and workers without new federal spending.

These policies included:

- expanded coverage options through **Association Health Plans (AHPs)** and **short-term limited-duration health plans**,
- new flexible financing methods through **individual coverage health reimbursement arrangements (HRAs)**, and
- **price transparency policies** intended to improve the functioning and efficiency of health care markets.

Key Facts: Limits of Insurance and Medicine

While access to affordable health coverage and care are important, it is vital for policymakers to recognize two key facts. First, a large amount of medical spending is wasteful—with some of it even harmful to patients. Second, health insurance expansions, particularly through government programs such as Medicaid, tend to have disappointing results in terms of health improvements.

A significant concern with our high medical spending is that a large share of it—estimated by some researchers to be 25 percent of spending—does not provide Americans with any benefit.¹⁶

¹⁵ “Marketplace 2022 Open Enrollment Period Report: Final National Snapshot,” CMS, January 27, 2022, <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot>.

¹⁶ William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, “Waste in the US Health Care System: Estimated Costs and Potential for Savings,” JAMA. 2019 Oct 15;322(15):1501-1509. doi:10.1001/jama.2019.13978. <https://pubmed.ncbi.nlm.nih.gov/31589283/>.

In fact, some of that spending may instead harm our overall health. A 2016 study found that medical errors are the third leading cause of death in the United States and as many as 250,000 people die each year from errors in hospitals and other health care facilities.¹⁷ Medical tests and treatments all carry some risk. Those that are unnecessary will result, on balance, in harm to patients.¹⁸

The impact of health insurance on health is not as clear or as positive as commonly believed. At a macro level, despite the significant increase in health coverage beginning in 2014 as a result of the ACA, American life expectancy declined for three straight years from 2014 through 2017.¹⁹ The 2018 Economic Report of the President by the White House's Council of Economic Advisers put it this way:

[T]he evidence shows that health insurance provided through government expansions and the medical care it finances affect health less than is commonly believed. Determinants of health other than insurance and medical care—such as drug abuse, diet and physical activity leading to obesity, and smoking—have a tremendous impact and have exacerbated recent declines in life expectancy, despite the ACA's increased coverage.²⁰

The report evaluated numerous studies, including the two well-known health insurance experiments—the RAND health insurance experiment and Oregon's Medicaid experiment—in its conclusion that expansions of government coverage produce limited health benefits. They suggest at least four reasons why health insurance, through government coverage expansions, have a minimal effect on health.

According to the report, “The first three of these reasons—that the uninsured were often able to obtain care before coverage, access problems for patients who gain Medicaid coverage, and mandated insurance benefits that have a minimal impact on health—are particularly salient when examining the results of the ACA coverage expansion.”²¹

The fourth reason raised by CEA is that “public coverage may have limited or possibly negative effects on health because of its long-run impact on innovation. Many governments, particularly in Europe, have paired large coverage expansions with the imposition of price and spending controls. These centralized controls may have an adverse impact on medical innovation and make healthcare less effective and more costly to obtain in the future.”²² Of relevance to policymakers given this concern, Tomas Philipson, former Chairman of the CEA, co-authored a study that estimated that HR 5376, the *Build Back Better Act*, would significantly reduce drug

¹⁷ Martin A. Makary and Michael Daniel. “Medical error—the third leading cause of death in the US.” *BMJ* 2016;353:i2139. <https://www.bmj.com/content/353/bmj.i2139> (published May 3, 2016).

¹⁸ Atul Gawande. “OVERKILL.” *The New Yorker*, May 11, 2015. <https://www.newyorker.com/magazine/2015/05/11/overkill-atul-gawande>.

¹⁹ Owen Dyer. “US life expectancy falls for third year in a row.” *BMJ* 2018;363:k5118. <https://doi.org/10.1136/bmj.k5118> (published December 4, 2018).

²⁰ *Economic Report of the President with The Annual Report of the Council of Economic Advisors*, February 2018, <https://www.govinfo.gov/content/pkg/ERP-2018/pdf/ERP-2018.pdf>.

²¹ *Id.*

²² *Id.*

innovation and that this reduction would lead to 135 fewer new drugs and a loss of 331.5 million life years in the U.S.²³

Two recent studies have purported to show that ACA coverage expansions reduced mortality; however, these studies have been criticized as flawed.²⁴ In his review of the studies, University of Chicago economist Robert Kaestner outlines several concerns about the methodologies employed and has concluded, “The studies were severely under-powered to detect a reasonably sized effect of health insurance ... on mortality and, because of that, were prone to grossly overestimating the effect of interest if not get the direction of the effect wrong. ... The flaws of the two studies leads me to conclude that we learned little about the effect of health insurance on mortality from them.”²⁵

The lack of clear health benefits from the expansion of Medicaid, which I detailed in a report released in the spring of 2020, should raise policymakers’ concern about additional subsidies that simply expand government spending on the current structure.²⁶ I concluded that large coverage expansions disappoint for several reasons: the uninsured receive nearly 80 percent as much care as similar insured people, the crowd-out of potentially superior private coverage, and the indirect effects on others such as longer wait times for care.²⁷

Furthermore, the ACA’s model of subsidization results in direct payments from the government to health insurance companies. A 2018 report from the Council of Economic Advisers found that health insurer profitability had soared—more than doubling the growth of the S&P 500 in the first four years of the ACA’s enactment.²⁸ As I discuss further below, both the design of the ACA’s premium subsidies as well as the ACA’s Medicaid expansion were inflationary and resulted in high payments to health insurance companies. There have been a variety of news stories documenting how these programs that are intended to benefit lower-income Americans have produced windfall profits for health insurance companies.²⁹

²³ Tomas J. Philipson and Troy Durie, “Issue Brief: The Impact of HR 5376 on Biopharmaceutical Innovation and Patient Health,” The University of Chicago, November 29, 2021, <https://cpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/d/3128/files/2021/08/Issue-Brief-Drug-Pricing-in-HR-5376-11.30.pdf>.

²⁴ Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, “Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach,” 136 *Quarterly Journal of Economics* 1 (2021), <https://law.stanford.edu/publications/health-insurance-and-mortality-experimental-evidence-from-taxpayer-outreach/>; Sarah Miller, Norman Johnson, and Laura R. Wherry, “Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data” (2021), <https://academic.oup.com/qje/article-abstract/136/3/1783/6124639?redirectedFrom=fulltext>.

²⁵ Robert Kaestner, “Mortality and Science: A Comment on Two Articles on the Effects of Health Insurance on Mortality,” *Econ Journal Watch*, September 2021, <https://econjwatch.org/File+download/1202/KaestnerSept2021.pdf?mime-type=pdf>.

²⁶ Brian Blase and David Balat, “Is Medicaid Expansion Worth?: A Review of the Evidence Suggests Targeted Programs Represent Better Policy,” Texas Public Policy Foundation, April 2020, https://www.texaspolicy.com/wp-content/uploads/2020/04/Blase-Balat-Medicaid-Expansion.pdf?utm_source=hs_email&utm_medium=email&hsenc=p2ANqtz--YDsEIYo0HwdUAmFOCZYsvqTBPbVvk3Sq2OPgi44tOkulo-jqQdpRmYR0c0jPGOfKITzymI.

²⁷ Id.

²⁸ Council of Economic Advisors, “The Profitability of Health Insurance Companies” CEA, March 2018, <https://trumpwhitehouse.archives.gov/wp-content/uploads/2018/03/The-Profitability-of-Health-Insurance-Companies.pdf>.

²⁹ Chad Terhune and Anna Gorman, “Insurers make billions off Medicaid in California during Obamacare expansion,” *Los Angeles Times*, November 17, 2017, <https://www.latimes.com/business/la-fi-medicaid-insurance->

Guiding Principles

Policymakers should look for ways to reorient existing expenditures to minimize harmful distortions in the health care market and to expand families' ability to access affordable health insurance coverage and affordable health care services. A guiding principle for reforming government health financing would be to allow Americans to control more of their own money for health care and coverage rather than to continue to have the government control how most of their money is spent. A guiding principle for reforming government health care subsidies should be to permit individuals and families' greater control over the resources instead of having the government pay so much directly to insurers for restricted choices of plans. This includes Medicaid recipients, who also deserve more control over their care and coverage. Of note, a prominent economics study of Medicaid recipients found that they only value the program at 20 to 40 percent of the program's cost—a testament to economic inefficiency.³⁰

Policies to Increase Americans' Options

Another way government policy inflates health care prices and costs is by restricting options available to consumers and patients and limiting the ability of doctors and other health care professionals to best treat their patients. I next provide several examples of how government can minimize harm caused by existing anti-competitive policies that push up prices. Given the Committee's jurisdiction over self-insured employer plans, I will begin by focusing on employer-sponsored coverage.

Employer-sponsored coverage

Roughly half of Americans receive health insurance through their employer or the employer of someone in their family.³¹ Typically, employers offer workers comprehensive health insurance that covers a large number of hospitals and doctors. Workers at large firms often receive several different plans from which to choose, while most workers at smaller firms only receive one plan option.

Employers provide coverage for a variety of reasons, including that it is a tax-free employee benefit. Economists universally agree that employees pay for their health insurance in the form of reduced wages. This reality means that the rising premiums and overall costs for employer coverage have significantly eaten away at wage increases over this period.

According to the Kaiser Family Foundation's survey of employers, the average premium for single coverage was \$7,739 and the average premium for family coverage was \$22,221 in

[profits-20171101-story.html](#); Chad Terhune, "Billions of tax dollars flow to private Medicaid plans. But is anyone minding the store?" *Los Angeles Times*, November 18, 2018, <https://www.latimes.com/business/la-fi-medicaid-private-insurance-20181018-story.html>.

³⁰ Amy Finkelstein, et al, "Effect of Medicaid Coverage on ED Use—Further Evidence from Oregon's Experiment," *New England Journal of Medicine* (2016): 375:1505-1507, <https://www.nejm.org/doi/full/10.1056/nejmp1609533>.

³¹ State Health Facts, "Health Insurance Coverage of the Total Population," Kaiser Family Foundation, 2019, <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=0%7B%22colId%22.%22Location%22.%22sort%22.%22asc%22%7D>.

2021.³² In 2000, the respective premiums were \$2,471 and \$6,438.³³ The premium includes both the employee share as well as the employer share; although referred to as the “employer share,” this amount is paid for by workers in the form of lower wages.

Over this two-decade period, premiums for individual coverage increased 213 percent, and premiums for family coverage increased 245 percent—much greater than the 60 percent increase in overall prices during this period. Although premiums for workplace coverage have increased, the increase in premiums for individual market coverage—which was much more affected by the ACA—rose far more rapidly since 2013.

Premiums for employer coverage increased by about 14 percent between 2013 and 2017, compared to the 105 percent increase in individual market premiums.³⁴ Using 2013 to 2017 is the best period to measure the effect of the ACA on premiums because the ACA’s key provisions took effect in 2014. Additionally, 2017 was the first year without the ACA’s transitional reinsurance and risk corridor programs, which were intended to reduce premiums in the ACA’s transition period.

Since 2010, when the ACA was enacted, there has been a 20 percent decline in the number of workers covered by employer health benefits at firms with fewer than 50 workers and a 7 percent decline in the number of workers covered by employer health benefits at firms with between 50 and 200 workers.³⁵ While there has been a sizeable drop in employees with employer coverage at small firms, coverage at large firms has remained steady.³⁶

According to the Kaiser Family Foundation’s survey, the number one reason that small employers do not offer coverage is the high cost.³⁷ Among small firms that do not offer health insurance, 74 percent believe employees prefer higher wages to health insurance benefits, compared to only 15 percent who believe employees prefer health insurance.³⁸

Clearly, as premiums have increased, particularly in the individual and small group markets most affected by the ACA, enrollment in private coverage has generally declined. To increase coverage—the topic of this hearing—it is imperative to make coverage more affordable.

Considering the health care challenges facing employers and workers, particularly at smaller companies—the previous administration expanded Association Health Plans (AHPs) and individual coverage health reimbursement arrangements (HRAs), and promulgated price transparency requirements to improve shopping.

³² Gary Claxton, et al, “Employer Health Benefits,” KFF, 2021, <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf>, Figure 1.12.

³³ Id.

³⁴ According to the Kaiser Family Foundation employer insurance survey, self-only premiums were \$5,884 in 2013 and \$6,690 in 2017. For family coverage, the respective premiums were: \$16,351 and \$18,764.

³⁵ Id., Figure 3.11.

³⁶ Id.

³⁷ Id., Figure 2.14.

³⁸ Id., Figure 2.16.

Association Health Plans (AHPs)

All employers—especially small employers—need additional options to provide coverage to their workers. One such option is to permit employers to band together to offer coverage through Association Health Plans. While AHPs have existed for decades, employers needed to have a close nexus in order to join together and offer coverage. For example, dental practices could form an AHP, but a dental practice and an auto mechanic shop in the same town could not.

In June 2018, the Department of Labor finalized a rule creating a new pathway for any employer, including sole proprietors, within a state and or common metropolitan area to join together and offer coverage through an AHP. This rule provided smaller employers a way to gain the regulatory advantages and economies of scale that large employers receive when offering health insurance.

As discussed in a *Washington Post* piece from early 2019, the AHP expansion had a promising start with most new AHPs launched by regional chambers of commerce.³⁹ According to the *Washington Post*, “there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces.”⁴⁰ The *Post* wrote that an analysis of the new plans showed they offered benefits comparable to most workplace plans and did not discriminate against people with preexisting conditions.⁴¹ A study by the Foundation for Government Accountability found that new AHPs produced savings of 29 percent on average.⁴² One local chamber of commerce that enrolled hundreds of employers was projected to save policyholders more than \$2,000 on average.⁴³ The Congressional Budget Office projected that these new AHPs would cover as many as 4 million people by 2023, half a million of whom would have been uninsured.⁴⁴

Unfortunately, a March 2019 decision by a federal judge invalidated this new pathway.⁴⁵ Although the Department of Justice appealed this decision and the appellate court heard

³⁹ Paulina Fiorzi, “The Health 202: Association health plans expanded under Trump look promising so far,” *Washington Post*, January 30, 2019, <https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/>.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² Hayden Dublois, “Association Health Plans Work: How the Trump administration expanded access to affordable & quality health care,” October 27, 2020, Foundation for Government Accountability, <https://thefga.org/wp-content/uploads/2020/10/AHPsWork-Trump-admin-expanded-access-to-affordable-quality-health-care.pdf>.

⁴³ Eugene Scalia, “How the Labor Department is defending your access to association health plans,” *Washington Examiner*, November 12, 2019, <https://www.washingtonexaminer.com/opinion/op-cds/how-the-labor-department-is-defending-your-access-to-association-health-plans>.

⁴⁴ “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” CBO, January 2019, https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

⁴⁵ In July 2018, a coalition of 12 Democratic attorneys general filed a lawsuit challenging the final AHP rule for violating the Administrative Procedure Act. The attorneys general argued that the DOL’s interpretation of “employer” was inconsistent with ERISA and the rule was intended to undermine the ACA. On March 28, 2019, Judge John D. Bates of the U.S. District Court for the District of Columbia found that the AHP rule was “clearly an end-run around the ACA” and struck down most of the rule. Judge Bates found that allowing any employers within a state or common metro area to join together did not meaningfully limit the types of associations that could qualify

arguments in November 2019, the court granted the Biden administration's motion to pause the appeal while the DOL considers further agency action.

Given the litigation challenges and the Biden administration's apparent opposition to AHPs, congressional action is likely necessary for businesses to benefit from the new AHP pathway. H.R. 4547, *the Association Health Plan Act*, introduced by Rep. Walberg, would codify the Department of Labor's 2018 rule. As projected by CBO, these new AHPs would help hundreds of thousands of businesses and millions of employees obtain more affordable health coverage and would reduce the number of uninsured. This increase in health coverage would involve no new federal spending.

Individual Coverage HRAs

In June 2019, the Departments of Health and Human Services, Labor, and the Treasury issued a rule creating individual coverage Health Reimbursement Arrangements (ICHRA). Like AHPs, individual coverage HRAs should be bipartisan. They work within the ACA's basic framework and should significantly increase individual market enrollment.

As of January 1, 2020, employers have been able to provide tax-preferred contributions through an individual coverage HRA, which their employees can use to purchase the individual market plan that work best for them. Most employers that offer health insurance only provide workers with a single option, so the HRA rule has the potential to significantly increase worker choice and control over their health insurance. Employees are currently limited to purchasing ACA-compliant plans in the individual market, although Congress could permit employees to use their HRAs to purchase a broader set of plans.

Individual coverage HRAs will help employers attract and retain employees, gain greater predictability over their health costs, and reduce administrative expenses, allowing them to better concentrate on their core business purpose. The rule should help reverse the decline in small employers that offer coverage to their workers. Moreover, the rule contains significant flexibilities for larger employers to offer coverage to part-time workers or hourly workers.

According to estimates provided in the June 2019 rule, 800,000 employers will offer individual coverage HRAs, and more than 11 million people will receive individual market coverage using this type of HRA by the middle of this decade.⁴⁶ This rule is expected to reduce the number of people without health insurance by about one million.⁴⁷ According to the Departments' analysis, "Most of these newly insured individuals are expected to be low- and moderate-income workers in firms that currently do not offer a traditional group health plan."⁴⁸ Similar to AHPs, the increase in insured people through individual coverage HRAs involves no new federal spending.

to sponsor an ERISA plan and that the working owner provision is inconsistent with ERISA, which is to regulate benefit plans that derive from employment relationships.

⁴⁶ Department of the Treasury, Internal Revenue Service, 84 Fed. Reg. 28959 (June 20, 2019) <https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf>.

⁴⁷ *Id.* At 28965.

⁴⁸ *Id.*

Congress should consider codification of the 2019 HRA rule to enhance employers' certainty about the future of defined contribution health insurance. Policies that improve the individual market would boost the opportunity for employers and employees to benefit from individual coverage HRAs. One such policy would be to permit states greater flexibilities over benefit requirements and pricing, such as widening the three-to-one age rating restriction in the ACA. There is not yet good data on the uptake of individual coverage HRAs, and there is a lot of education needed to ensure that employers and brokers understand them. Moreover, migration to individual coverage HRAs has been affected by employers' understandable focus on weathering the pandemic as well as a general risk aversion to changing employee benefits in such a tight labor market.

Price Transparency

In 2019, HHS finalized a rule requiring hospitals to post complete price information starting in 2021. In 2020, HHS with the Departments of Labor and Treasury finalized a separate rule that requires health insurers and health plans to post complete price information starting this year.

Price information can enable both individual consumers as well as employers to be better shoppers of health care. Price information is particularly important in health care because it is a large part of the typical families' budget and because there is significant variation in prices—with prices for the same service often varying by magnitudes, even within the same geographic area.

I analyzed these requirements and their potential impact in a 2019 report.⁴⁹ Expanded price transparency should result in five benefits.

- First, price transparency will encourage more consumers to shop and obtain lower prices.
- Second, price transparency will help employers establish better payment structures. These payment structures include reference pricing models, in which the plan sets a payment rate regardless of which provider delivers the service and which have been shown to generate significant savings.
- Third, price transparency will better enable employers to monitor the effectiveness of their insurers by comparing different rates received by providers across payers and across regions.
- Fourth, transparent prices should help employers eliminate counterproductive middlemen and contract with other entities that will incentivize employees to utilize lower-cost providers, including ones outside of their local region.
- Fifth, just as sunlight is often the best disinfectant, price transparency will better enable consumers and the broader public to hold providers accountable when prices reach outrageous levels.

⁴⁹ Brian Blase, "Transparent Prices Will Help Consumers and Employers Reduce Health Spending," Galen Institute, September 27, 2019, https://galen.org/assets/Blase_Transparency_Paper_092719.pdf.

All these policy recommendations are organized around increasing choice and competition in the health sector, leading to greater affordability of care and coverage.

Expanding Health Care Choice and Competition While Limiting Wasteful Subsidies

The remainder of my testimony is focused on policies that would put needed downward pressure on health care costs and expand consumer access to more affordable care. I discuss four areas:

- 1) Empowering consumers financially
- 2) Promoting consumer-directed coverage options
- 3) Enhancing competition to lower prices
- 4) Reducing wasteful and inefficient subsidies.

Empowering Consumers Financially

Very little of our health care spending is under the consumers' direct control. Nearly 90 percent of Americans' spending on health care consists of third-party payment—either through their private insurance plan or through a government program. Health savings accounts (HSAs) are one example of initiatives created to put more control in the hands of consumers and improve their incentives to obtain value from their health care expenditures.

Unfortunately, current government rules allow HSA contributions only for people who have insurance coverage that meets narrow criteria. This restrictive structure precludes most Americans from contributing to an HSA. In 2019, the IRS expanded the number of preventive services that could be covered by plans below the deductible and remain HSA-qualified.⁵⁰ This reform enabled plans to reimburse for medications like statins and insulin before enrollees reached the plan deductible.

The most important HSA reform would be to expand the number of people who can contribute to HSAs. Specifically, people enrolled in plans with a variety of benefit designs, including seniors with Medicare, should be allowed to make HSA contributions.

Promoting Consumer-Directed Coverage Options

Consumer-directed coverage could be promoted by codification of not only the AHP and HRA rules discussed above but also a 2018 rule by the Departments of HHS, Labor, and the Treasury, which modified federal rules impacting the allowable contract period for short-term, limited-duration health insurance plans. These plans, which are subject to state regulation, are exempt from federal health insurance rules, including ACA requirements. As a result, they are generally

⁵⁰ “IRS expands list of preventive care for HSA participants to include certain care for chronic conditions,” Internal Revenue Service, July 17, 2019, <https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>.

much less expensive and more flexible for individuals and families. According to the Congressional Budget Office, premiums for short-term plans may be 60 percent lower than premiums for the lowest-priced ACA bronze plan.⁵¹ Unlike ACA-compliant plans, these plans are available to be purchased year-round, so consumers do not have to wait for open season to enroll.

In a fall 2016 rule, the Obama administration reduced the allowable contract length of these plans to three months, an action which drew strong criticism from the National Association of Insurance Commissioners (NAIC). NAIC argued that restricting short-term plans would harm people whose three-month coverage expired and who acquired some condition or illness in their coverage period:

[I]f the person develops a new condition while covered under the first policy, the condition would be denied as a pre-existing condition under the next short-term policy. In other words, only the healthy consumers would have coverage options available to them; unhealthy consumers would not.⁵²

NAIC also argued that the Obama rule would not improve the individual market risk pool since healthy people could continue to get short-term coverage. “Only those who become unhealthy will be unable to afford care, and that is not good for the risk pools in the long run.”⁵³

The 2018 rule change, reversed the Obama-era restrictions, allowing people to purchase plans with up to 364 days of coverage with renewals permitted for up to three years. This change has the effect of better protecting people, since they can maintain coverage without having to go through medical underwriting as frequently.

More than half of states fully allow their residents to benefit from short-term plans, and from 2018-2021, the individual market improved more in states that fully permit short-term plans than those that restricted them.⁵⁴ Codifying this rule is another way to decrease the number of the uninsured without any new federal spending. The Congressional Budget Office estimated that the short-term plan rule would cover 700,000 people who would have otherwise been uninsured.⁵⁵

⁵¹ “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” CBO, January 2019, https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

⁵² National Association of Insurance Commissioners and Center for Insurance Policy and Research, Letter to IRS, August 9, 2016, https://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf.

⁵³ *Id.*

⁵⁴ Brian Blase, “Individual Health Insurance Markets Improving in States that Fully Permit Short-Term Plans,” Galen Institute, February 2021, <https://galen.org/assets/Individual-Health-Insurance-Markets-Improving-in-States-that-Fully-Permit-Short-Term-Plans.pdf>.

⁵⁵ “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” CBO, January 2019, https://www.cbo.gov/system/files/2019-01/54915-New_Rules_for_AHPs_STPs.pdf.

Enhancing Health Care Competition to Lower Prices

In December 2018, the Departments of HHS, Labor, and the Treasury with input from the Federal Trade Commission (FTC) released a report recommending more than 50 actions that federal and state governments can take to increase competition in the health care sector.⁵⁶ In my position at the National Economic Council, I coordinated the work across the federal departments and agencies on this report. The following are important recommendations contained in or based on recommendations made in that report:

- **Expanding site-neutral payments.** In the previous administration, HHS pursued site neutral payments in the Medicare program. These payments reduce spending and—perhaps more importantly—reduce incentives for hospitals to acquire physicians’ offices. Medicare should not pay more for care provided in hospital-affiliated medical facilities that could be safely and effectively provided in either physicians’ offices or ambulatory surgical centers. Further reductions in spending, increased competition, and lower prices could be accomplished by Congress expanding the number of services paid the same through Medicare regardless of the site of care.
- **Lifting limits on physician-owned hospitals.** The ACA prohibited Medicare from reimbursing for services provided in physician-owned hospitals constructed after 2010. The moratorium on physician-owned hospitals reduces competition in hospital markets and seems especially problematic since such hospitals have a track record of providing high-value care. Rescinding the moratorium will increase competitive pressure on existing hospital systems and should lead to decreased prices with improved accessibility and quality of services.
- **Improved Federal Trade Commission (FTC) oversight.** There has been enormous growth in health sector consolidation over the past few decades. Yet, federal antitrust policy is limited in its ability to review mergers between nonprofit health care entities. Amending the FTC Act to extend FTC’s jurisdiction to nonprofit health care entities would address this problem.
- **Encouraging states to lift barriers to competition.** Unfortunately, many restrictions on competition are enacted at the state-level. As discussed in Paragon’s state health reform book *Don’t Wait for Washington: How States Can Reform Health Care Today*, states place barriers on telehealth services, restrict access to health care services through certificate of need and certificate of public advantage laws, and limit health care professionals’ ability to practice to the top of their ability as well as their mobility to practice wherever their services are most in demand.⁵⁷ These restrictions all reduce patient access to care. Congress could consider conditioning some of the enormous

⁵⁶ “Reforming America’s Healthcare System Through Choice and Competition,” HHS, December 2018, <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>

⁵⁷ Brian Blase, et al. (edited by Brian Blase), *Don’t Wait for Washington: How States Can Reform Health Care Today*, Paragon Health Institute, 2021, <https://paragoninstitute.org/dont-wait-for-washington/>.

amount of money it sends to states for health care purposes on state laws and policies that affect overall competition in the market.

Reforming Wasteful and Inefficient Health Care Subsidies

The federal government—through tax and spending programs—inflates health care spending and is responsible for substantial expenditures that provide little, if any, benefit to Americans. As mentioned above, estimates indicate that up to 25 percent of spending on health care provides no benefit, with some of it actually harmful, to our health. Reforms are clearly needed, particularly to our health care entitlement programs, but first it is important to not make the current problems worse.

Several recent health care proposals would increase inefficient health care spending and, in doing so, would exacerbate inflationary pressures in the economy. A far more efficient approach than expanding ACA subsidies would be for policymakers to redirect a portion of existing government spending on health care to financing high risk pools or state reinsurance programs. Such an approach, as demonstrated by the 15 states that have used Section 1332 waivers to establish reinsurance programs, would better target federal funds to individuals who have expensive medical conditions or who experience significant spending during a period of time.⁵⁸

American Rescue Plan Act's problematic expansion of ACA subsidies

The American Rescue Plan Act (ARPA) contained a significant expansion of subsidies for ACA exchange plans. ARPA increased the amount of taxpayer assistance that people receive to purchase exchange plans in two ways. First, it reduced what people with income between 100 and 400 percent of the federal poverty level (FPL) need to pay for a benchmark plan. Second, it lifted the cap on subsidy eligibility at 400 percent of the FPL.

The expansion of these subsidies is particularly problematic for many reasons.

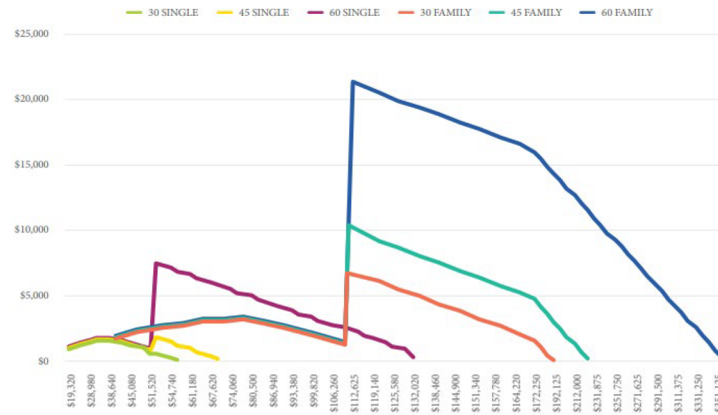
- First, three-quarters of the new spending is on people who already have coverage. Because of this, the projected cost per newly insured person is \$17,000 a year.
- Second, as the figure below (taken from a report I authored for the Galen Institute last year)⁵⁹ demonstrates, the relatively wealthy receive far more benefit from the subsidy expansion than lower-income families. The figure shows the benefit in expanded premium tax credits (PTCs) for six different households at various income levels.

⁵⁸ Doug Badger, “How Health Care Premiums Are Declining in States That Seek Relief from Obamacare’s Mandates,” Issue Brief No. 4990, The Heritage Foundation, August 13, 2019, <https://www.heritage.org/sites/default/files/2019-08/IB4990.pdf>.

⁵⁹ Brian Blase, “Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality,” Galen Institute, June 11, 2021, <https://galen.org/assets/Expanded-ACA-Subsidies-Exacerbating-Health-Inflation-and-Income-Inequality.pdf>.

FIGURE 1

Increase in Premium Tax Credit Amount for Households at Various Income Levels



SOURCE: Author's calculations based on the subsidy formula and using national averages for premiums.

NOTE: The figure scale changes at an income of \$172,250 so the information can fit on the figure.

- Third, the subsidies go directly to health insurance companies, subsidizing their profits even though enrollees may place low value on the coverage and would prefer different health care and health coverage products.
- Fourth, if the subsidies are extended, millions of people will likely lose workplace coverage. This will be especially true of employees at smaller firms that are not subject to tax penalties from the ACA's employer mandate.
- Fifth, the subsidies are inflationary in their design and will drive up health care prices and health spending, as well as prices throughout the economy.
- Sixth, the expansion of these subsidies will likely result in an annual federal spending increase of about \$30 billion or more, depending on the extent of employer drop as the subsidies are generally larger than the tax revenue loss associated with the tax exclusion for employer coverage.

In areas of the country where exchange premiums are high, the expansion of the ACA subsidies leads to generous taxpayer subsidies for affluent households. For example, the benchmark premium for an exchange plan in Prescott, Arizona, for a family of five with a 60-year-old household head is \$50,412 in 2022.⁶⁰ A benchmark plan covers 70 percent of a household's

⁶⁰ The numbers that appear in this testimony are from the Kaiser Family Foundation's health insurance subsidy calculator. The zip code was 86301 and the information is for two 60-year-old adults and children with the ages of 20, 18, and 16.

expected health care expenses on average. Of note, the fact that the exchange plan for a family of five can be more than \$50,000 a year suggests serious underlying problems with the program.

- If that family made \$150,000, they would qualify for a subsidy of \$37,662.
- If that family made \$350,000, they would qualify for a subsidy of \$20,662.
- If that family made \$500,000, they would qualify for a subsidy of \$7,912.
- This family does not lose subsidy eligibility until they make more than \$593,000.

Injecting more federal Medicaid dollars to states

The Medicaid program finances health and long-term care expenses for mostly lower-income Americans, although lax eligibility enforcement has resulted in many people with income above eligibility thresholds enrolled in the program. A provision in the Families First Coronavirus Relief Act (FFCRA) exacerbated this problem by penalizing states that removed ineligible Medicaid recipients.

FFCRA increased the federal share of state spending by 6 percentage points, or by about 10 percent. In exchange for accepting these funds, states could not remove anyone from Medicaid, even individuals who were no longer eligible for the program. As such, there are as many as 15 million people on Medicaid who are ineligible.⁶¹ Previous audits conducted by HHS suggest that some of these people may not even know they are enrolled in Medicaid.⁶²

In addition to worsening eligibility problems, the surge of Medicaid spending has been misdirected and inflationary. States enjoyed record revenue collections over the past two years, so they did not need additional funds.⁶³ States used the additional federal money, including about \$30 billion in higher Medicaid payments in 2021 from ARPA, to increase overall spending. As spending by government goes up, more money is chasing the same amount of goods and services, so prices rise.

The ACA expanded Medicaid to a new class of enrollees—able-bodied, working-age, and generally childless adults with incomes below 138 percent of the FPL. From 2014 to 2016, the federal government reimbursed 100 percent of state spending on this expansion population.

⁶¹ Megan Messerly, “Next big health crisis: 15M people could lose Medicaid when pandemic ends,” *POLITICO*, February 2, 2022, <https://www.politico.com/news/2022/02/02/medicaid-states-pandemic-loss-00004153>.

⁶² “California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements,” HHS Office of Inspector General, February 20, 2018, <https://oig.hhs.gov/oas/reports/region9/91602023.asp>. The OIG “identified a weakness in the State agency’s procedures related to determining eligibility for individuals who may not have intended to apply for Medicaid. . . . The State agency’s procedures may pose a risk that individuals are determined eligible for Medicaid without their knowledge.”

⁶³ Jimmy Vielkind, “States Are Swimming in Cash Thanks to Booming Tax Revenue and Federal Aid,” *Wall Street Journal*, January 21, 2022, <https://www.wsj.com/articles/states-are-swimming-in-cash-thanks-to-booming-tax-revenue-and-federal-aid-11642761003>.

Although that rate has declined, it is now 90 percent. There are serious equity concerns with the federal government paying a much higher rate for the expansion population than for traditional Medicaid enrollees, such as lower-income children, pregnant women, seniors, and people with disabilities. It is likely that these higher payment rates divert resources away from those most in need. For example, most states have waiting lists for Medicaid services for people with intellectual disabilities.

The higher payment rates also present states with significant incentives to misclassify individuals as eligible under the Medicaid expansion. Following the ACA's expansion of Medicaid, improper payment rates in the program surged—from less than 6 percent in 2013 to 22 percent now.⁶⁴ Federal improper Medicaid payments are now \$100 billion per year, a figure which likely grows to \$150 billion a year when state spending is also included. In a Mercatus Center research project, University of Kentucky economist Aaron Yelowitz and I reviewed many state audits of Medicaid eligibility processes conducted by the Inspector General at the Department of Health and Human Services.⁶⁵ Across those audits, the IG found “systemic errors include neglecting to obtain proper documentation; failing to properly verify income eligibility; misclassifying individuals, including into the newly eligible category; and failing to properly verify citizenship.”⁶⁶

This waste of taxpayer dollars is a growing problem that speaks directly to the rising costs of health coverage. There is a crucial need for policymakers to address this waste, so taxpayer resources can be focused on ensuring the programs are serving their target populations.

In the past few months, various proposals have emerged that would further increase federal Medicaid spending, including a new home and community-based program through Medicaid. If states want to enact new programs, they can. Crucially, programs would likely be much more efficient if they were financed with state dollars instead of mostly with federal dollars. Although this principle always applies, pumping up federal Medicaid spending at a time of record high inflation and state revenues is certainly not fiscally responsible or wise. Rather than expanding federal Medicaid spending, conducting meaningful oversight of the program, including the surging improper payments in the program, would be a more prudent approach for Congress.

Conclusion

Renowned health economist and Harvard Business School professor Regina Herzlinger has written that “choice supports competition, competition fuels innovation, and innovation is the only way to make things better and cheaper.”⁶⁷ Unfortunately, government policies—despite good intentions—often stifle choice, competition, and innovation in health care. Furthermore,

⁶⁴ “Improper Payments Fact Sheet,” CMS, November 15, 2021, <https://www.cms.gov/newsroom/fact-sheets/improper-payments-fact-sheet>.

⁶⁵ Brian Blase and Aaron Yelowitz, “The ACA’s Medicaid Expansion: A Review of Ineligible Enrollees and Improper Payments,” Mercatus Center, November 25, 2019, <https://www.mercatus.org/system/files/blase-medicaid-expansion-mercatus-research-v1.pdf>.

⁶⁶ Id.

⁶⁷ Regina Herzlinger, *Who Killed Health Care?: America’s \$2 Trillion Medical Problem - and the Consumer-Driven Cure*, McGraw-Hill, 2007.

these programs and policies produce incentives that lead to waste rather than value in our health care expenditures.

- Government mandates have pushed up the price of insurance. The high price of insurance necessitates large subsidies, so people can afford the coverage.
- Government restricts people from buying coverage that works best for them and prevents small employers from joining together to gain the same advantages that large employers obtain in their coverage.
- Government prohibits health care professionals from practicing to the top of their license and limits health care supply through rules such as anti-competitive certificates of need.
- Government contributes to higher health care prices and overall inflation with poorly designed subsidies.

Although increasing subsidies may be tempting, expanding inefficient health care subsidies makes health care less affordable. Government spending replaces private spending that would have otherwise occurred. Government subsidies often permit insurers to raise premiums with taxpayers on the hook for the higher premium cost. The subsidy cost of \$17,000 per newly insured individual from the expansion of exchange premium subsidies by ARPA is testament to its inefficiency. Extending the ACA premium subsidies beyond 2022 would further fuel higher health care prices and inflation in the economy.

Fortunately, by reforming existing government programs and pursuing policies that promote choice and competition in health care, policymakers can expand access to affordable health coverage without new government spending.

The following policies, if fully implemented, would help millions of families, and reduce the number of uninsured by a projected two million people—all without any new federal spending:

- Association Health Plans, which offered significant savings to small employers for high-quality coverage.
- Short-term plans, which helped families in need of flexible, affordable coverage.
- Individual coverage health reimbursement arrangements, which permit employers to provide health coverage in ways that employees may prefer.

In addition to the expansion of coverage opportunities, new price transparency rules that are properly implemented can improve the functioning of health care markets and expand opportunities for consumers and employers to maximize value from their expenditures.

Another policy strategy needs to be reconsidered: much of federal policy in the past decade has focused on increasing funds to states to expand Medicaid. However, increasing federal Medicaid funds is inflationary because it increases federal debt and states can raise spending—with weak

evidence of overall health benefit from Medicaid expansion. Moreover, those for whom Medicaid was created are being crowded out:

- The ACA's funding structure discriminates against traditional program recipients such as low-income children, pregnant women, seniors, and individuals with disabilities in favor of the expansion population of able-bodied, working-age adults.
- Millions of people are currently enrolled in the program who are not eligible because of lax state approaches to ensuring eligible people are in the program. Given the 22 percent improper payment rate in Medicaid, Congress should strengthen and expand oversight of the program that has clearly grown beyond some states' ability to properly manage.

Lastly, policymakers should avoid centralized regulatory or price controls that would diminish health care innovation. Rather, policymakers should pursue policies that create a climate conducive to innovation in which entrepreneurs are best serving patient needs.

Thank you for the opportunity to testify before the Committee today, and I look forward to your questions.

Chairman DESAULNIER. Dr. Blase, you get a gold star for perfect timing. Very efficient.

Dr. BLASE. Thank you.

Chairman DESAULNIER. You are welcome. Next speaker, our last witness, is Katie Keith, is a Visiting Professor and Director of the Health Policy and Law Initiative at the O'Neill Institute for the National and Global Health Law at Georgetown University Law Center.

She is also a contributing editor at Health Affairs, where she writes extensively about the Affordable Care Act and other topics relating to health coverage. Dr. Keith the floor is yours.

STATEMENT OF MS. KATIE KEITH, JD, MPH, VISITING PROFESSOR AND DIRECTOR OF THE HEALTH POLICY AND THE LAW INITIATIVE, O'NEILL INSTITUTE FOR NATIONAL AND GLOBAL HEALTH LAW, GEORGETOWN UNIVERSITY LAW CENTER

Dr. KEITH. Thank you so much, Chair DeSaulnier, Ranking Member Allen and members of the subcommittee, I am honored to appear before you on a topic that is near and dear to my heart, and the need for affordable universal health coverage.

My written testimony covers four main issues. First, we have made significant progress under the Affordable Care Act. The Chair mentioned some of these statistics already, but I think they are worth repeating. The uninsured rate has reached historic lows, we have narrowed racial and ethnic health disparities and coverage and access to care, and we have improved families' financial stability thanks to the Affordable Care Act.

The law has also served as a critical part of the safety net throughout the pandemic. Millions of families who would otherwise have gone uninsured, have instead been able to enroll in Medicaid, or the Marketplace, and access the coverage they need, including coverage for COVID-19 tests, vaccines and treatment.

Second, the American Rescue Plan Act has built on the important gains we have made under the Affordable Care Act. For 2021 and 2022 the new law provides increased premium tax credits for lower income people, and for the first time extends premium tax credits to middle income families.

Unsurprisingly to me there has been strong demand for this affordable comprehensive coverage, we have seen record high Marketplace enrollment of 14 and 1/2 million people enrolling for 2022. Nearly 6 million new consumers enrolled in Marketplace coverage throughout 2021.

The American Rescue Plan Act consumer savings are also significant. Average monthly premiums fell by 23 percent for Healthcare.gov consumers, one-third of whom selected a plan for \$10 a month or less. Deductibles are also down as a result of the American Rescue Plan; more generous premium tax credits have meant many consumers can afford to choose to enroll in a more generous plan with a lower deductible.

As you can tell these gains are critical, but they could soon be lost if Congress does not extend the subsidy enhancements beyond 2022. Third, there is a continued need to protect consumers from the range of what I refer to as non-comprehensive insurance prod-

ucts. These include short-term limited duration insurance, fixed indemnity plans, excepted benefits, health care sharing ministries, there's more detail about each of these types of products in my written testimony.

In general, these products do not offer the protections that patients have come to expect and appreciate under the Affordable Care Act, and these products can and do discriminate against people with pre-existing medical conditions. Sadly, the media has been filled with stories of those who enrolled in these non-comprehensive products, only to be left with devastating medical bills after their plan did not cover their care.

These products proliferated during the Trump Administration, and in my view are a particularly ripe area for consumer protection because of the often egregious, aggressive, and misleading marketing tactics that are used to sell these products to consumers.

There is also evidence to suggest that some of these non-comprehensive products are being offered as a primary form of coverage in the employer market, which raises significant concerns for workers and their families. I believe that a comprehensive approach is needed to protect consumers from these types of products, and I fear that other efforts by the subcommittee to advance universal coverage will fail if we do not also address these other products.

Fourth and finally, we must continue to push ahead on improving access to affordable high-quality coverage. Congress should extend the American Rescue Plan subsidies, provide a coverage option for low-income adults, and states that have not yet extended their Medicaid program, and support continued access to Medicaid at the end of the public health emergency.

As you address the next wave of health reforms, I also encourage the subcommittee to consider high health care spending by commercial plans. Previously panelists have hit on this, and my written testimony touches on recent data on these issues, but I want to emphasize that high health care costs, and high provider prices are increasingly a challenge for those with job-based coverage.

As health care costs rise and we know employers pass those higher costs to employees through higher premium contributions, higher deductibles, narrower benefits and higher cost-sharing. As a result, under insurance is on the rise, especially for those with employer plans.

Congress has tools at its disposal to address high provider prices and one mechanism to do so would be to create a public health insurance option that pays lower rates and competes alongside private plans. I will close there but thank you again for the opportunity to address you, and I look forward to your questions.

[The prepared statement of Dr. Keith follows:]

Testimony of Katie Keith, J.D., M.P.H.

Visiting Professor and Director of the Health Policy and the Law Initiative
O'Neill Institute for National & Global Health Law | Georgetown University Law Center

Hearing on “Exploring Pathways to Affordable, Universal Health Coverage”

U.S. House of Representatives Committee on Education & Labor

Subcommittee on Health, Employment, Labor, and Pensions

February 17, 2022

Good afternoon, Chair DeSaulnier, Ranking Member Allen, and members of the Subcommittee, and thank you for the opportunity to testify today. I am Katie Keith, a Visiting Professor and Director of the Health Policy and the Law Initiative at the nonpartisan O'Neill Institute for National & Global Health Law at Georgetown University, where I study and teach courses on private health insurance and the Affordable Care Act (ACA). I am also the author of the “Following the ACA” blog series for *Health Affairs*, the leading journal of health policy thought and research, where I serve as a contributing editor and am responsible for chronicling implementation of the ACA and new developments in health reform.

My testimony focuses on progress made under the ACA, the law's role in the pandemic response, the importance of the American Rescue Plan Act's enhancements to the ACA, the threat that non-comprehensive products pose to people with preexisting conditions, and the need for additional policies to improve access to affordable, high-quality coverage. The views I express today are my own and do not reflect those of Georgetown University or *Health Affairs*.

Significant Progress Under the Affordable Care Act

The ACA has resulted in historic coverage gains: the uninsured rate among the non-elderly population reached a record low in 2016,¹ and a record 31 million Americans had coverage through expanded Medicaid as of late 2020 and the marketplaces as of early 2021.² Millions more—including those with job-based coverage—have benefited from the law's consumer protections. These protections include the coverage of preventive services without cost-sharing, a cap on annual out-of-pocket expenses for care, and a ban on lifetime and annual dollar caps on care. The ACA's coverage expansions have helped improve families' financial stability and is linked to increased food security³ and reduced out-of-pocket costs,⁴ unpaid bills,⁵ and evictions.⁶

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Trends in the U.S. Uninsured Population, 2010-2020, HP-2021-02 (Feb. 2021).

² The ACA's total effect on coverage is likely higher since the estimate of 31 million people does not include other coverage expansions such as an additional 1 million people enrolled in coverage through the ACA's Basic Health Program or the more than 2 million young adults who could remain on their parents' plan until age 26. See U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates, HP-2021-13 (Jun. 2021).

³ Gracie Himmelstein, “Effect of the Affordable Care Act's Medicaid Expansions on Food Security, 2010–2016,” *Am J Public Health* (2019) 109(9):1243–8.

The ACA served as a critical part of the safety net throughout the pandemic. Prior recessions led to coverage losses as economic upheaval caused employees and their families to lose coverage.⁷ Despite predictions of severe coverage losses as a result of the COVID-19 pandemic,⁸ the uninsured rate remained stable in 2020.⁹ Coverage losses were staved off in part because those who lost job-based coverage could enroll in individual market coverage or Medicaid.¹⁰ Congress also leveraged existing ACA standards—such as the requirement to cover evidence-based preventive services without cost sharing—to quickly mandate the coverage of COVID-19 testing and vaccines for those with comprehensive coverage. Thanks to the ACA, millions of would-be uninsured people have instead been able to enroll in marketplace or Medicaid coverage that covers COVID-19 testing, vaccines, and treatment.

The ACA also narrowed racial and ethnic disparities in insurance coverage and access to care.¹¹ The uninsured rate for Black adults dropped from 24.4% in 2013 to 14.2% in 2019 while the rate for Hispanic adults fell even more significantly—from 40.2% to 25.7%—over the same period.¹² Improved access to coverage has led to improved access to health care. Black and Hispanic adults reported fewer cost-related access problems and were more likely to have a usual source of care (such as a primary care physician) in 2019 compared to 2013.¹³ Coverage gains have also been observed for other historically underserved communities, such as Asian Americans and Pacific

⁴ Hiroshi Gotanda et al., “Out-of-Pocket Spending and Financial Burden Among Low Income Adults After Medicaid Expansions in the United States: Quasi-Experimental Difference-in-Difference Study,” *British Med. J* (2020) 368:m40.

⁵ Luojia Hu et al., “The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing,” *J Public Econ* (2018) 163:99–112.

⁶ Naomi Zewde et al., “The Effects of the ACA Medicaid Expansion on Nationwide Home Evictions and Eviction-Court Initiations: United States, 2000–2016” *Am J Public Health* (2019) 109(10):1379–83.

⁷ See, e.g. John Holahan & Vicki Chen, Changes in Health Insurance Coverage in the Great Recession, 2007–2010, Kaiser Family Foundation (Dec. 2011).

⁸ See, e.g., Jessica Banthin & John Holahan, Making Sense of Competing Estimates: The COVID-19 Recession’s Effects on Health Insurance Coverage, Urban Institute (Aug. 2020).

⁹ See Katherine Keisler-Starkey & Lisa N. Bunch, Health Insurance Coverage in the United States: 2020, U.S. Census Bureau, Report No. P60-274 (Sep. 2021); see also Katie Keith, Uninsured Rate Steady But High: More Work Needed, Health Affairs Forefront (Sep. 2021) (summarizing multiple studies on the uninsured rate).

¹⁰ Sara R. Collins et al., As the Pandemic Eases, What is the State of Health Care Coverage and Affordability in the U.S.? The Commonwealth Fund (Jul. 2021) (finding that about 6% of working-age adults lost job-based coverage since the pandemic began and that, of these individuals, 25% gained coverage through Medicaid or the marketplaces).

¹¹ See e.g., Jesse C. Baumgartner et al., Racial and Ethnic Inequities in Health Care Coverage and Access, 2013–2019, The Commonwealth Fund (Jun. 2021); Thomas C. Buchmueller & Helen G. Levy, “The ACA’s Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care,” *Health Affairs* (2020) 39(3); Samantha Artiga et al., Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010–2018, Kaiser Family Foundation (Mar. 2020); Susan L. Hayes et al., Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference? The Commonwealth Fund (Aug. 2017).

¹² Baumgartner et al. *supra* note 11.

¹³ *Id.*

Islanders,¹⁴ American Indians and Alaska Natives,¹⁵ and LGBTQ people.¹⁶ Although much more can and must be done, the ACA has helped narrow care and coverage disparities in important ways.

The American Rescue Plan Act Improved Access to Coverage and Affordability

Record-high ACA enrollment has continued thanks to enhancements made by Congress and the Biden administration under the American Rescue Plan Act. This historic law increased the affordability of coverage for millions by extending subsidies to many middle-income people for the first time and increasing subsidies for those with lower incomes for 2021 and 2022. Among many other changes, the American Rescue Plan Act also fully subsidized COBRA continuation coverage for laid-off workers through September 30, 2021 and included new incentives for states that have not yet expanded their Medicaid programs.

These investments in affordable coverage have already had a significant impact. As of January 15, 2022, a record 14.5 million people had enrolled in marketplace coverage, including many new consumers.¹⁷ Overall, 5.8 million people have newly gained coverage since 2021, including 2.8 million people who enrolled during the Biden administration's six-month COVID-19 special enrollment period and 3 million people who enrolled during the 2022 open enrollment period.¹⁸ This is a significant reversal of marketplace enrollment trends: after previously peaking at 12.7 million people for 2016, enrollment largely stagnated under the Trump administration.¹⁹

Record enrollment is driven in large part by the availability of enhanced subsidies under the American Rescue Plan Act. Under the new law, consumers that use HealthCare.gov saw average monthly premiums fall by 23%, and 32% of HealthCare.gov consumers selected a plan for \$10 per month or less.²⁰ Consumer out-of-pocket costs have also dropped: more generous premium tax credits mean consumers can opt to enroll in a more generous plan with lower out-of-pocket

¹⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage Changes: Asian Americans and Pacific Islanders, HP-2021-11 (May 2021). This analysis suggests that Asian Americans and Pacific Islanders (AAPIs) experienced the largest improvement in coverage rates among any racial or ethnic group between 2013 and 2019, although considerable variation remains by AAPI subgroup.

¹⁵ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges, HP-2021-18 (Jul. 2021).

¹⁶ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage and Access to Care for LGBTQ+ Individuals: Current Trends and Key Challenges, HP-2021-14 (Jun. 2021).

¹⁷ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Marketplace 2022 Open Enrollment Period Report: Final National Snapshot (Jan. 27, 2022).

¹⁸ U.S. Department of Health and Human Services, Biden-Harris Administration Announces 14.5 Million Americans Signed Up for Affordable Health Care During Historic Open Enrollment Period (Jan. 27, 2022).

¹⁹ Enrollment for 2022 is higher by about 2.5 million people than for 2021—and about 1.8 million more people than the prior enrollment record from the 2016 plan year. See Kaiser Family Foundation, Marketplace Enrollment, 2014-2021 (last visited Feb. 2022).

²⁰ U.S. Department of Health and Human Services, *supra* note 18.

costs.²¹ Higher enrollment was also aided by the Biden administration's significant financial investments in marketing and the navigator program, under which 1,500 certified navigators held over 1,800 outreach and education events during the 2022 open enrollment period.²²

The American Rescue Plan Act has already resulted in significant savings for millions of Americans. But these changes are temporary. Unless Congress extends the American Rescue Plan Act's subsidy enhancements, many consumers will face premium hikes beginning in 2023 and marketplace enrollment could decline. In contrast, making these subsidies permanent would further reduce the number of uninsured people, lower household costs, and reduce premiums.²³

Protecting Consumers From Non-Comprehensive Insurance Products

Beyond extending the American Rescue Plan Act subsidy enhancements, Congress should protect consumers from the range of non-comprehensive insurance products that fail to offer the protections that patients have come to expect under the ACA. This need to protect consumers, while not new, has been made even more urgent due to the ongoing pandemic.

Non-comprehensive insurance products may include short-term limited duration insurance (STLDI), fixed indemnity plans, other excepted benefits, and health care sharing ministries.²⁴ These products vary in their design but generally discriminate against people with preexisting medical conditions and do not have to comply with the ACA's other consumer protections—often with devastating medical and financial effects. These products proliferated under the Trump administration, and the media has reported many stories of consumers who unknowingly enrolled in a non-comprehensive product only to learn that their health costs are not covered, leaving them with thousands of dollars in unpaid medical bills.²⁵

²¹ Data is not yet available for the 2022 open enrollment period, but the median deductible for new consumers that enrolled during the six-month COVID-19 special enrollment fell from \$450 to \$50. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, [Health Insurance Deductibles Among HealthCare.gov Enrollees, 2017-2021](#), HP-2022-02 (Jan. 2022).

²² U.S. Department of Health and Human Services, *supra* note 18.

²³ Jessica Banthin et al., [What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022](#), Urban Institute (Apr. 2021).

²⁴ See Christen Linke Young, [Taking a Broader View of "Junk Insurance"](#), Brookings Institution (Jul. 2020).

²⁵ See, e.g., Amy Lotven, "AZ Man Pursues RICO Case Against STLDI Issuers, Charges Broker With Fraud," *Inside Health Policy* (Jan. 28, 2022); Anna Wilde Mathews & Tom McGinty, "Hospital Prices Are Unpredictable. One Type of Health Coverage Often Gets The Worst Rates," *Wall Street Journal* (Dec. 22, 2021); Michelle Andrews, "Think Your Health Care Costs Are Covered? Beware the 'Junk' Insurance Plan," *NPR* (Dec. 3, 2020); Jeremy B. Merrill & Marshall Allen, "'Trumpcare' Does Not Exist. Nevertheless Facebook and Google Cash In On Misleading Ads for 'Garbage' Health Insurance," *ProPublica* (Oct. 20, 2020); Dylan Scott, "How Trump Gave Insurance Companies Free Rein to Sell Bad Health Plans," *Vox* (Jun. 30, 2020); Stephanie Armour, "Shorter-Term Health Plans Force Many to Pay for Lifesaving Treatments, Report Finds," *Wall Street Journal* (Jun. 25, 2020); Ben Conarck, "A Miami Man Who Flew to China Worried He Might Have Coronavirus. He May Owe Thousands," *Miami Herald* (Feb. 24, 2020); Jenny Deam, "A Doctor's Scribbled Note Leads to Patient Losing Health Insurance," *Houston Chronicle* (Nov. 27, 2019); Jenny Deam, "Complaints Against Faith-Based Health Share Ministry Sent to FBI," *Houston Chronicle* (Jul. 12, 2019); Jenny Deam, "Buyer Beware: When Religion, Politics, Health care and Money Collide," *Houston Chronicle* (Jul. 2, 2019); Sarah Gantz, "Villanova Prof

These products are inadequate across multiple fronts.²⁶ STLDI products, for instance, can and often do exclude entire categories of benefits (such as prescription drugs, maternity care, and mental health care),²⁷ deny coverage or benefits to those with preexisting conditions,²⁸ discriminate against women,²⁹ engage in medical underwriting,³⁰ require much higher cost sharing than ACA products,³¹ and lead to exorbitant out-of-pocket costs for those who become ill.³² Some STLDI does not cover even routine preventive care or injuries,³³ and many of these policies do not cover treatment for COVID-19³⁴ or have a provider network, putting enrollees at risk of significant balance bills.³⁵ As a result, those who purchase these plans risk (often unknowingly) catastrophic medical bills that can lead to financial instability and uncompensated care for hospitals and other providers. These and other gaps were documented in an extensive investigation of STLDI by the Democratic staff of the U.S. House of Representatives Energy and Commerce Committee.³⁶

Despite predictions that STLDI would evolve to offer more comprehensive benefits under a Trump administration rule that allowed these products to be sold for up to 364 days and renewed for up to three years, 12-month STLDI continues to deny coverage based on health status, exclude major benefit categories, exclude coverage for preexisting conditions, and impose low

Contracted Sepsis and Needed an Amputation—And Her Health Plan Wouldn't Pay," *Philadelphia Inquirer* (Apr. 5, 2019); Zeke Faux et al., "Health Insurance That Doesn't Cover the Bills Has Flooded the Market Under Trump," *Bloomberg* (Sep. 17, 2019); Noam N. Levey, "Skimpy Health Plans Touted by Trump Bring Back Familiar Woes for Consumers," *Los Angeles Times* (Apr. 2, 2019); Reed Abelson, "Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans," *New York Times* (Nov. 30, 2017); Erik Larson & Zachary Tracer, "The Health Plans Trump Backs Have a Long History of Disputes," *Bloomberg* (Oct. 16, 2017).

²⁶ See Leukemia & Lymphoma Society et al., Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed (Mar. 2021); see also Linke Young, *supra* note 24.

²⁷ Karen Pollitz et al., Understanding Short-Term Limited Duration Health Insurance, Kaiser Family Foundation (Apr. 2018).

²⁸ See American Cancer Society Cancer Action Network, Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans (May 2019).

²⁹ See, e.g., JoAnn Volk et al., Trump Administration Promotes Coverage That Fails to Adequately Cover Women's Key Health Care Needs, The Commonwealth Fund (Oct. 2020).

³⁰ Pollitz et al., *supra* note 27; American Cancer Society Cancer Action Network, *supra* note 28.

³¹ Dania Palanker et al., New Executive Order: Expanding Access to Short-Term Health Plans is Bad for Consumers and the Individual Market, The Commonwealth Fund (Oct. 2017).

³² Dane Hansen & Gabriela Diguez, The Impact of Short-Term Limited Duration Policy Expansion on Patients and the ACA Individual Market, Milliman (Feb. 2020).

³³ Cheryl Fish-Parcham, Seven Reasons the Trump Administration's Short-Term Health Plans Are Harmful to Families, Families USA (Aug. 2018), (finding STLDI exclusions for sports injuries and tonsillectomies).

³⁴ See Emily Curran et al., In the Age of COVID-19, Short-Term Plans Fall Short for Consumers, The Commonwealth Fund (May 2020).

³⁵ Dania Palanker & Kevin Lucia, Opportunities to Better Protect Consumers and Markets from the Negative Impact of Short-Term Plans, The Commonwealth Fund (Jan. 2021).

³⁶ U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk (Jun. 2020), [hereinafter *Shortchanged*].

dollar limits on care.³⁷ These gaps, researchers concluded, show that the STLDI market “continues to place enrollees at huge risk.”³⁸ Given the concerns raised by STLDI, it is unsurprising that there is broad support among Americans of all political stripes to require these products to comply with the same rules as traditional health insurance.³⁹

Other products, such as association health plans and similar group purchasing arrangements, are not regulated under the same rules that apply to the individual and small group markets, leading to discrimination through eligibility rules, rating practices, and benefit design.⁴⁰ This can lead to risk segmentation and higher premiums in the traditional individual and small group markets.⁴¹ These arrangements are also plagued by a long history of fraud, scams, and insolvency.⁴² Some entities have tried more creative ways to evade state insurance regulation and much of the ACA by arguing that their coverage arrangements with non-employees qualify as a single-employer self-insured group health plan under the Employee Retirement Income Security Act.⁴³

Although much focus has been given to STLDI and association health plans, similar concerns extend to a range of other products that are exempt from the ACA’s consumer protections but often masquerade (and are marketed) as comprehensive coverage.

Health care sharing ministries, for instance, can be designed and marketed to mimic insurance. Yet these products do not guarantee to reimburse members for medical expenses and do not have to meet financial or other standards that ensure they can cover members’ medical needs.⁴⁴ As enrollment in ministries has increased, at least some members have been left with significant unpaid medical bills or forced into debt collection over even small bills that go unpaid.⁴⁵ Concerns that some health care sharing ministries are operating as unlicensed insurers has led

³⁷ Dania Palanker et al., Limitations of Short-Term Health Plans Persist Despite Predictions That They’d Evolve, The Commonwealth Fund (Jul. 2020).

³⁸ *Id.*

³⁹ Leukemia & Lymphoma Society, U.S. Adults Widely Agree It’s Time to Protect Consumers from Short-Term, Limited-Duration Health Plans (Jan. 2022).

⁴⁰ See, e.g., Christina Lechner Goe, Non-ACA-Compliant Plans and the Risk of Market Segmentation: Considerations for State Insurance Regulators (Mar. 2018). The Trump administration finalized a rule in 2018 to dramatically alter the regulation of association health plans; however, the rule’s most significant changes were set aside by a federal district court in March 2019. See Timothy S. Jost, The Past and Future of Association Health Plans, The Commonwealth Fund (May 2019).

⁴¹ Goe, *supra* note 40.

⁴² *Id.*

⁴³ See Katie Keith, CSR Litigation, New Non-ACA Plan Decision, Health Affairs Forefront (Oct. 2020). In litigation over this arrangement (known as the Data Marketing Partnership arrangement) before the Fifth Circuit Court of Appeals, amicus briefs were filed in support of the Department of Labor by the National Association of Insurance Commissioners, individual state insurance commissioners, patient advocates, consumer advocates, insurer associations, and state attorneys general.

⁴⁴ JoAnn Volk et al., Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets? The Commonwealth Fund (Aug. 2018).

⁴⁵ See, e.g., Jenna Carlesso, “‘I’m Relying on Prayer.’ Complaints Pile Up Against Health Care Sharing Ministries As State Mounts a Defense,” *CT Mirror* (Mar. 2, 2020); Reed Abelson, “It Looks Like Health Insurance, But It’s Not. ‘Just Trust God,’ Buyers Are Told,” *New York Times* (Jan. 2, 2020).

several state insurance departments and attorneys general to shutter or otherwise warn consumers about these products.⁴⁶

Fixed and hospital indemnity products raise similar concerns. While comprehensive data is not available, anecdotal evidence and research suggests that the fixed and hospital indemnity market has evolved from a form of income replacement (where consumers receive a fixed payment amount per day of illness or hospitalization) to more complex products with provider networks and payment amounts that vary based on an enrollee's specific health care needs.⁴⁷ These more complex products mimic traditional health insurance but are exempt from major consumer protections and thus can discriminate based on preexisting conditions, refuse to cover the essential benefits, and have very low annual limits.⁴⁸ As a result, these products may not cover enrollee health needs or costs.

Non-comprehensive products are also being offered as a primary form of coverage in the group market, raising serious concerns for workers and their families.⁴⁹ For instance, a 36-year-old man in Texas paid \$130 per month for what he thought was a major medical plan through his employer—until he received \$67,000 in hospital bills following a heart attack and learned that his fixed indemnity plan would only pay out \$400 towards his hospital bills.⁵⁰ In response to these types of concerns, the Committee on Education and Labor and this Subcommittee have requested information from federal regulators on complaints received, enforcement actions taken, and efforts to protect workers from noncompliant fixed indemnity and other products.⁵¹

The significant gaps associated with non-comprehensive products are especially pernicious given the aggressive and misleading tactics used to market these products. Investigations and studies have shown that insurers, agents and brokers, and sales representatives misrepresent coverage to consumers, urge consumers to purchase plans over the phone without written information, or fail to disclose major coverage limitations.⁵² Some deliberately design and sell these products to

⁴⁶ See, e.g., Samantha Liss, "Healthcare Sharing Ministry 'Sham' Faces Suit for Allegedly Defrauding Consumers in California," *Healthcare Dive* (Jan. 13, 2022); Liuan Huska, "Health Care Sharing Ministries Fight for Legitimacy Amid Lawsuits," *Christianity Today* (Oct. 21, 2020); Reed Abelson, "Christian Health Sharing Group is Target of Customer Lawsuits," *New York Times* (Apr. 21, 2020).

⁴⁷ Christen Linke Young & Kathleen Hannick, Fixed Indemnity Health Coverage is a Problematic Form of "Junk Insurance," Brookings Institution (Aug. 2020).

⁴⁸ *Id.*

⁴⁹ *Id.*; see also Linke Young, *supra* note 24.

⁵⁰ See Jaic Avila, "Show Me Your Bill Helps Wipe Out \$70k in Charges After Heart Attack," *News 4 San Antonio* (Oct. 10, 2019).

⁵¹ Rep. Robert C. "Bobby" Scott & Rep. Frederica S. Wilson, Letter to U.S. Department of Labor (Oct. 2020).

⁵² See, e.g., Dania Palanker & JoAnn Volk, Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period, Georgetown University Health Policy Institute Center on Health Insurance Reforms (Oct. 2021); *Shortchanged* at 29-41; Linke Young & Hannick, *supra* note 47; U.S. Government Accountability Office, Private Health Coverage: Results of Covert Testing for Selected Offerings, GAO-20-634R (Aug. 2020); Christen Linke Young & Kathleen Hannick, Misleading Marketing of Short-Term Health Plans Amid

mimic ACA-compliant plans, or target consumers searching for comprehensive coverage, promising coverage for specific medical conditions without disclosing exclusions.⁵³

Rising concerns about deceptive and misleading marketing recently led state insurance regulators to establish a new formal working group at the National Association of Insurance Commissioners—the Improper Marketing of Health Insurance (D) Working Group—devoted entirely to monitoring improper marketing, coordinating enforcement, and addressing the use of lead generators.⁵⁴ Federal and multi-state efforts are critical as insurers increasingly use out-of-state associations to circumvent state restrictions on the sale of these products.⁵⁵

A comprehensive approach from Congress and the Biden administration is needed to protect consumers from non-comprehensive products. Federal policymakers can close gaps in how federal law defines individual and group coverage and clarify key terms such as excepted benefits. Congress can also improve regulatory standards for employer health plans, such as requiring job-based plans to cover essential health benefits at a minimum actuarial value.

Additional Policies to Improve Access to Affordable, High-Quality Coverage

In addition to extending the American Rescue Plan Act’s subsidy enhancements and addressing non-comprehensive insurance products, more work remains. The uninsured rate remained stable during the pandemic but is still high. An estimated 31 million people were uninsured in 2021.⁵⁶ Worse, more coverage losses could be on the horizon as states resume Medicaid eligibility redeterminations at the end of the declared public health emergency.⁵⁷ Up to 15 million people, including 6 million children, could lose coverage.⁵⁸

To further reduce the uninsured rate, Congress should 1) extend the American Rescue Plan Act’s subsidy enhancements; 2) provide a coverage option for low-income adults in states that have not

COVID-19, Brookings Institution (Mar. 2020); Office of Senator Bob Casey, [Health Care Sabotage Online: A Warning to Consumers](#) (Oct. 2019); Sabrina Corlette et al., [The Marketing of Short-Term Health Plans](#), Robert Wood Johnson Foundation (Jan. 2019).

⁵³ *Shortchanged* at 29-41; see also U.S. Government Accountability Office, *supra* note 52.

⁵⁴ See National Association of Insurance Commissioners, [New Working Group Formed on Improper Marketing of Health Plans](#) (Aug. 2021) (“The working group will address the deceptive marketing of health plans and other products that lead consumers to believe they are purchasing comprehensive health coverage when they are really purchasing coverage that does not cover all pre-existing conditions or hospital care.”).

⁵⁵ See Emily Curran et al., [Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections](#), The Commonwealth Fund (Jan. 2019); *Shortchanged* at 25.

⁵⁶ Robin A. Cohen et al., [Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2021](#), National Center for Health Statistics (Nov. 2021); see also Collins et al., *supra* note 10.

⁵⁷ See, e.g., Sara Rosenbaum et al., [Winding Down Continuous Enrollment for Medicaid Beneficiaries When the Public Health Emergency Ends](#), The Commonwealth Fund (Jan. 2021).

⁵⁸ Matthew Buettgens & Andrew Green, [What Will Happen to Unprecedented High Medicaid Enrollment After the Public Health Emergency?](#) Urban Institute (Sep. 2021).

expanded their Medicaid program; and 3) support aggressive outreach and enrollment efforts and streamlined Medicaid redetermination and enrollment processes.⁵⁹

Over the long-term, Congress should address high health care spending by commercial insurance plans.⁶⁰ High provider prices are increasingly a challenge for workers with job-based coverage. By one measure, the average annual health care spending for people with job-based coverage increased to an all-time high of \$6,001 in 2019, up by 21.8% from 2015.⁶¹ Other studies have documented just how much more commercial insurers pay for health care services than public programs like Medicare or Medicaid.⁶² For instance, employers and commercial plans paid hospitals an average of 247% of what Medicare would have paid in 2018 for the same services at the same facilities, a level that has risen over time and varies significantly by and within states.⁶³ Insurers often pay these high prices even though the prices far exceed hospitals' costs.⁶⁴

High prices mean ever-higher costs for employers *and* employees. The costs of job-based coverage are increasingly passed onto employees and their families through higher premium contributions and deductibles. To keep costs down, employers and commercial plans might also narrow the scope of covered benefits or impose higher cost sharing on key benefits like prescription drugs; high health care costs can also slow the growth of wages for employees.⁶⁵

For 2021, annual premiums for job-based coverage rose to more than \$7,700 for single coverage and more than \$22,000 for family coverage.⁶⁶ The average premium for family coverage has increased 22% over the last five years and 47% over the last 10 years. Similar trends have been observed with deductibles: the average deductible for job-based coverage in 2021 was nearly \$1,700 for single coverage, an amount that has increased 13% over the last five years and 68% over the last 10 years.⁶⁷

⁵⁹ See Kinda Serafi et al., The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID-19 Public Health Emergency Ends, The Commonwealth Fund (Sep. 2021).

⁶⁰ See Congressional Budget Office, The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services (Jan. 2022).

⁶¹ See, e.g., Health Care Cost Institute, 2019 Health Care Cost and Utilization Report (Oct. 2021). About two-thirds of this growth has been attributed to increases in service prices, rather than utilization.

⁶² See Congressional Budget Office, *supra* note 60 at 5; Matthew Fiedler, Capping Prices or Creating A Public Option: How Would They Change What We Pay for Health Care? Brookings Institution (Nov. 2020) (summarizing existing studies on commercial prices as a percentage of Medicare prices).

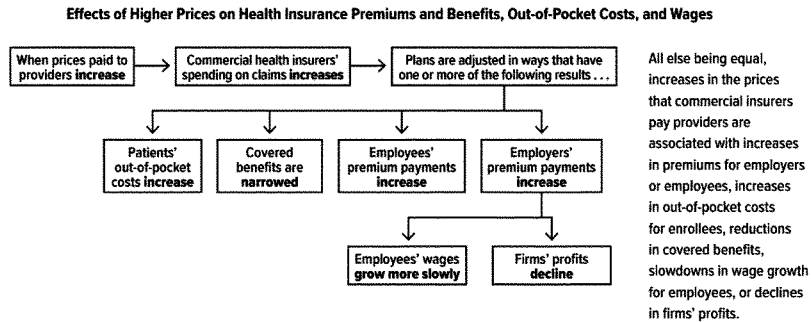
⁶³ Christopher M. Whaley et al., Nationwide Evaluation of Health Care Prices Paid by Private Health Plans, RAND Corporation (2020).

⁶⁴ Congressional Budget Office, *supra* note 60.

⁶⁵ *Id.*

⁶⁶ Gary Claxton et al., 2021 Employer Health Benefits Survey, Kaiser Family Foundation (Nov. 2021).

⁶⁷ *Id.*



Source: Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services* at 9 (Jan. 2022).

Given these changes, *underinsurance* is on the rise, especially for those in employer plans: in 2018, an estimated 87 million people (45% of non-elderly adults) were underinsured.⁶⁸ Being underinsured has implications for access to care and financial stability. Those who are underinsured report cost-related problems getting care and difficulty paying medical bills at higher rates than those with continuous, adequate coverage.⁶⁹ This can lead to medical and credit card debt, lower credit scores, loss of savings, and an inability to pay for basic life necessities (like food or rent).⁷⁰

The impact on workers is even clearer when premiums and deductibles are considered together. In 2020, premium contributions and deductibles in job-based coverage accounted for 11.6% of median household income in 2020, up from 9.1% in 2010.⁷¹ Overall, premiums and deductibles amounted to more than 10% of worker median income in 37 states in 2020.⁷²

The American Rescue Plan Act helped address some affordability challenges in the individual market, and the No Surprises Act newly protects the privately insured from the most pervasive types of surprise out-of-network bills. But more clearly can be done to improve job-based coverage, which is the primary source of coverage for most of the nation's population.

⁶⁸ Sara R. Collins et al., *Health Insurance Coverage Eight Years After the ACA*, The Commonwealth Fund (Feb. 2019). Underinsurance refers to people with health insurance but whose plan out-of-pocket costs are at least 5% of household income for low-income people and at least 10% of household income for higher-income people.

⁶⁹ *Id.*

⁷⁰ Sara R. Collins et al., *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability*, The Commonwealth Fund (Aug. 2020).

⁷¹ Sara R. Collins, *State Trends in Employer Premiums and Deductibles, 2010-2020*, The Commonwealth Fund (Jan. 2022).

⁷² *Id.*

Congress could address the high provider prices paid by commercial plans by creating a public option plan.⁷³ A public health insurance option could achieve cost savings through lower provider and prescription drug payment rates, lower administrative costs, and eliminating the need for a profit margin. Estimated savings vary depending on how a public option would be structured, but recent analyses have suggested potential federal savings between \$6 billion and 28 billion.⁷⁴ These estimates do not reflect the even greater savings that families and employers would see from reduced premiums and household spending.⁷⁵ In general, a public option would have a far greater impact on savings when available to individuals in the nongroup market *and* businesses and employees in the group market.

A public option plan could have other benefits as well. It could offer families and employers an additional, lower-cost choice for comprehensive coverage, while also leading to similar cost reductions among competing private health insurance plans. It could also expand access to coverage for the uninsured and underinsured, lower out-of-pocket costs, and reduce health disparities. The success of a public option in achieving these goals will, however, depend on the specific policies adopted by Congress. Policymakers will want to consider key questions such as how the public option will be administered, who will be eligible, what benefits will be covered, how provider payment rates will be determined, and how quickly the public option would be implemented.⁷⁶

Conclusion

The ACA has resulted in historic coverage gains and played a crucial role in the nation's pandemic response. The American Rescue Plan Act has further cemented these gains by dramatically improving access to affordable marketplace coverage. As the Subcommittee considers the next wave of health reforms, policymakers should extend the American Rescue Plan Act's enhanced subsidies, protect consumers from non-comprehensive insurance products, and lower health care costs with an emphasis on protecting those in job-based coverage. Expanded access to comprehensive health insurance will help improve the health and financial security of families across the country and has never been more important.

⁷³ See, e.g., Matthew Fiedler, [Designing A Public Option That Would Reduce Health care Provider Prices](#) Brookings Institution (May 2021); John Holahan et al., [What Are the Effects of Alternative Public Option Proposals?](#) Urban Institute (Mar. 2021); Fiedler, *supra* note 62; Linda J. Blumberg et al., [Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer](#), Commonwealth Fund (Oct. 2019).

⁷⁴ See John Holahan & Michael Simpson, [Introducing a Public Option or Capped Provider Payment Rates Into Private Insurance Markets](#), Urban Institute (Mar. 2021); Jodi L. Liu et al., [Effects of a Public Option on Health Insurance Costs and Coverage](#), RAND Corporation (2020).

⁷⁵ By one estimate, a public option could result in savings for employers of up to \$86 billion and household spending could fall by up to \$58 billion; savings would be even higher with capped payment rates. Holahan & Simpson, *supra* note 74.

⁷⁶ See, e.g., Georgetown University Center on Health Insurance Reforms, [Understanding Public Health Insurance Options: Design Considerations](#) (last visited Feb. 2022); Congressional Budget Office, [A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications](#) (Apr. 2021); Suhas Gondi & Ziniu Song, "Expanding Health Insurance Through a Public Option—Choices and Trade-Offs," *JAMA Health Forum* (2021) 2(3):e210305.

Chairman DESAULNIER. Thank you that was great. Under Committee Rule 9(a), we will now question witnesses under the 5-minute rule. I will be recognizing subcommittee members in seniority order, and again to ensure that the member's 5-minute rule, and I want to thank the witnesses for being so good, is adhered to, staff will be keeping track of time. Please be attentive to the time, and wrap up when your time is over, and re-mute your microphone.

Now I will see if I can adhere to the rules as I recognize myself for 5 minutes. Secretary Reich and Dr. Benjamin, for both of you. You and I both talked about the overall costs and the under performance of the American health care system, and you mentioned a little bit about what we get for that, so the outcomes do not nearly replicate the investments for the Americans.

One thing, and Dr. Benjamin in particular, those outcomes point members to a really wonderful study by the Kaiser Family Foundation about life expectancy internationally comparing countries, for people over 65, and also regionally. Here on the west coast the United States would be 13th out of that study in nations, but then regionally California and the west coast would be first in the world if it was a country for life expectancy, they are now diving into that.

As somebody who is a survivor of chronic cancer, and has spent 4 weeks in an ICU, I have seen the best and the worst of American health care personally. The public option we have here, as a former small employer owning restaurants, we use that and it is on our Exchange. It helps the employer. A question for both of you starting with Secretary Reich is what do we get out of this, not just consumers, but our economy and businesses, in particularly small businesses?

Mr. REICH. Well, Mr. Chairman, the costs overall of health care are increasing dramatically. They are now 19 percent of our entire economy. Within the next 5 years if present trends continue, we are going to be up beyond 22 percent. When I say that that is not sustainable, I mean it is not sustainable not only for the individual, it is not sustainable for the Nation as a whole because there are a lot of other things we as a nation need to spend our money on as individuals, and as a country.

Pharmaceutical costs are skyrocketing, but it is not just pharmaceutical costs, it is also all forms of hospitalization and medication as well as tests, machinery, equipment. Now it has been pointed out, and I think it is true, the United States does have for those who can afford it, a terrific medical system. That is like many other areas of our national life, if you are very wealthy, if you are able to spend the money, you can get better health care here than you can almost anywhere else.

The problem is that not only is it expensive from the Nation as a whole standpoint, but from individuals who are middle income, or working-class, or poor. It is simply unaffordable, and we have a lot of data showing that people because of mostly the high deductibles, or copayments, but also because they do not have insurance to begin with, do forego the kinds of medical care they need that would have prevented more serious problems, particularly diabetes, and certain forms of cancers, and other potentially

preventable diseases that are extremely expensive to deal with once they get out of control as it were.

Again, Mr. Chairman, both on the standpoint of the Nation, and on the standpoint of the individual, we are not doing nearly as well as we should. We are on a trend line that is unsustainable, and we are not doing nearly as well as comparable nations.

Chairman DESAULNIER. Dr. Benjamin, outcomes, are we getting what we are paying?

Dr. BENJAMIN. We are not yes sir, by any means getting what we are paying for. There are really four reasons why we differ from those other nations. No. 1 the fact that we do not have universal access to all of our citizens. Second, that we have—we focus too much on specialty care, and not enough on primary care.

We have a much more complex system, both on the finance and the delivery side, and we do not spend enough on the social determinant's, a huge difference of what we spend on societal. We do not spend as much on societal needs as other nations.

Chairman DESAULNIER. Thank you. Ms. Keith you mentioned that some of this, but just some of the loopholes that this committee could work on, and I would hope we could work on this in a bipartisan effort because it seems like people are abandoning the system, which is all too frequently. Maybe you could expand a little bit on junk health, excepted benefits, short-terms plans and the subcommittee, what we can do collectively.

Dr. KEITH. Certainly. There is many products out there, and I think a comprehensive approach is needed. At a minimum I think you know Congress should look to minimum standards. Some of these products might be appropriate, but they are being misused, so there could be ways to tighten up the Federal definitions, and do increased enforcement, so a whole range of options I would be happy to talk about further, thanks.

Chairman DESAULNIER. Thank you. I will note for my colleagues I am 11 seconds over. I will now go to the ranking member for the purpose of questioning witnesses, Mr. Allen.

Mr. ALLEN. Thank you, so much Mr. Chairman, and Dr. Blase, in my—of course I have been staying in close touch with all of our healthcare providers, and our hospitals during COVID. It has been kind of amazing to see how public medicine, private medicine, can't agree on COVID.

I guess we are going to make it all public now. The fact that I talked to patients, I do not know, maybe you guys should go to an emergency room on a Friday or a Saturday night. People are not happy. They are just not happy with their healthcare period.

They expect much more. Again, you talk to these folks, but you talk to the providers. Let me tell you something, our hospitals were operating at 50 percent capacity during Omicron because of a shortage of providers. We have a terrible, terrible issue in this country. We are losing providers. Why? Yes, they are very unhappy with the way the government is running healthcare, I can tell you that.

I do not know of anybody who is not complaining. Dr. Blase, you know this committee is advocating Medicare for All, and other forms of government run healthcare. We have not talked much about the quality of care. It is not surprising because frankly the

Federal Government has its issues in dealing with any type of a government program.

I mean most of my constituent services is dealing with VA healthcare, and I just had two big issues on that in the last week or so. What would Medicare for All do to employer sponsored insurance, and how would this affect the 155 million Americans currently enrolled in employer sponsored coverage?

Dr. BLASE. Mr. Allen, in most proposals of Medicare for All that I have seen would outlaw private coverage. The government, the Federal Government would take over as the single insurer. There would be no more employer sponsored insurance, and even you would take away Medicare, both Medicare Advantage where 25 million seniors get their care, as well as traditional Medicare where there are deductibles, where there are cautionary benefits under the Medicare for All, sort of general rubric.

Mr. ALLEN. In the previous administration the Department of Labor made it easier for businesses to band together to form associated health plans. This rule was in effect for several months until a Federal judge ended it. What did you learn about this rule, and its effect on healthcare choices for Americans?

Dr. BLASE. The rationale for the rule was to make it easier for small businesses to offer coverage to their workers, to get some of the advantages that large employers get when they offer coverage. That rule was finalized in June 2018.

It was in effect for several months, and my written testimony cites a Washington Post story and a study that shows that these plans were comprehensive coverage, typically covered far more doctors and hospitals than ACA plans, and it delivered significant premium savings to employers and employees that were using them.

Mr. ALLEN. Yes. It is amazing we cannot even secure our borders, and in fact we have got more Fentanyl that is coming over that border to kill every American seven times over, and we are talking about a government takeover of healthcare. We lost 100,000 lives to overdoses in this country, the largest ever last year, which might be one of the reasons that there are lengths of age is dropping.

I know that Obama Care significantly raised individual market premiums, but I was shocked to learn that for example, a benchmark for a family in Prescott, Arizona was \$50,000.00 a year. You use this as an example, Dr. Blase. Could you elaborate more on the problems of Obama Care, and these subsidies?

Dr. BLASE. You could—people could find this information out on their own too. They could go to the subsidy calculator that the Kaiser Family Foundation puts out, and again you could get families that face benchmark premiums of \$50,000.00 or more. Importantly, a benchmark premium only covers about 70 percent of the plan's spending, so it is going to come with high deductibles and copayments as well.

There has to be underlying problems with a program that has caused such significant premiums. Because the premiums are so high, the subsidies need to be so high in order for people to afford coverage. I think we need to get out of the increasing subsidies, and we should look at what is the underlying driver of the high premiums of these plans.

Mr. ALLEN. Thank you, sir. I am out of time, and Mr. Chairman sorry, I yield back.

Chairman DESAULNIER. Quite all right, Mr. Allen. Thank you very much. We will now go to the very distinguished gentleman from the great State of Connecticut, Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman, and thank you to all the witnesses. Professor Keith, I mean you did a really nice job of explaining the enhancements to the Affordable Care Act under the American Rescue Plan, and there is a big blinking light in front of Congress right now that it is going to—it is time limited. In terms of trying to understand this issue better, I reached out to my good friend locally who is an insurance broker, lifelong Republican, but you know who is enthusiastic about the ACA in terms of an enrollment per client.

She told me a story that she had a couple who in 2020 were uninsured, their annual joint income was about \$70,000, which put them just above the 400 percent Federal poverty level, so the private market did not offer them anything that was of any value, or that they could possibly afford.

We passed the American Rescue Plan. The husband had been laid off, so that brought the premium down to the maximum you know benefit, which was about \$7 a month. It is a good thing they had it because sadly both husband and wife were stricken with COVID. The husband lingered in the hospital for a long time, was on ventilators, and sadly he passed away.

It is a horrific tragic story, but there is no question that if we had not passed the American Rescue Plan his widow would be looking at hundreds of thousands of dollars in terms of medical bills.

Jenn, the broker, told me another story about a dairy farmer in our district. Again, who in the private health insurance market was looking about \$30,000 for family coverage, with the enhancements they were able to bring that down to about \$50 a month. Again, the margins which dairy farms operate on as many of you know, is you know wafer thin. They qualified for this assistance.

I mean it is hard to imagine letting those enhancements lapse, and I just wondered if the O'Neill Center has looked at, really looked at the damage that would occur if that were to you know ever happen?

Dr. KEITH. Thank you so much for that question. I would emphasize I think what the American Rescue Plan did is sort of get rid of that subsidy cliff above 400. It is not a free giveaway by any stretch. What it says is that no one should be paying more than 8 and 1/2 percent of their entire income toward premiums, so I think it is a huge protection, including for middle-income people.

To your point the biggest benefits have flowed to older, middle-income people living in rural areas, which is where premiums were the highest before the Rescue Plan set in. In terms of the impact, if these subsidies are allowed to expire, people would see premium shock this fall for coverage next year.

Many folks who are paying as I mentioned, a third of healthcare.gov consumers are paying ten dollars or less for their coverage, they would see those premiums increase. You would have many of those middle-income folks who have been able to you know purchase coverage for the first time.

There is data that shows that more middle-income people came into the marketplace over time as a result of the subsidies. The impact has been huge. I am deeply concerned that those impacts you know could be undone if these subsidies are not extended without more lead time for folks to understand.

Mr. COURTNEY. Then the evidence is all around us. I do not care what district you are from. In your testimony, or in your written testimony Professor, I know you talked about the fact that a public option, you know, which would help the cost issues could also be extended to employer-based plans that in fact you could allow an employer buy-in, which would for I think a lot of particularly small employers would be incredibly attractive.

It would help stabilize what is the largest component of our health care coverage system. By the way, I want to thank Professor Reich for helping us when we got rid of the Cadillac tax a couple years go. Your outspoken support for that, actually I think protected a lot of employer-based plans.

Again, Professor Keith, maybe you could just sort of talk about whether or not you could design a public option that would benefit small employers.

Dr. KEITH. Yes absolutely. There is a whole range of this sort of design decisions that would need to be made around the public option. I think one key one is exactly what you touched on. Would you want a public option to be limited to the individual market, available to small employers, or even extended up into the large group market?

There are also questions about whether to allow employers to buy in, or even let employees on their own buy in. I think it is all those would have different implications that need a lot more study and analysis, but I would emphasize I think extending some kind of a public option that does in fact lower cost to the group market is going to have the biggest impact for Federal savings, for employers, and for families in terms of really bringing costs down.

Mr. COURTNEY. Great thank you. I am under the 5-minutes mark, so.

Chairman DESAULNIER. You must have gotten a really good schooling. Thank you, Mr. Courtney. I will now be happy to recognize the Ranking Member Virginia Foxx, Dr. Foxx the floor is yours.

Ms. FOXX. Thank you, Mrs. Chairman. Dr. Blase, I have read—and you had mentioned in your testimony that life expectancy was lower in 2019 than in 2013, despite the significant rise in government healthcare spending, the implementation of Obama Care and Medicaid expenditures.

By the way, thank you very much for being here, and I know you have a piece out today that is very informative, and I thank all of our other witnesses too. What does this drop in life expectancy say about the effect of government healthcare problems and spending on health.

You have already talked a little bit about it with Ranking Member Allen, so how will proposals like Medicare for All affect health spending on American's quality of care, maybe something you have not already said.

Dr. BLASE. Thank you, Representative Foxx. It is a very important question. When you hear things, statistics that Americans do not live as long as people in other countries that is true, but there is a lot of differences that account for that that surround behavior, social circumstances, genetics. That is really not an indictment on the healthcare system.

When we look at things, like what happens when people get cancer. The Chairman mentioned that he dealt with cancer. Where do you want to be if you have cancer? You want to be in the U.S. Cancer survival rates in the U.S. are much better than in Europe. If you look at access to care, Americans have much better access to care than people in a lot of those other countries, for instance, stacked between the U.S. and Canada.

This is a percent of seniors who waited at least 4 weeks to see a specialist in the past 2 years. In the U.S. it was 21 percent, in Canada it is 59 percent. We do not have to wait as long to get access to specialist care in the U.S. Now with respect to Medicaid expansion, we had a big expansion of the program starting in 2014.

We had a deterioration in American health outcomes after that. I think when you have had a big expansion in demand, what you get from a huge coverage expansion, you are going to reallocate healthcare services. There is only a fixed amount of doctors and nurses, and one of the things that we should focus on, and which I have in my testimony, is what we can do to expand and increase the supply of healthcare.

If you just increase demand, you are going to reallocate healthcare services. And you could reallocate healthcare services in a way that is overall harmful by taking care away from those who most need it and providing services to people who least need it. That certainly happened to some degree. We see with the Medicaid expansion, wait times for care increased, as well as ambulance response times increased.

I think it is also important to recognize that people who are uninsured, they can still get healthcare. If you take a similar person with insurance and to a person without insurance, the person without insurance is receiving 80 percent as much care as the person with insurance.

Ms. FOXX. That is an excellent statistic. Unfortunately, our colleagues on the other side of the aisle totally ignore the role of individual behavior and responsibility. When you hold those things constant you see a totally different picture. Dr. Blase, the Education and Labor Committee was instrumental in the passage of the No Surprises Act, which increased price transparency requirements for insurers.

I have also very supportive of the Trump Administration's regulatory actions to increase transparency within the healthcare market. How will increased transparency translate to lower cost coverage for patients and their families?

Dr. BLASE. Sure, Congresswoman and thank you for our work on this. I will keep my answer here brief. Price transparency helps consumers shop. A lot of services in healthcare are shoppable. There are huge price variations among providers, so knowing price information can really matter, and I think the price information is also really important for employers in both how they design their

benefits, and encourage employees to go to high quality, high value providers, as well as holding accountable the insurers that they have administering their plans.

Ms. FOXX. Quick question. Inflation has hit a 40-year high. It is a tax on Americans, it has increased every month since Joe Biden became President. How would healthcare proposals like those included in the so-called Build Back Better Act, exacerbate inflation?

Dr. BLASE. Sure. The expansion of the ACA subsidies is inflationary because above a certain point the taxpayer picks up the full cost, so the insurer can raise premiums with taxpayers on virtually the full hook. The other part that is inflationary is the Federal payments to states.

A lot of the Federal support for states goes through Medicaid financing. States do not need Federal support right now. They have record revenues, and Medicaid financing just sort of allows states to increase spending in other areas.

Ms. FOXX. Thank you, Mr. Chairman. I apologize for going over also.

Chairman DESAULNIER. It is duly noted, Ms. Foxx, and I do take exception to my friend about totally ignoring personal responsibility. I do take responsibility for most everything. I do not know how I became a Member of Congress, but that is my fault. With that, I will go to Mr. Norcross from New Jersey.

Mr. NORCROSS. Thank you, Chairman, for leading this meeting, and to our witnesses. I really appreciate the input. First of all, I want to start off by thanking those in the health care industry for helping us during this pandemic, 2 years, almost a million people dying, particularly in the beginning showing up for work every day to keep us alive. I very much appreciate what they have done.

What we have seen is that even in the pandemic, and the No. 1 way that health insurance is applied in this country is through your employer. There was a law passed in 2008 called the Mental Health Parity Quality Act, which simply says if you spend it on the physical side, you need to spend it on the mental side, the mental health.

Well record OD's this year, over 100,000, and as many members have already talked about, it has been rough, particularly mental health, yet that stigma that they have to break through access to mental health, even with this law is still a problem. With the employer-based plans, there is no enforcement ability to speak of by the Federal Government to hold these plans accountable.

I recently introduced, along with my colleague, a mental health parity enforcement, which says that they have the ability to investigate and to levy fines where this is going on. People need access to mental health services. It contributes to more problems in our country than most of us realize.

Dr. Benjamin, when you look at our health care system and to quote my chairman, "Are we getting what we paid for in mental health?" Is that happening?

Dr. BENJAMIN. Congressman Norcross, no, absolutely not. When I was practicing in the emergency department far too often patients would come in with somatic symptoms, physical symptoms, when they really needed help for their mental health. When I was Sec-

retary of Health, we never had enough resources to provide services to people in mental health.

In fact, it clogged up our emergency department, people that required care, and in many cases, people knew that they needed help, and yet those services just were not there. We really need to have more services, more resources, and as you said more enforcement because there are all kinds of service limits on people receiving mental health services, and we do not necessarily do that for somatic care.

Mr. NORCROSS. Well, certainly you bring up a good point. The way that the system works now. If you are caught you have to reimburse the system, but there is still no penalty. I just asked my colleagues when you go down the highway you know there is no policeman, I am sure each of us will stick to the speed limit. We know that does not happen, and quite frankly that is what is happening in mental health.

The earlier the access to mental health services it saves you money on the physical side. This is something that is addressed in Medicare because we do not have that problem, and certainly Medicare for All this wouldn't be a problem. Again, I want to thank the Chairman for holding this hearing, and I yield back the balance of my time.

Chairman DESAULNIER. Thank you, Representative Norcross. Thank you very much for your comments and advocacy, and I know having driven with you, you always adhere to the speed limit in New Jersey and other states. All right. Now I recognize Mr. Walberg from Michigan for 5 minutes.

Mr. WALBERG. Thank you, Mr. Chairman, and I thank the witnesses for taking part as well. While my democratic colleagues look for ways to increase the government's control in healthcare, I along with my republican colleagues, believe we should be promoting policy solutions that expand the ability for employers to continue offering high-quality health coverage for their employees.

If the committee is serious about exploring pathways to affordable health coverage, and not just a Medicare for All approach, then I would encourage them to take up the Association Health Plans Act, legislation I have authored with republican leaders on this committee, that would lower healthcare costs for hundreds of thousands of small businesses, employees and sole proprietors.

Indeed, employers are finding health benefits more important than ever during the ongoing labor shortage as 75 percent of Americans say that coverage played a role in their decision to accept their current job. Employers want to offer health coverage to their employees.

However, small employers lack the resources and the bargaining power of large employers, and therefore struggle to offer comprehensive coverage at an affordable price. By obtaining health coverage through an Association Health Plan, or AHP, small employers will be able to compete with large employers and offer top quality, affordable plans.

In 2018 the Trump Administration issued a rule that expanded AHPs dues, that rule has been held up in the courts, and last year the Biden Administration continued to thwart that rule by asking the Appellate Court to hold the appeal. On that basis, Dr. Blase,

and it is good to see you again, some critics of the Trump Administration's rule say that AHPs provide skinny coverage that fails to adequately meet the needs of employees.

After the rule was released, and AHP's began to form, was that the case? Second, what kind of coverage did AHPs provide?

Dr. BLASE. Thank you, Congressman, it is good to see you again too. That is not the case. AHP's did not provide skinny coverage. AHP's provided comprehensive coverage. AHP's are employer coverage, it is how you explained it in your opening. It is a way that small employers can get on the same level playing field as large employers. There is a lot of efficiencies when they can do that.

There was a study that was done of the AHP's that were formed as a result of the rule. They were mostly through local Chambers of Commerce. They provide a comprehensive coverage, you know there were no pre-existing conditions exclusions, there was no medical underwriting, it was employer coverage, it was working well for those small businesses and employees.

Mr. WALBERG. It increased health coverage, didn't it?

Dr. BLASE. Yes, the projections the CDO did an analysis, and they projected there would be 4,000,000 people in the new AHPs and that 500,000 of them, half a million, would otherwise have been uninsured, so here you're increasing insurance coverage with no new Federal spending.

Mr. WALBERG. I appreciate that information. Dr. Blase, your testimony discusses how Federal Government policies exacerbate inflationary pressures in the economy, and you site the American Rescue Plan's expansion of the premium tax credit as an example. Could you elaborate on how this policy will drive up prices throughout healthcare and the economy?

Dr. BLASE. Sure. The way the subsidies in the ACA work is that they limit the amount of household income that a family has to pay for a benchmark plan. Any price above that benchmark plan is the taxpayer burden. That enables the insurers, they know this. Right? They know that they can raise premiums, and the premium is going to be almost completely paid by the taxpayer, so it gives insurers pricing power.

It disincentivizes enrollees to premium increases, and it creates inflationary pressure where you are going to have higher healthcare prices results from that. You also have the Medicaid provisions in the proposals that are also inflationary.

Mr. WALBERG. Expanding AHPs really would reduce inflationary pressure, would it not?

Dr. BLASE. It would. It would save the Federal Government money to the extent that people who use AHP's use employer coverage, and not the premium cash credits. Ranking Member Allen talked about the concern with the budgetary cost of the premium tax credits. If they really—the tax exclusion, so employer sponsored insurance is not subject to income and payroll taxes.

That reduces Federal tax revenue by about \$2,000.00 for each person. The premium tax credits in the ACA are much larger, so as people move from employer coverage to the ACA market, the overall cost grows. If the subsidies are made permanent, I think there is a real risk that a lot of employers are going to drop coverage so that their workers qualify for these enormous subsidies,

and the budgetary cost is going to be really significant, and the inflationary impacts. Thank you.

Mr. WALBERG. I yield back. Thank you.

Chairman DESAULNIER. Thank you. The Chair will now recognize the sage of Utica, New York, Mr. Morelle.

Mr. MORELLE. Wow no one has ever called me a sage, but Mr. Chairman thanks. I very much appreciate you holding this valuable hearing to discuss I think one of the most important topics, and thanks to the witnesses for their testimony.

Prior to coming to Congress, I had the honor of serving in the New York State Assembly as Chair of the Insurance Committee, where I worked to expand access to high-quality health care for tens of millions of New Yorkers, and I was particularly proud to pass one of the first permanent mental health parity laws in the country, and I appreciate comments by my friend Mr. Norcross about that at the Federal level.

We expanded insurance coverage for mental health services and provided access to those services in our State. We also enacted prior approval of health insurance rates, strengthened the states MLR, or medical loss ratio, supported the expansion of telehealth, required health coverage of people on the autism spectrum, and enacted the ACA.

When I came to Congress one of the goals of continuing that work to help people get access to high-quality health care, and I know that protecting that is how we ensure success at work, home and school. I wanted to just expand on a couple of questions that were asked. First of all, Ms. Keith, I appreciated your comments. Can you talk about how the Affordable Care Act uses community rating, and the influence of community on health insurance premiums, and some thoughts perhaps, as to how the public option, depending on how its constructed, could be designed to better reflect risk in consumer premiums.

I just would say Rochester, New York, where I represent is really the founder of community rating through aggregation of our business employers decades ago. If you could just comment on that I appreciate any thoughts you have on that.

Dr. KEITH. Sure. The Affordable Care Act's community rating protections really reshaped most states, perhaps other than New York. Really only allows premiums to vary based on four factors, so age up to three to one, geography represent you know acknowledging that health care rates vary, and the cost of health care differs by geography, whether it is a single coverage, or family coverage, and tobacco use, up to a certain limit.

The idea there was before the Affordable Care Act in those states you could face higher premiums because of your gender, because of your health status, because of your family history, not even your own health status, and the Affordable Care Act came in and said we're not going to allow that anymore.

We are going to protect people with pre-existing conditions who are not going to face higher rates. It really constrained the factors that insurance companies could use, and sort of leveled the playing field for sick and healthy people if you will.

Mr. MORELLE. Great. Thanks so much for your answer. I wonder if Dr. Benjamin, I lead a project back in Rochester, which is trying

to have an integrated delivery system for health, education and social services—you talk about social determinants. One of the things that I struggle with, and perhaps you can offer some insight to, and maybe the other panelists as well.

How would you pay for social determinants? How would we find a sustainable way of making sure that those social determinants which are so critical to health care quality, how we would pay for those in a sustainable way?

Dr. BENJAMIN. You know one of the things that we do not pay enough attention to is managing policy and spending other people's money. What I mean by that is there is a fair amount of money in the social services system. We just do not coordinate it very well with the health care side of the House. First of all, doing a much better job of coordinating the systems between the health care system and the social services system we already have, and leveraging those dollars.

We also spend a lot of money between those two systems redetermining people that are already eligible for one system, and we used to only accept that eligibility for the other system, so we spent a lot of—we frankly waste a lot of time and effort, and staff time, in doing these kinds of things that don't necessarily result in really excluding people. It just costs more money.

Mr. MORELLE. Well, I would love to come back to you and talk to you a little bit about that because we are—our goal is to have a single platform where integrated benefit eligibility for health care, for social services, and really utilize expenditures and investments in the social determinants to lower health care costs, have better outcomes, better experience for people who are in the system.

The challenge is, and I think it is probably a value-based payment system, or somehow using some of the insurance premium to be able to pay for it. It is a bit of the sustainability of the model we are building that continues to confront us, and I do think it is probably using health insurance premiums, at least a percentage of it to help pay for the sustainability of an integrated system of delivery.

Dr. BENJAMIN. One way you might want to think about it because using those dollars to help pay for workers for example, paying the salaries of folks could help.

Mr. MORELLE. Yes. Well, thank you very much. Mr. Chair, I yield back and thank the witnesses.

Chairman DESAULNIER. Thank you, Mr. Morelle. The Chair will recognize the gentleman from Indiana the floor is yours.

Mr. BANKS. Thank you, Mr. Chairman. Mr. Blase, I wonder if you could speak for a moment about the effects of monopolies and the healthcare sector have on the overall costs of medical services.

Dr. BLASE. Yes, thanks for that question. I have actually done a lot of work in the State of Indiana on hospital prices there. Consolidation raises prices. It is clear. Consolidation has been growing. It is actually one of the things that we know has happened after the ACA was enacted between 2009 and 2014.

Hospital consolidation increased, hospitals applying for physician practices increased. When hospitals acquire physician practices, one of the problems is you get referrals within that hospital system

without competition. It is a clear sort of evidence agreement across health economics, that consolidation significantly increases prices.

Mr. BANKS. Can you quantify it? Is there an easy way to quantify what the share of healthcare price inflation is related to, or explained by hospital monopolies?

Dr. BLASE. Congressman, it is not a particular datapoint that I am familiar with. I think at top of head within a local area if hospitals merge, I think that leads to higher prices around you know 10 to 15 percent. I am doing that off of sort of memories and studies I have read.

Mr. BANKS. You mentioned the efforts at the State House in Indiana this year addressing some of these important issues. What would be your recommendation at the Federal level for Members of Congress to address what is obviously a major driver of increased healthcare costs and hospital monopolies?

Dr. BLASE. Yes, so I think some of it could be anti-trust policy, so and I would prefer resource. In 2018 the Departments of HHS Labor and Treasury released reports called Reforming America's Healthcare System to a choice of competition that has 50 recommendations. Allowing FTC to scrutinize the mergers of non-profits, right now they are excluded from looking at non-profits.

Reversing the ACA's prohibition on physician-owned hospitals. Physician-owned hospitals can serve as a competition to traditional hospitals. Price transparency efforts, codifying price transparency, so that consumers and employers are able to put more pressure and sort of bring greater benefit design to their healthcare spending.

Honestly, there are a lot of things that states do that are anti-competitive, where the Federal Government could look at trying to incentivize states to get rid of things. Probably the most insidious is something called certificate of need loss where they were to expand healthcare in many states, you have to go before a Board, a government Board, that is often dominated by incumbent providers in order to bring on more hospital beds, or you know, expand MRI machines.

Mr. BANKS. Can you unpack a little bit further? The Federal Government continues to ignore hospital monopolies, and what it does to drive up overall health costs on all American families. What can states do without actions of the Federal Government? You mentioned the common laws, but what else?

Dr. BLASE. States can make sure they do not enact these things called certificates of public advantage, and actually some states have done this, and certificates of public advantage allow hospitals to escape Federal anti-trust scrutiny and it's a move by a lot of hospitals. We have seen this actually in Indiana over the past year with a couple of hospitals there that are trying to enact these.

I think things like expanded telehealth, expanded scope of practice can help lighten some of the problems caused by consolidation. You are right to focus here. It is a real problem in American healthcare.

Mr. BANKS. Thank you very much. I agree, incredibly important and very helpful. Thank you very much, Mr. Chairman. I yield back.

Chairman DESAULNIER. Thank you, Mr. Banks. We will now go to Representative Wild for 5 minutes.

Ms. WILD. Thank you, Mr. Chairman. My question is for Ms. Keith. Ms. Keith, last Congress I introduced the Family Health Care Affordability Act, which would fix the family glitch, a loophole that has prevented some workers from being able to access the subsidies they need to afford health coverage for their spouse and their children.

I am proud to say that it passed the House as part of the Patient Protection and Affordable Care Enhancement Act, but it has not yet gotten through the Senate, and I will keep fighting until we get that done. You wrote about the family glitch in Health Affairs just last year, and I would appreciate it if you could tell the committee how the family glitch has prevented workers and their families from accessing affordable coverage.

Dr. KEITH. Thank you so much for this question. It is such an important issue and thank you for all your work and leadership here. Under the family glitch if anyone in your family is offered affordable job base coverage for themselves as an individual worker, it unfortunately bars their entire family from accessing marketplace premium tax credits, even if that employer offers unaffordable family coverage.

The offer of affordable coverage for one person, and only one person, bars the entire family from accessing affordable coverage through the marketplace. The most recent data that I am aware of on this comes from the Kaiser Family Foundation.

It is about 5.1 million people have been affected by this family glitch, more than half of those 2.8 million are children, and this is primarily you know family members of low-income workers who do not have any sort of affordable option at this point, and again are barred from marketplace access, so I think this is a huge incredible issue, and would be able to lead to increased coverage significantly.

Ms. WILD. Well, thank you. My next question was going to be you know how important it is in the whole context of providing high-quality affordable health coverage, but I think you just answered that. Do you have any thoughts on other things that can be done to solve the family glitch, other than me personally trying to convince members of the Senate to pass this bill?

Dr. KEITH. I think there is some you know potential administrative options that the Biden Administration could look into, as well, that would be sort of a narrower fix, but there might be some room to fix it there.

I guess the one thing I would emphasize in terms of the impact is that you know these 5.1 million people, again primarily children that I am talking about, they got no relief under the American Rescue Plan Act either, so again I think there is a lot of urgency to extending coverage here so that these families have some relief.

Ms. WILD. Thank you so much for that information. I think it is vitally important. As I said I will continue to work and press forward on this, and I look forward to interacting with you in the future. With that, Mr. Chairman, I yield back.

Chairman DESAULNIER. Thank you, Congresswoman. The Chair will now recognize Mr. Fitzgerald from Wisconsin. There we go. Mr. Fitzgerald, the floor is yours.

Mr. FITZGERALD. Thank you, Chair. Something that we talked about earlier I guess, and that would be Dr. Blase I am a member of the Small Business Committee, and that means that I hear from a lot of these small business owners in my district as well.

The trouble that they are having hiring people, this is kind of shocking, but providing health insurance is obviously one of the incentives that is oftentimes goes along with hiring. In fact, there was an AHIP study recently reported that three-fourths of Americans said that employer provided health benefits played a role in their decision to accept the job.

Clearly, employees want health benefits from their employers. What do you think we could do as Members of Congress to enable more small businesses to provide more health benefits to their employees? I will just tell you a quick story. Many of the Chambers of Commerce in my district, which I also represented a good portion of the State legislature, that was one of the things that many of those Chambers had worked on was devising a plan that included their members so they could continue to expand coverage.

I know this is all in light of the Affordable Healthcare Act, but I just would like your opinion on that. What specifically could we do?

Dr. BLASE. Sure. Well, thank you for that question, Congressman. One of the things that inspired the AHP rule, and another rule that I will talk about, Individual Coverage HRA's, is that small employers were increasingly not offering coverage after the ACA.

I think off of that I would say you could codify that 2018 Department of Labor rule that allows small employers to join together and get the same advantages that large employers get when they offer coverage. Again, CDO said that would be 4 million individuals making access of that coverage, reduce the number of people without health insurance by half a million.

These employers, and more importantly employees, would be better off. They have coverage that is better for them, and many of them would have coverage that they wouldn't otherwise have. The other thing that was really attractive to small businesses was to just get small businesses out of the business of dealing with health insurance so that they could focus on their core business purpose.

The Trump Administration finalized the rule in 2019 that would have allowed employers to offer a contribution that their workers could take to buy coverage that worked best for them in the individual market. This is one way to expand worker choice over insurance plans. A lot of workers only get one option when it comes to their health insurance.

It really does not make a lot of sense for a lot of reasons. What other major financial project do people only get one choice over? This would have allowed employers to make this kind—it is really the analogy would be like 401K's. The employer provides a contribution on its tax-deferred, it has the same tax advantage as traditional employer sponsored insurance.

The worker takes that contribution and buys a plan that works best for them in the individual market. That rule is expected, we are expected to get about 11 million people using that rule, when

it is in full effect. It will also reduce the number of people that do not have health insurance by potentially up to a million.

Mr. FITZGERALD. Correct me if I am wrong. Rules to expand association health plans for short-term limited duration plans, and the individual coverage HRA's. I mean, there must have been a decision as to why that was a good move. It sounds like you just mentioned some of those. Is there anything else that was considered?

Dr. BLASE. Yes. I mean, I think it was about maximizing options for middle class families that have been priced out of coverage because of these ACA, as well as for small employers, and their employees that were increasingly not getting enough coverage through the workplace.

It was giving them more options. They still have the options of the status quo nothing affected the options that were already available to them, but just giving them new ways to obtain health coverage that for many of them would be more affordable and attractive.

Mr. FITZGERALD. Very good. Thank you, and I yield back Chairman.

Chairman DESAULNIER. Thank you, Mr. Fitzgerald, and the Chair will now recognize the gentlelady from Georgia, Congresswoman McBath for 5 minutes.

Mrs. MCBATH. Thank you, Chairman, DeSaulnier, and thank you to all the witnesses for being here today to talk about this very, really vitally important topic. At a time when so many are suffering financially, lowering the cost of health care so everyone can afford the treatment they need is just absolutely essential. Health care now accounts for about 20 percent of our total gross domestic spending.

That is a staggering number, and we continue to see it rise across all services. For my question, I want to focus on the cost of prescription drugs. We have seen costs continue to rise at rates much faster than inflation. Prices that have become seemingly divorced from innovation, with even previously inexpensive generic drugs, subject to random changes.

These are life-saving medications, which I myself as a two-time breast cancer survivor, have had the advantage to be able to use. People are having to make unthinkable decisions about whether to purchase their medications, or put food on the table, or gas in their car.

The American people, they are just sick, and they are tired of seeing endless price increases while pharmaceutical companies see record profits. We know that this market needs reform. Drug companies often argue that we already have a system in which prices are negotiated by health plans, and pharmacy benefit managers, and therefore it is not needed for the Federal Government to negotiate directly.

However, I can clearly see that the system is as it is, is currently designed, it is just failing millions of patients in my district, and throughout the country.

I just hope we can all be clear. You know it is taxpayer dollars that go into the discovery of many of these drugs, and its taxpayer dollars and wages that go toward paying for these outrageous prescription drug prices. My question is for Secretary Reich.

How would addressing out of control drug prices to bring them more in line with those paid by other countries create a fairer system for the American people? Secretary Reich?

Mr. REICH. Yes, I am sorry. Let me just say, Congresswoman, that retail prescription drug spending per capita by country, and I have in my testimony a chart to this effect, is relative to any other advanced country. The United States is spending far more per person, we are up to about \$1,000—\$1,500 per person, and there is no doubt, and there are a number of studies that if the Federal Government were to use its bargaining power through primarily Medicaid and Medicare, but also veterans, that bargaining power would be substantial in terms of lowering drug prices.

Having worked in and around Congress, and being Secretary of Labor and so on, I can tell you something that obviously is an open secret. One of the reasons that the pharmaceutical companies are so opposed to allowing the Federal Government to have that kind of negotiation power at the Federal level is because they are afraid that the Federal Government could actually reduce the increase in drug prices or reduce drug prices overall.

Mrs. MCBATH. Thank you. Secretary Reich given this significant taxpayer support for the development of new drugs so that you know, how do you respond to the argument by drug companies that high prices are needed to foster innovation?

Mr. REICH. Well, I do not think that that is true. There is a great deal of innovation by drug companies in other countries, Switzerland would be a good example. The National Institutes of Health provide American drug companies with extraordinary health and basic research, not the development side.

That's up the individual companies. But the basic research is paid for by taxpayers, and it strikes me as unfair for Americans to on top of that bear the highest drug prices in the world.

Mrs. MCBATH. Well, thank you so much for your answers, and I believe it is past time that we have addressed the rising cost of health care and make coverage affordable to all Americans. Access to health care is a right, you know, it is definitely a right, and we need to do what is necessary to make universal health coverage a reality. Thank you so much, Chairman. I yield back.

Chairman DESAULNIER. Thank you, Congresswoman McBath. The Chair will now recognize the gentleman from Michigan for 5 minutes, Mr. Levin.

Mr. LEVIN. Thank you, so much, Mr. Chairman. Secretary Reich, let me start with you. I have very fond memories of working for you sir when I was a staff attorney for the Dunlop Commission, and then under your direction we fended off Newt Gingrich's effort to undermine the 40-hour work week, and so forth.

Let us talk about health care. We are all united by the difficult reality that we are going to have a loved one, we ourselves are going to face a serious health scare in our lives. Health care is an absolute necessity. It is a fundamental human right.

This pandemic has illustrated the importance of quick and easy access to life-saving cures and preventative medicines, right? The question remains. If we can make COVID vaccines widely available, and free at the point of use, why cannot we do the same for other cures and treatments?

We still have, despite all of our efforts, 30 million people uninsured. There is just no question that we need Medicare for All, a national health program to afford everyone excellent health care from when they are born to when they die. Mr. Secretary, you are an economist.

The U.S. spent 4.1 trillion dollars on health care in 2020, according to the data from the Department of Health and Human Services. That means that health care spending accounts for nearly a fifth of our gross domestic product. That is a lot of money, so building off of your testimony, I wanted to ask you to break this down a little more.

When we add up the taxes, the premiums, the deductibles, the prescription drug costs, even after you pay all of your other stuff, then they start hitting you with coinsurance and stuff right? Spending by public and private sectors together, are we not already paying as much as we would nationally for universal health care?

If we are paying that much, why is not the system universal for all that money?

Mr. REICH. Well, Congressman, that is the most important question I have heard today in the sense that we are not getting nearly our money's worth, the 30 million people who are uninsured, have no health insurance at all, and they do not have any preventive care. Even those who do have insurance are paying copayments and deductibles that are so high that they are deterred from seeing doctors.

That means that they are not getting the preventive care they need, which is driving up the total costs. In the background of a lot of this discussion is an understandable concern about Federal bureaucracy. I want to just bring everybody's attention to the fact that the two most popular programs in history in the Federal Government are social security and Medicare.

I mean people rely on Social Security and Medicare. There is nothing socialist about these things. Social Security and Medicare are paid for out of basically payroll taxes. They are universal in the sense that they are available to everybody who meets certain criteria with regard to Medicare.

It is a—I should know. I am now eligible for my age. Why not continue to lower the age of eligibility of Medicare? Why not expand what Medicare can do for people? Why not use the models that are available to us? I think the Affordable Care Act is enormously helpful. It is a step in the right direction, but given the scale of the problem, and given how much we are spending as a society, as you say, more than 20 percent of our entire gross national product, gross domestic product, we can do so much better.

Mr. LEVIN. All right. What about overhead? What is the overhead and the administrative costs of Medicare compared to you know the private insurance?

Mr. REICH. Well as I suggested in my testimony, there have been a number of studies looking at the specific issue. What they show is that the overhead, that is basically the administering costs for private, for-profit health insurance, are substantially higher than the administrative costs of what might be called Medicare for All, or Medicare generally.

The other aspect of these administrative costs, I mean because you have got one-third of nurses' time for example, looking at billing, and you have got all sorts of marketing, and advertising costs, but there is another aspect of this that was brought up by one of your members just a moment ago, and that is the consolidation.

We see in private for-profit health insurance, more and more consolidation, which means more and more market power to drive up these costs, and that is another additional burden on many, many Americans.

Mr. LEVIN. Well, thanks. Mr. Chairman, unlike Representative McBath and many others, I am a bad child, and I went slightly over, so I wanted to ask Dr. Benjamin questions too, but we will submit them for the record, and I appreciate maybe he can answer them in writing, and I appreciate your indulgence. I yield back.

Chairman DESAULNIER. Thank you. Duly noted, Andy, and there will be consequences outside of the hearing.

Congresswoman Haley Stevens.

Ms. STEVENS. Well, thank you, Mr. Chair, and thank you to our distinguished group of panelists. I could not agree with the conversation more that we have a serious problem in the United States of America, even post ACA with millions of Americans still struggling to afford health care, individuals not receiving coverage if they experience a job loss.

We saw this play out in the middle of the pandemic, even in a State like Michigan, which embraced the Medicaid expansion, and halved the uninsured rate we still have the sticking point of 6 percent of Michiganders not receiving adequate health care coverage, or getting on those junk insurance plans, which is something that this subcommittee, and our full committee have explored at length.

I actually because this hearing has been so elucidating, and important, just jumping in. How we give folks adequate coverage. I wanted to drill down on an area that is continuing to expose Americans and Michiganders alike, and that is with regard to the cost of prescription drugs.

If you cannot afford your prescription drug you are not getting the health care you need, and time and time again I hear from individuals, particularly older Americans as I spend time volunteering for Meals on Wheels, or at our various senior centers, and folks tell me you know they are afraid to go to the pharmacy to get their prescription drugs refilled that they you know worked hard all their life, and saved for retirement, and now they have got to go back to work just to cover the cost of the prescription drug, be it for arthritis or obviously, very famously we see insulin costs going through the roof. We know we have a plan to lower the cost of prescription drugs, but Dr. Benjamin specifically, I wanted to ask you given your role with the American Public Health Association, how does delaying, or skipping medications negatively impact patients, because we know that this happening.

Dr. BENJAMIN. Well, people get sick. We know not only do they skip their medications, but they also split them. You see husband and wives for example, and you know, partners sharing medication. I will take this one today, I will give you the other one tomorrow.

Then you see real significant clinical consequences, their diabetes does not get well controlled, their hypertension does not get well

controlled. That is a big issue. Then if you are totally uninsured, you know you pay the full costs of that medication.

Ms. STEVENS. Right.

Dr. BENJAMIN. For example, you know Trulicity is a diabetic medication. It is a shot you take it once a week. It is a great medication. It is for type 2 diabetes; its list price is over \$800. If you are insured the price can be anywhere from nothing, depending on the plan you are in, to \$30—\$40 a month.

These things can be very, very expensive, and the big problem is that when you do not have those dollars you do not take your medications.

Ms. STEVENS. Right. I will tell you, I am in Oakland County, Michigan, and at least I had talked about retirees, I know folks who have retired and gone back to work to get that job to just cover the extra cost. The other point is families. If you have got a kid with a rare disease, or is taking medication and you lose your job, and then you are paying that full cost, and you are just stressing and stressing.

I heard folks on the other side of the aisle talk about inflation right, and we know costs are going through the roof, and we know we have got a plan to lower the cost of prescription drugs. We have got it in Build Back Better. We are certainly waiting to take that vote.

Are there other ways in which we could rein in out-of-control drug costs to improve public health in this country?

Dr. BENJAMIN. Well, as the Secretary said, allowing the Federal Government to negotiate for prescription drugs is the way to do this. It is clear with capitalism that we can get these negotiations done, and the volume of those negotiations would control them to a great deal degree.

The other thing of course is limiting their ability to advertise.

Ms. STEVENS. Yes.

Dr. BENJAMIN. That would make a big difference. I have got to tell you they spend a lot of money advertising for medications, and that drives up utilization. People are now going to their doctors saying I want to get drug A, which may or may not be the best drug for them.

Ms. STEVENS. Yes. Well, I think it is clear if you do not have affordable universal health care coverage, you do not have access to prescription drugs, you know, you are really left out to dry as a result, so thank you so much Mr. Chairman, and thank you to our distinguished group of panelists for being here today. I yield back.

Chairman DESAULNIER. Nice job. Thanks, under time. I am now pleased to recognize the Chairman of the committee, Chairman Scott, the floor is yours.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman. Mr. Blase, I was intrigued about the option you had where the employer could make a contribution to the costs. I did not see any barrier to doing that now. As I understand your plan, the employer would make a contribution. The employee would go on the Marketplace, get a plan, and use the money.

Do you expect that contribution to be tax-exempt to the employee on the plan?

Dr. BLASE. Mr. Chairman, thank you for that question. It was actually rule changes in the Obama administration made it illegal for employers to make contributions that employees could take to buy individual market coverage. The policy change we did reversed that and set up a set of rules where employers can make these contributions, so that the workers can buy coverage in the market, and yet those are totally tax deferred, so these contributions aren't subject to Federal income or payroll taxes.

Mr. SCOTT. Well, that means they would be getting a benefit from the first, from the tax-free income for the contribution, and then go and get benefits in the Marketplace, so they would be kind of double dipping.

Dr. BLASE. I am sorry. You cannot qualify for both the premium tax credit and the employer contribution. It works just like normal employer coverage. If you take the employer contribution, you are precluded from receiving a tax credit with the changes.

Mr. SCOTT. You would be buying the Exchange at the sticker price with no credits?

Dr. BLASE. You would use the employer contribution, which would be you know for a family it could be \$10,000.00 or more. You take that employer contribution, and you would use it to buy an individual market plan. For the most part their—

Mr. SCOTT. Wait a minute, at sticker price with no credits?

Dr. BLASE. Well, you are taking—there is no premium tax credit. You are taking the employer contribution. Basically, what this did was it equalized the tax treatment between plans that employers select for all the employees, and the employer contributions.

Mr. SCOTT. Wait a minute. They would get on the Marketplace, so they would buy the sticker price with no credits?

Dr. BLASE. Well, they would have the employer contribution. So—

Mr. SCOTT. Right, okay, so—

Mr. BLASE. Employers right now contribute to family plans about \$15,000.00 on average. You can take that \$15,000.00 that the employers provide, and instead of the employer buying the plan for the employee, they give that money in one of the HRA's, the employee takes that \$15,000.00, and buys a plan in the individual market.

Mr. SCOTT. At sticker price? Wait a minute, at sticker price with no tax credits, no reductions for income?

Dr. BLASE. If the premium is \$20,000.00.

Mr. SCOTT. Right.

Dr. BLASE. The employer contribution would be \$15,000.00, and then the employee would pay the \$5,000.00 on their own. It would work just like the way a regular employer plan would.

Mr. SCOTT. Let me get to the simple question that I think I got the answer, I am not sure. On the HSAs can an association insure a low-risk group? The problem with the association plans of course is that they pull out a healthy group and pay less, and by simple arithmetic, everybody else pays more. That is the part that people do not talk about.

Dr. BLASE. The AHP determines who the membership is, but there is no underwriting within that group.

Mr. SCOTT. Yes, but it could be a group of healthy people just by virtue of their employment. There is no barrier to insuring healthy groups. If it is not a healthy group, if it costs more than average, then nobody is going to buy the product.

You have a healthy group, you pay less, and does not everybody else pay more?

Dr. BLASE. It works the same way as employer provided coverage works. If you are a large employer, and you like have younger, healthier workers, then you are going to pay less, you are self-insured. You are paying less than workforces that are older and sicker. The thing with AHPs is it is basically just an extension of employer coverage.

Mr. SCOTT. The answer is yes, you would pull out healthy people. They would pay less, everybody else would pay more. Do they have to cover pre-existing conditions?

Dr. BLASE. Yes.

Mr. SCOTT. They have to?

Dr. BLASE. Yes.

Mr. SCOTT. Essential benefits?

Dr. BLASE. I mean all the AHP's are covered comprehensive health insurance benefits.

Mr. SCOTT. Wait a minute, essential benefits?

Dr. BLASE. Yes, I mean they are subject to—

Mr. SCOTT. Can they place lifetime limits, or annual limits on coverage?

Dr. BLASE. No. They are subject to the ACA requirements.

Mr. SCOTT. There is no limit. There is no annual limit. There is no lifetime limit.

Dr. BLASE. Correct.

Mr. SCOTT. My time has expired, Mr. Chairman.

Chairman DESAULNIER. Mr. Chairman, I am not going to cut you off if you want to followup please.

Mr. SCOTT. Well, if there is no lifetime limit to these HSAs you have a very serious problem of financial stability because one sick person can bust the whole operation. You have said that you cannot limit just like a marketplace policy cannot limit annual, or lifetime benefits, that was your testimony.

Dr. BLASE. AHPs are going to be subject to the same regulations that apply to ACA regulated plans, and that apply to employer plans.

Mr. SCOTT. Ms. Keith, is that your understanding?

Dr. KEITH. I would say that AHPs have to comply with the large group market rules, at least the way I understand the 2018 rule that Dr. Blase has been talking about, so could not use pre-existing conditions exclusions, but you are absolutely right Chairman, could restrict eligibility, it could restrict benefits, and could do selected ratings, so higher rates based on age, based on industry, based on gender would not have to sort of comply with those core what we think of as individual and small group market protections that were put in place by the ACA, so some may see reductions, but narrow.

Mr. SCOTT. What about annual benefits?

Dr. KEITH. The limit on lifetime annual dollar limits does apply to the large group market, and so that would apply here, but again

there is very few ACA requirements that apply to the large group market, which is where these association health plans visit.

Mr. SCOTT. On an ACA policy, there is no limit. You have to keep paying. You cannot stop at a certain level you have to keep paying? Is that right?

Dr. KEITH. Correct. There are no dollar limits on annual or lifetime care.

Mr. SCOTT. Can an AHP have an annual limit?

Dr. KEITH. It should not have, at least not on essential health benefits, but it does not have to cover essential health benefits. You can keep people out. Everything you said about the ability to select risk and healthier people, and cause premiums to increase for everyone else is exactly right.

Mr. SCOTT. Okay. Thank you, Mr. Chairman. I have gone way over.

Chairman DESAULNIER. You are entirely welcome. Nice job for a BC graduate, law school graduate. I would like to pursue this. We have done a lot of work with this in California, and I know other states have tried to help small businesses, particularly restaurants, of which I am familiar, you know coming out of COVID. With that, I will now recognize the Congresswoman from Washington, Congresswoman Jayapal, welcome to our subcommittee.

Ms. JAYAPAL. Thank you so much, Mr. Chairman. Thank you for allowing me to participate in this incredibly important hearing. Many important points that have been made, and I share Representative Bank's concern about hospital consolidation increasing health care costs, and Mr. Blase's suggestion that the FTC be able to scrutinize mergers among non-profits is actually exactly what my forthcoming bill would do, something I think will have tremendous bipartisan support.

Let me also put an emphasis on Secretary Reich's comment that it would be hard to invent a more complicated and expensive health care system than what we currently have, and one that produces some of the worst health outcomes compared to other peer countries in spite of what we spend.

During COVID-19, an estimated 27 million people lost their health insurance due to job loss, a perverse tie in that put a double whammy on working people. Medicare for All would have prevented that and would have ensured that all workers have the health care they need from birth to death, regardless of employment status, or socio-economic status, or race, ethnicity, gender, or any other classification that is now used to deny people health care.

The committee has a chart that I want to share, and so Banyan if you could put that up, thank you so much. This chart is from the Institute of Medicine, and it shows the ranking of U.S. mortality by age group among peer countries. The United States has the highest mortality rate for all ages up to 65 when we rise to the top of the rankings with one of the lowest mortality rates.

It is no coincidence that this happens as soon as Medicare coverage begins. Dr. Benjamin, as one of the Nation's leading voices on public health issues, can you explain how having stable universal health coverage such as Medicare improves health outcomes?

Dr. BENJAMIN. Yes. You know coverage matters. The fact that you actually get the care that you need when you need it makes a big difference. The number of times that people do an insurance card biopsy when you first show up to the health care center asking what your insurance plan is, and it drives a whole lot of things.

Quite frankly, the cheapest way to reduce health care costs to everybody is to make sure that everybody's covered.

Ms. JAYAPAL. Thank you so much Dr. Benjamin. Dr. Reich, a couple of questions for you. I want to talk about this tie in between health care and insurance. What harms does a system that tethers health insurance to employment, even with the presence of a public option present? That's the first question.

Then second, researchers at the Economic Policy Institute, which you cofounded, found that Medicare for All would increase wages and salaries for workers. Right now, labor unions struggle to bargain for increased wages, while they also have to bargain for adequate health insurance. Can you talk about the effect that Medicare for All would have on labor union bargaining and the wages and benefits that are bargained?

Mr. REICH. Yes. First of all, Congresswoman, by tying medical insurance to employment as we now do, we find ourselves more and more people are tied to their employment. At a time when not only have we been through a pandemic, and we have seen how fragile that employment relationship can be, but also, we have more and more people who are working part-time, who are contract workers, who are self-employed.

We have probably the largest portion of our workforce in terms of growth right now, are people who are not tied to individual employers. They really get shut out of a health care system that is employer based. We need if we are just looking at trend lines, and if we need to make sure that they have affordable health insurance.

Labor unions you asked, labor unions have limited bargaining power obviously. What they are now doing is using part of that limited bargaining power not on wages and working conditions, but on health care. This is something that you know if it were, if we had an established health care system, a Medicare for All system, like most other peer nations do, labor unions would not have to utilize their bargaining power on this particular issue, they could seek higher wages and better working conditions instead.

Ms. JAYAPAL. That is why we have so many labor unions that are now supporting and have endorsed the Medicare for All Act. One last question. One in six Americans stay in a job that they do not like to maintain health coverage even worse some people are forced to stay in unhappy and dangerous relationships to keep their health insurance.

Secretary Reich, how would Medicare for All affect workers who want to leave their jobs, or start a small business, or do many other things, but feel that they are unable to?

Mr. REICH. Well, the "job lock" is the term we use. That does mean that many people simply cannot get better jobs, they cannot get worker training, they cannot get out of relationships that might be abusive, and they cannot get out of workplaces that they find abusive. They are locked into jobs that they otherwise really should

not be locked into for a whole variety of economic and sociological reasons, but it is because of the health care.

Ms. JAYAPAL. Thank you so much, Secretary Reich and Mr. Chairman. I hope we just continue to add to the number of people that understand we have got to revamp our system, and Medicare for All would provide real health care for everyone in this country. Thank you, Mr. Chairman, I yield back.

Chairman DESAULNIER. Thank you, Congresswoman. Thank you for your passion and leadership on this issue. Next, I would like to welcome our newest member to the committee, and welcome you to this subcommittee, from Florida Congresswoman Cherfilus-McCormick please.

Ms. CHERFILUS-McCORMICK. Thank you, Mr. Chairman and thank you for allowing me to participate today. My question is for Secretary Reich. Opponents of universal health care often use scare tactics to describe what such a system would look like. They often say that it will cost too much, that the public sector is less efficient, and that private sector, or the government bureaucrats will get in between you and your doctor.

Secretary Reich, how would you—
[inaudible].

Mr. REICH. I am sorry Congresswoman; I couldn't hear the question. I do not know whether it was my server, or not, but can you repeat it please?

Chairman DESAULNIER. Yes, she froze up for a moment, so.

Mr. SCOTT. Right at the end just froze up right at the end.

Ms. CHERFILUS-McCORMICK. Okay. They often say that it costs too much, that the public sector is less efficient than the private sector, the government bureaucrats get in the way between you and your doctor. How would you respond to these claims?

Mr. REICH. Well, you know if you look at our for-profit private insurance system, and you ask about bureaucracy, a concentration, administrative costs, all of the things that people complain about, or the goblins that are created with regard to government. It is really a maze, M-A-Z-E. Anybody who has ventured into the system knows how complicated and impossible it is to get through.

One thing I tried to emphasize before is that Social Security and Medicare are the most popular programs in the Federal Government, but they are popular across the board. I do not care whether you are a Republican or a Democrat, where you live. I mean, they are popular because they work because they are relatively simple for people to navigate.

Why do we not take something that works like Medicare and expand it to deal with a problem that we all have, that we all understand, that really makes our entire system less efficient and less humane, and that is Medicare for All.

I want to again compliment those of you who are leading the charge on this, there are very few things that are more important to average working people.

Ms. CHERFILUS-McCORMICK. Thank you so much Secretary Reich for brining that up. As a health care executive for the last 15 years, I have watched insurance companies become increasingly more confusing for working class people to even try to exercise to get cov-

ered, or even go through the preauthorization process, we move them without health insurance.

I am happy that you brought up how, and in some instances, it is actually simpler to move toward a Medicare for All system. Now do these experiences of the other countries that have universal health care systems resemble the scenarios described by our opponents?

Mr. REICH. If you are still asking me Congresswoman, there have been a number of studies, very good studies, and I am happy to refer you to them, that compare the United States system to many other advanced systems, and other advanced countries. They are not exactly alike. They are different in many respects. They are not all single payer for example, they are not all what we would consider Medicare for All, but they all have elements of Medicare for All.

They are you know they are not all great. I mean there are some waiting times, there are some inefficiencies obviously, but it is all relative. I mean you have got to compare what they have, what they cost, and how many people they reach, and what job they do with our system.

I think that anybody looking at the data and making that kind of comparison cannot possibly conclude anything other than the reality that most other advanced countries do it better, cheaper and reach more people.

Ms. CHERFILUS-McCORMICK. Thank you so much, and Mr. Chairman, I yield my time.

Chairman DESAULNIER. Thank you. Welcome again to the committee.

Mr. SCOTT. Did she yield her time?

Ms. CHERFILUS-McCORMICK. Yes, I yielded it to Chairman.

Mr. SCOTT. Thank you. Chairman Secretary Reich, I know the Ranking Member mentioned we can get things done. We did the surprise billing together, and so we might be able to do something. Let me ask you about the public option. You indicated in your testimony that the Medicare for All could save 21 trillion over 10 years.

The public option would not cover as many people, but could we expect similar cost reductions with a public option that we could with a Medicare for All?

Mr. REICH. Well, I am not sure that it would be similar, but the key with the public option, and that is definitely a step that could be taken, should be taken in my view. The key is to make sure that the public option provides the same sort of insurance coverage that Medicare would provide.

That is and we cannot create a kind of Medicare Advantage situation which you have for profit insurance companies that are raking off and seeking to rake off through their marketing and advertising, just skimming the cream. If it is a genuine public option, I think that could be a major step in the right direction.

Mr. SCOTT. Could I have one followup, Mr. Chairman?

Chairman DESAULNIER. Of course, Mr. Chairman.

Mr. SCOTT. Thank you. If the public option is less expensive and more effective, would we necessarily have to eliminate private insurance?

Mr. REICH. No. I think that this is a false sort of goblin here. It is possible to do Medicare for All itself, and still have private insurance, I mean just like with Social Security, just like with Medicare itself. There are private insurance options, people can supplement what they get, and they keep their same doctors under Medicare, Medicare for All.

It is—it can be designed in a variety of ways. I think the key to it is to try to get the private for-profit insurers out of the picture, so that people do not have to pay a fortune for the administrative cost and marketing, the advertising, the profits, you know the shareholders, the private equity managers, and everybody else who is making a fortune off of our people, and our government right now.

Mr. SCOTT. When this idea came up first one Senator said it would be unfair competition because the public option would be able to charge less and provide more. My reaction to that is if that's the question, if that is the issue, let us just call the question.

Mr. REICH. Well, that is my—bring. Mr. Chairman you could say in effect bring it on. I mean that is what we want. That is what the public needs.

Mr. SCOTT. Thank you. Thank you, Mr. Chairman.

Chairman DESAULNIER. Thank you, Mr. Chairman, and just a comment on that last line of questions. Your predecessor and my predecessor, who's portrait hangs above us, Congressman Miller, he was influential in creating Contra Costa Health Plan in his 40 years in Congress. I am a member. I have had to use it extensively as you know in the last few years.

It is not perfect, but it works, and Kaiser and private insurer companies compete with it on a level playing field. You go to the exchange right now in our area, you can go into it. As a former employer I offered this to my employees, and as a former small business employer, in spite of the fact that Kaiser is very competitive, many of them chose it.

It is very frustrating, I hate to be parochial and personal, but knowing that a program works, and this committee helped make it work. Right now, and for 25–30 years is extremely frustrating. Anyways, with that I want to really thank everyone for participating. A terrific, terrific hearing.

Let me read what I am obligated as Chair to read, and then I will go to the ranking member for closing comments. Then myself. Again, thank you all. I want to remind my colleagues that pursuant to committee practice materials for submission for the record must be submitted to the committee clerk within 14 days following the last day of the hearing, so by close of business on March 3, 2022, preferably in Microsoft Word format.

The materials must be submitted and address the subject matter of the hearing. Only a member of the subcommittee or an invited witness may submit materials for the inclusion in the hearing record. Documents are limited to 50 pages. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the committee clerk within the required timeframe, but please recognize that in the future that link may no longer work.

Pursuant to House rules and regulations, items in the record should be submitted to the clerk electronically by emailing submissions to edandlabor.hearings@mail.house.gov.

I have one submission that was just texted to me before I give a closing on this part, I would like to submit for the record a letter from Families USA.

[The letter from Families USA follows:]



Statement for the Record

**House Committee on Education and Labor
Health, Employment, Labor, and Pensions Subcommittee**

Hearing on Exploring Pathways to Affordable, Universal Health Coverage

Prepared by Jen Taylor, Senior Director for Federal Relations, on behalf of Families USA

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On behalf of Families USA, a leading national, non-partisan voice for health care consumers dedicated to achieving high-quality, affordable health care and improved health for all, we thank you for holding today's hearing focused on how to achieve affordable, universal health coverage in America. Thanks to the extraordinary leadership by members of this Committee, as well as your colleagues across Congress and in the administration, American families have experienced major gains in health coverage during the past decade. But as we all know our work is not yet done. Families USA believes that achieving equitable and unfettered access to care for everyone in America is an essential goal for Congress to strive towards, as is seizing opportunities at hand to make health care more affordable and accessible right now.

In 2010, Congress sought to guarantee all families affordable access to quality health care and protection from high costs by passing the Affordable Care Act (ACA). Because of this landmark legislation 20 million people gained health insurance from 2010 through 2016ⁱ – many for the first time in their lives. The ACA also prohibited insurance companies from discriminating against people with preexisting conditions; guaranteed essential preventive care, free from copayments and deductibles, to hundreds of millions of Americans through their employer; and slashed prescription drug costs for millions of senior citizens by closing the infamous Medicare “prescription drug donut hole.” Put simply, the ACA provided the greatest advancement in American health coverage since President Johnson signed Medicare and Medicaid into law in July 1965.

However, starting in 2017, health coverage in America reversed course. The number of people without health insurance again began to rise, growing from 27 million in 2016 to nearly 30 million in 2019.ⁱⁱ In a particularly shocking development, the number of children without any health insurance whatsoever rose for the first time since Congress passed the Children’s Health Insurance Program (CHIP) in 1997, two decades earlier.ⁱⁱⁱ These insurance losses proved still more tragic in 2020, when the worst pandemic of deadly disease in more than a century and the steepest economic drop since the 1929 stock market crash devastated our country. As millions of workers lost their jobs, the number of people receiving health coverage from their employers fell by nearly 6 million — one of the largest losses in history.^{iv} Uninsured individuals were also at greater risk for COVID-19, meaning our persistent problem of uneven and inadequate access to affordable insurance cost people their lives.^v The fallout would have been far worse, but thanks to Medicaid and the ACA’s health insurance marketplaces, 70% of people who lost employer-sponsored insurance were able to obtain other forms of coverage.^{vi}

While Congress has sought to alleviate these coverage losses in recent legislation, including through passage of the American Rescue Plan Act (ARPA) (Public Law No: 117-2), the goal of ensuring that everyone in this country is guaranteed access to affordable, high-quality health care remains elusive. The need for affordable, reliable health care has never been more urgent than in the wake of the devastation caused by COVID-19. If Congress does not act quickly, 2021 will be a high-water mark for health coverage in the United States, and insurance levels will likely drop to levels experienced in 2017-2020.



There are a number of specific health policies Congress could enact right now to protect coverage for those who have been able to secure it, while improving access for millions of others who cannot afford it. Those policies include:

- Making permanent the ACA market subsidies passed in last year's ARPA legislation,
- Providing federal opportunities to access Medicaid for families in states that refuse to expand their Medicaid programs,
- Providing affordable access to oral health coverage which alludes millions of families,
- Ensuring continuity of coverage for people who are eligible for Medicaid, especially as the public health emergency winds down.

Making ACA Subsidies Permanent

The American Rescue Plan fixed one of the biggest remaining holes in America's health insurance system: unaffordable costs that prevent people from buying insurance when they don't get health benefits on the job. Before the ARPA provisions took effect, almost 75% of uninsured families said they lacked health care because they could not afford insurance.^{vii}

The American Rescue Plan cut families' average premium costs by 50% in the health insurance marketplace and lowered median deductibles by 90%.^{viii} The American people showed how much this legislation improved their ability to afford health care for their families: During the COVID-19 special enrollment period that ended on August 15, 2021, the number of people insured through health insurance marketplaces shot upward by nearly 3 million, or 35%, in just six short months.^{ix} And during the most recent marketplace Open Enrollment Period from November 1, 2021 through January 15, 2022, a record-breaking 14.5 million people signed up for coverage, including 5.8 million people who newly gained coverage in 2021. Thanks to the American Rescue Plan, HealthCare.gov consumers saw their average monthly premium reduced by 23% compared to the previous year's enrollment period.^x

Making permanent the ACA marketplace subsidies is critical for millions of families who fall outside Medicaid expansion eligibility and yet still would not be able to afford needed coverage. These policies help create an important bridge towards universal coverage, and ensure that families can afford the coverage they need right now.

Closing the Medicaid Coverage Gap

The Medicaid program is a cornerstone of American health care. It covers nearly half of all births and, together with the Children's Health Insurance Program, half of all children under age 6.^{xi} It is the country's largest source of funding for substance use treatment and prevention, covering almost 40% of adults suffering from opioid use disorders.^{xii} Medicaid is America's leading source of coverage for long-term services and supports, serving six out of every ten nursing home residents.^{xiii} And after controlling for socioeconomic factors, low-income families often have better access to care and more financial protection in Medicaid than in private coverage, at a cost that is 10% lower for children and 25% lower for adults.^{xiv}



More than two million adults in this country are currently uninsured because they live in one of the dozen states that stubbornly refuses to extend Medicaid coverage to their lowest-income residents. While people of every race and ethnicity have their lives and economic security endangered by their states' refusal to offer them Medicaid, families of color are in particular danger. Compared to white adults in non-expansion states, Black adults are 46% more likely and Latino adults more than twice as likely to lack insurance because they fall into the Medicaid coverage gap, unable to afford marketplace coverage but lacking access to Medicaid.^{xv}

Closing the Medicaid coverage gap is an essential step toward achieving the goal of universal, affordable health coverage while addressing systemic health inequities.

Expanding Oral Health Coverage

Universal coverage is meaningless if it does not ensure comprehensive access to the services people need to lead a healthy life.

Today, millions of people do not have access to or cannot afford oral health coverage, which has devastating impacts for their overall health. This includes 60 million older adults and people with disabilities currently covered through Medicare, as well as people who are covered through their state's Medicaid program if it does not cover oral health or only provides minimal benefits. Even before the pandemic, roughly half of Medicare enrollees did not have a dental visit in the past year—often skipping care due to cost. Moreover, 68% of Black beneficiaries and 61% of Latino beneficiaries did not have a dental visit in the same year.^{xvi} Similar concerns persist in Medicaid, where 28 state Medicaid programs currently provide either no oral health coverage, emergency-only coverage, or limited coverage.^{xvii}

Adding oral health coverage to Medicare and making it mandatory under Medicaid would allow people in every community in America not only to be able to get important dental care, but to also be healthier, have lower health care costs, and be better able to get and keep jobs.

Ensuring Continuity of Coverage and Reducing Churn in Medicaid and CHIP

People who are eligible for Medicaid coverage should not arbitrarily lose access to that coverage due to administrative process barriers. Yet, loss of Medicaid coverage due to challenges posed by annual eligibility paperwork was a major driver of the increased numbers of uninsured people in 2017-2020, and the main driver of increased numbers of uninsured children. In the last two years, Medicaid and CHIP enrollment has grown by over 13 million compared to before the pandemic. The Assistant Secretary for Planning and Evaluation (ASPE) stated this is the result of "numerous strategies and flexibilities to support Medicaid and CHIP operations during this time" as well as a pandemic-related freeze on churn and disenrollments.^{xviii} As the public health emergency winds down and Medicaid programs prepare to resume eligibility redeterminations, it is imperative that Congress and the Biden Administration take steps to prevent a recurrence of massive coverage losses among eligible people experienced from 2017-2020. Both Congress and the Centers for Medicare and Medicaid Services (CMS) must act now to strengthen and enforce the clear federal legal requirement that states conduct automated Medicaid and CHIP renewals using an ex parte process.



To further improve continuity of coverage, Congress should also require states to maintain 12-month continuous eligibility for children who are insured by Medicaid and CHIP, permanently authorize CHIP, and provide mandatory Medicaid coverage in the 12-month postpartum period, all of which were included in the Build Back Better Act that passed the House in 2021.

The Path towards Universal Coverage

The American health care system is complex, but that complexity also means that there are many avenues through which coverage can be expanded to reach the noble goal of health care for all. With careful policy design, longer term and more foundational structural changes to our coverage system - such as expansion of the Medicaid and/or Medicare programs, automatic enrollment mechanisms, and enactment of a public option (via the ACA Marketplace, employer-sponsored insurance, and/or a state option for experimentation) - could be especially valuable to the historically disadvantaged and marginalized populations that continue to encounter disproportionate barriers to coverage and care.

As families across the nation continue to struggle with the economic and health effects of COVID-19, Families USA urges Congress to move quickly to pass legislation that protects health care access and coverage and continues its work to move our nation closer to the goal of affordable, universal coverage for everyone in America. As stated above, there are an array of critical opportunities Congress can seize right now to advance our health care system towards universal coverage while also providing families immediate relief. We urge Congress to work without further delay to enact the key coverage provisions that were included in the House-passed Build Back Better Act.

Families USA looks forward to working with members of this subcommittee, the Education and Labor Committee at large, and all of your Congressional colleagues to meet these goals. Thank you for your continued dedication and leadership on behalf of American families.

ⁱ U.S. Census Bureau, 2008 to 2019 American Community Surveys (ACS). "Table HIC-9_ACS. Population Without Health Insurance Coverage by Race and Hispanic Origin: 2008 to 2019." https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/acs/hic09_acs.xlsx

ⁱⁱ U.S. Census Bureau, 2008 to 2019 ACS, Table HIC-9_ACS.

ⁱⁱⁱ For estimates from 1997 through 2015, see Brian W. Ward, Tainya C. Clarke, Colleen N. Nugent, and Jeannine



- S. Schiller. "Early Release of Selected Estimates Based on Data from the 2015 National Health Interview Survey." National Health Interview Survey Early Release Program. National Center for Health Statistics. May 2016. <https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201605.pdf>. For estimates from 2008 to 2019, see U.S. Census Bureau, 2008 to 2019 American Community Survey (ACS), "Table HIC-5_ACS. Health Insurance Coverage Status and Type of Coverage by State-- Children Under 19: 2008 to 2019." https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/acs/hic05_acs.xlsx
- ^{iv} From 2019 to 2020, the number of people with employer-sponsored insurance fell by 5.8 million, according to Census Bureau estimates based on the Current Population Survey (CPS). Katherine Keisler-Starkey and Lisa N. Bunch. "Health Insurance Coverage in the United States: 2020." Current Population Reports, P60-274. U.S. Census Bureau, September 2021. <https://www.census.gov/library/publications/2021/demo/p60-274.html>
- ^v <https://familiesusa.org/resources/the-catastrophic-cost-of-uninsurance-covid-19-cases-and-deaths-closely-tied-to-americas-health-coverage-gaps/>
- ^{vi} The Census Bureau's CPS estimates also showed that the number of uninsured increased by 1.8 million from 2019 to 2020, even as employer-based insurance covered nearly 6 million fewer people. Keisler-Starkey and Bunch. Health Insurance Coverage in the United States: 2020.
- ^{vii} The second most common reason given in response to the survey, ineligibility for coverage, was cited by only 25% of uninsured families. Survey respondents could give more than one explanation for lacking insurance. Jennifer Tolbert, Kendal Orgera, and Anthony Damico. Key Facts about the Uninsured Population. Kaiser Family Foundation, November 6, 2020. <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>
- ^{viii} CMS. 2021 Final Marketplace Special Enrollment Period Report.
- ^{ix} By the end of the Special Enrollment period, 8.0 million people previously receiving marketplace coverage were joined by an additional 2.8 million new members, representing a 35% increase. CMS. 2021 Final Marketplace Special Enrollment Period Report.
- ^x CMS. Marketplace 2022 Open Enrollment Period Report: Final National Snapshot. <https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot>
- ^{xi} Manatt, Phelps & Phillips, LLP. Medicaid's Role in Children's Health. Robert Wood Johnson Foundation, Feb. 1, 2019. <https://www.rwjf.org/en/library/research/2019/02/medicaid-s-role-in-children-s-health.html>. From July 2019 to April 2021, the number of children covered through Medicaid and CHIP rose from 35.2 million to 38.9 million. Center for Medicaid and CHIP Services (CMCS), Medicaid and CHIP Enrollment Trends Snapshot through June 2020 (undated), <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/june-medicaid-chip-enrollment-trend-snapshot.pdf>; CMCS, Medicaid and CHIP Enrollment Trends Snapshot through April 2021 (undated), <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/april-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.
- ^{xii} Manatt, Phelps & Phillips, LLP. Medicaid's Role in Fighting the Opioid Epidemic. Robert Wood Johnson Foundation, Feb. 1, 2019. <https://www.manatt.com/Manatt/media/Media/Images/White%20Papers/Issue-6-Medicaid-s-Role-in-Fighting-the-Opioid-Epidemic.pdf>.
- ^{xiii} Kaiser Family Foundation. Medicaid's Role in Nursing Home Care. June 2017. <https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/>
- ^{xiv} Julia Paradise and Rachel Garfield. What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Kaiser Family Foundation, August 2, 2013. <https://www.kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/>; John Holahan and Sharon K. Long. Costs, Access, and Utilization under Medicaid: A Review of the Evidence. Urban Institute, June 30, 2006. <https://www.urban.org/sites/default/files/publication/50326/1001002-Costs-Access-and-Utilization-Under-Medicaid-A-Review-of-the-Evidence.PDF>; Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope and Dean Resnick. What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults. Urban Institute, May 2013, <https://www.kff.org/wp-content/uploads/2013/05/8440-what-difference-does-medicaid-make2.pdf>.
- ^{xv} Analysis of Figure 3, results for adults ages 19-64, in Samantha Artiga, Latoya Hill, Kendal Orgera, and Anthony Damico. Health Coverage by Race and Ethnicity, 2010-2019. Kaiser Family Foundation, July 16, 2021. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>



^{xvi} Meredith Freed, Nancy Ochieng, Nolan Sroczynski, Anthony Damico, and Krutika Amin. Medicare and Dental Coverage: A Closer Look. Kaiser Family Foundation. July 2021. <https://www.kff.org/medicare/issue-brief/medicare-and-dental-coverage-a-closer-look/>

^{xvii} Marko Vujcic, Ph.D.; Chelsea Fosse, D.M.D., M.P.H.; Colin Reusch, M.P.A.; Melissa Burroughs. Making the Case for Dental Coverage for Adults in All State Medicaid Programs. July 2021. <https://familiesusa.org/resources/making-the-case-for-dental-coverage-for-adults-in-all-state-medicaid-programs/>

^{xviii} Office of the Assistant Secretary for Planning and Evaluation's Health Coverage Changes from 2020-2021. Rose C. Chu, Aiden Lee, Christie Peters, Benjamin D. Sommers. Jan 2022. <https://t.co/EyhIMS7RXv>

Again, I want to really thank you all. It has been a terrific, terrific hearing, and one I think the subcommittee and the full committee can work on to answer the question do Americans get what they pay for, and clearly, we can agree that they do not. Whatever we can do to make sure that the investment Americans make in their health care system gets results that are worthy of this country.

Thanks again one last time to this panel. All of you have been great. I really appreciate and look forward to following up in our staff. I want to remind once again my colleagues that pursuant to committee practice, witness questions for the hearing must be submitted to the majority committee staff or committee clerk within 7 days.

The questions submitted again must subject the matter of the hearing. Now I want to recognize our distinguished ranking member, and thank Representative Allen as always, for working with me to make these hearings successful, and a good product subsequent to the hearings, Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. I ask unanimous consent to enter into the record statements from the American Hospital Association, the Coalition to Protect and Promote Association Health Plans, and the Partnership for Employer Sponsored Coverage.

I also request to enter into the record letters opposing a government takeover of private healthcare from the following organizations: Corporate Healthcare Coalition; Council for Affordable Health Coverage; Job Creators Network; National Association of Health Underwriters; National Federation of Independent Businesses, the U.S. Chamber of Commerce.

In addition, I request to enter articles opposing Medicare for All from the American Enterprise Institute, the Grace Marie Turner, the Mercada Center, and the National Taxpayers Union Foundations.

Last, I would like to enter into the record public survey showing that Americans prefer employer sponsored coverage to government plans from the Alliance to Fight for Healthcare, Americans for Prosperity, and the Heritage Foundation.

Chairman DESAULNIER. Thank you, Mr. Allen. I take it you are yielding back. Thanks again.

Mr. ALLEN. No, I am not. I am waiting for you, without objection, and then I will finish.

Chairman DESAULNIER. Without objection, I am sorry.

Mr. ALLEN. No problem.

[The information from Mr. Allen follows:]



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**Statement
 of the
 American Hospital Association
 to the
 Subcommittee on Health, Employment, Labor, and Pensions
 of the
 Education and Labor Committee
 of the
 U.S. House of Representatives**

“Exploring Pathways to Affordable, Universal Health Coverage Care”

February 17, 2022

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record.

America's hospitals and health systems play a central role in delivering health care in this country and are committed to the goal of affordable, comprehensive health coverage for every American. We believe we should build upon and improve our existing system to increase access to coverage of comprehensive health benefits.

THE IMPORTANCE OF HEALTH COVERAGE

Meaningful health care coverage is critical to living a productive, secure and healthy life. Studies confirm that coverage improves access to care; supports positive health outcomes, including an individual's sense of their own health and wellbeing; incentivizes appropriate use of health care resources; and reduces financial strain on individuals and families.¹ Coverage has broader community benefits as well, from ensuring adequate resources to maintaining critical health care infrastructure to being associated with decreased crime. We, therefore, appreciate Congress' focus on opportunities to close the remaining coverage gaps and achieve comprehensive health coverage for every American.



Despite recent coverage gains, approximately 9% of the U.S. population remains uninsured. Many of the uninsured are likely eligible for, but not enrolled in subsidized coverage, including through Medicaid, the Health Insurance Marketplaces or their employers. For example, millions of the lowest income uninsured could be covered if all states expanded Medicaid.

While the AHA shares the objective of achieving health coverage for all Americans, we do not agree that a government-run, single-payer system is right for this country. Such an approach could upend a system that is working for the vast majority of Americans and throw into chaos one of the largest sectors of the U.S. economy.

Results from a 2019 study give some idea of the financial impact a public option program based on Medicare rates could have on the health care system. The study found that a proposal to create a government-run, public option Medicare-like health plan on the individual exchange could create the largest ever cut to hospitals – nearly \$800 billion – and be disruptive to the employer-sponsored and non-group health insurance markets, while resulting in only a modest drop in the number of uninsured as compared to the 9 million Americans who would gain insurance by taking advantage of building upon the existing public/private coverage framework. This coverage proposal would enroll significantly fewer people than a single-payer model, and yet the reimbursement cuts would be catastrophic.

Even if the proposed single-payer program increased reimbursement rates above Medicare's rates, our members' experience suggests that the government does not always act as a reliable business partner. Delays in payment and retroactive changes to reimbursement policies leave providers at risk of inadequate payment. Politicization means that providers cannot always trust that the rules of today will be the rules of tomorrow, which presents a challenging – if not impossible – environment for large, complex organizations. Recent examples of the uncertainty of working with government.

We also are deeply concerned that a single-payer model would seriously distract from the important delivery system reform work underway. Hospitals and health systems have invested billions of dollars in technology and delivery system reforms to improve care, enhance quality and reduce costs. Moving to a single-payer model could stymie these efforts by, at best, diverting attention and, at worst, being deemed irrelevant if the government can simply ratchet down provider rates to achieve spending objectives.

WAYS TO PROMOTE BETTER CARE FOR AMERICA

Health coverage is too important to risk such levels of disruption. The better path to achieving comprehensive coverage for all Americans lies in continuing to build on the progress made over the past decade. To advance our objective of covering all Americans, we support:

- Continued efforts to expand Medicaid in non-expansion states, including providing the enhanced federal matching rate to any state, regardless of when it expands. This would give newly expanded states access to three years of 100% federal match, which would then scale down over the next several years to the permanent 90% federal match.

- Providing permanent federal subsidies for more lower- and middle-income individuals and families. Many individuals and families who do not have access to employer-sponsored coverage earn too much to qualify for either Medicaid or marketplace subsidies and yet struggle to afford coverage.
- Strengthening the marketplaces to improve their stability and the affordability of coverage by reinstituting funding for cost-sharing subsidies and reinsurance mechanisms.
- Robust enrollment efforts to connect individuals to coverage. The majority of the uninsured are likely eligible for Medicaid, subsidized coverage in the marketplace or coverage through their employer. We need an enrollment strategy that connects them to – and keeps them enrolled in – coverage. This requires adequate funding for advertising and enrollment efforts, as well as navigators to assist consumers in shopping for and selecting a plan.

We stand ready to work with Congress as we look for ways expand coverage to patients and families.

¹ American Hospital Association, "The Importance of Coverage," November 2018.
<https://www.aha.org/system/files/media/file/2019/04/report-coverage-overview-2018.pdf>

STATEMENT FOR THE RECORD

SUBMITTED TO THE

**Committee on Education & Labor,
Subcommittee on
Health, Employment, Labor, and Pensions**

**Hearing on Exploring Pathways to Affordable,
Universal Health Coverage**

February 17, 2022

SUBMITTED BY THE

**The Coalition to Protect and Promote
Association Health Plans**

I. Overview

The Coalition to Protect and Promote Association Health Plans (the “AHP Coalition”) respectfully submits this Statement for the Record.

The AHP Coalition is currently comprised of 25 like-minded organizations – including membership-based organizations and industry-service providers – that believe employees of small employers and self-employed individuals with no employees deserve quality and affordable health coverage with strong consumer protections. Our members include: American Composites Manufacturers Association; American Farm Bureau Federation; American Society of Association Executives; American Society of Travel Advisors; American Veterinary Medical Association; Associated Employers Benefit & Trust; Consoliplex; Food Marketing Institute; Foundation for Government Accountability; Global Cold Chain Alliance; Indiana Credit Union League; International Sign Association; Manufacturer & Business Association; Marsh McLennan; McDonald’s Licensees Health & Welfare Trust; Mercer; Michigan Business and Professional Association; Michigan Dental Association; National Association of Mortgage Brokers; National Association of REALTORS®; National Restaurant Association; NFIB; Small Business Association of Michigan; Tailorwell; Vimly Benefit Solutions.

Ever since its formation in August 2018, the AHP Coalition has been working tirelessly to correct-the-record.¹ Specifically, contrary to what critics are saying, Association Health Plans (“AHPs”) are *not* an “end-run around” the Affordable Care Act (“ACA”). Quite to the opposite, AHPs are currently offering better coverage than ACA-compliant “small group” and “individual” market plans. How do they do that?

AHPs are *voluntarily* covering all ten of the ACA’s “essential health benefits” (EHBs), including pediatric major medical coverage. AHPs also cover pediatric dental and vision services either through their AHP insurance contract or through a stand-alone product.

In addition, AHPs offer broader “health care provider networks” relative to many existing ACA “small group” and “individual” market plans, and they are priced at an “actuarially fair premium” for both young and old AHP participants. Doing so encourages more young and healthy individuals to enroll in AHP health coverage, which in turn benefits older and less healthy AHP participants by increasing the size of, and balancing out, the risk pool.

AHPs are also subject to specific rules that prevent them from discriminating against individuals/employees based on a health condition. Most importantly, AHPs are prohibited from denying people coverage if they have a pre-existing condition.

To date, at least 30 States have signaled that they want to allow AHPs to (1) cover small employers in the *same industry*, (2) cover small employers in *different industries*, and (3) cover self-employed individuals with no employees.² This is compared to the 11 States and the District of

¹ See e.g., Amicus Brief submitted by The Coalition to Protect and Promote Association Health Plans to the Court of Appeals for the District of Columbia Circuit at https://www.thepowerofa.org/wp-content/uploads/2019/06/Amicus-Brief-The-Coalition-to-Protect-and-Promote-Association-Health-Plans-and-AssociationHealthPlans.com_.pdf.

² See Association Health Plans (AHPs) and States’ Rights: An Accounting of How States Want to Regulate AHPs, Bloomberg Tax, Tax Management Compensation Planning Journal, Nov. 2019 at https://www.thepowerofa.org/wp-content/uploads/2019/11/Condeluci_CPJ_Nov2019.pdf.

Columbia (“DC”) that have filed a lawsuit to invalidate the Department of Labor’s (“DOL”) final AHP regulations (issued on June 21, 2018). Importantly, these 11 States and DC *already* prohibit certain types of AHPs from operating in their State.

II. Small Employers Want to Offer the Same Comprehensive and Affordable Health Coverage that Large Employers Offer

It is important to emphasize that one of the main reasons why employers – both large and small – offer health coverage to their employees is to attract and retain talented workers and to keep their workers healthy and productive. Large employers do just that, through an offer of comprehensive health benefits that talented workers often time demand, especially in a tight labor market.

Small employers – just like large employers – want to attract and retain talented workers and to keep their employees healthy and productive. As a result, small employers – just like large employers – want to, and will, offer comprehensive health coverage.

However, because small employers lack the resources and bargaining power of large employers, the majority of small employers are unable to offer comprehensive coverage at an affordable price. This is where AHPs play such an important and socially-beneficial role. By obtaining health coverage through an AHP – which will be treated as a health plan sponsored by a large employer – small employers can “group purchase” and effectively compete with large employers by offering comprehensive and affordable health benefits to their employees.

III. Membership-Based Organizations That Include Self-Employed Individuals Want to Offer Comprehensive and Affordable Health Coverage Too

It is also important to emphasize that the type of “groups or associations” interested in sponsoring an AHP are membership-based organizations (this includes member-based organizations with self-employed individuals with no employees). These organizations *want* to offer AHP coverage – which again, is treated like a large employer plan – not only to help their individual members obtain quality and affordable coverage, but as a member benefit to attract new members and retain their current members. An offer of less comprehensive, sub-standard health coverage will actually be detrimental to these organizations (i.e., their current members will leave the organization and they will be unable to attract any new members).

IV. During the 2019 Plan Year, Membership-Based Organizations Offered Comprehensive and Affordable Coverage Through an AHP

Our Coalition’s membership-based organizations represent over 1 million small employers, and millions more who are employees of these small employer-members or who are self-employed with no employees, the majority of whom would be eligible to obtain health coverage through an AHP if Federal law allowed AHPs to cover (1) employers in *different industries* and (2) self-employed individuals with no employees.³ Membership-based organizations with employers in the *same*

³ On March 28, 2019, the District Court for the District of Columbia ruled that the Department of Labor’s (“DOL’s”) final regulations issued on June 18, 2018 that allowed AHPs to cover (1) employers in *different industries* and (2) self-employed individuals with no employees are invalid. The U.S. Department of Justice appealed the ruling to the Court of Appeals for the District of Columbia Circuit. On May 10, 2019, the Circuit Court granted an expedited review of the District Court ruling. Almost three years later, a final ruling from the Circuit Court has yet to be released.

industry already provide comprehensive and affordable health coverage to tens of thousands of employees through an AHP in accordance with existing law.⁴

A. Voluntary Coverage of the “Essential Health Benefits”

All of our AHP Coalition members that offered an AHP to (1) employers in the *same industry*, (2) employers in *different industries*, and (3) self-employed individuals with no employees during the 2019 plan year *voluntarily* covered all ten of the ACA’s EHBs.⁵

It is important to emphasize that the tenth EHB requires “pediatric services, including oral and vision care.” Every AHP in our Coalition provided pediatric major medical health coverage. Some AHPs covered oral (i.e., dental) and vision care through the AHP insurance contract itself, while others provided dental and vision care through stand-alone products. In both cases, *all* ten of the EHBs were covered.

Those AHPs that offered pediatric dental and vision services through a stand-alone product chose to do so because the Board governing the AHP determined that pediatric dental and vision benefits can be provided through a stand-alone product at a lower cost, while providing the same – if not a better – level coverage than if these services were offered through the AHP insurance contract itself. It is important to point out that the “control” test applicable to an AHP imposes a fiduciary duty on the Board governing the AHP, requiring the Board to “act solely in the interest” of the AHP participants and “for the exclusive purposes of providing benefits to participants and their beneficiaries...and...defraying reasonable expenses of administering the plan...”⁶ The requirement to adhere to these fiduciary duties drove the Board’s decision-making (to do otherwise would result in a fiduciary breach under ERISA).

B. These Same AHPs Offered Broader Provider Networks Than “Individual” and “Small Group” Market Plans

In addition to *voluntarily* covering the EHBs, these AHPs offered broader “health care provider networks” relative to many existing ACA “small group” and “individual” market plans.

It is well-established that ACA-compliant “small group” and “individual” market plans primarily have “narrow networks.”⁷ In fact, the Congressional Budget Office (CBO) has explained that “individual” market plans generally have narrower provider networks than employment-based

⁴ It is important to emphasize that the District Court ruling involving the DOL’s final regulations issued on June 18, 2018 has *no* impact on existing law that allows membership-based organizations in the *same industry* to offer AHP coverage to their employer members with at least one common-law employee. See Q&A-1 of Frequently Asked Questions issued by the DOL on May 13, 2019 at <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/ahp-q-and-a-court-ruling-part-2.pdf> (although it appears that the DOL has de-activated this web link, requiring a formal request to review the DOL’s public pronouncement).

⁵ The list of ten medical services that make up the “essential health benefits” (“EHBs”) include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. [ACA section 1302(b)].

⁶ Section 404(a)(1)(A) of the Employee Retirement Income Security Act (“ERISA”).

⁷ Industry studies confirm that ACA-compliant small group and individual market plans primarily have “narrow networks.” See *Plans with More Restrictive Networks Comprise 73% of Exchange Market*, Avalere Health, Nov. 30, 2017.

plans.⁸ For those AHP participants that were covered by these AHPs (i.e., an employment-based large group plan) during the 2019 plan year, their plan's broader provider network meant that they were no longer required to drive hours to and from a physician's office or a hospital that were in-network to receive medical treatment or to even get a routine medical check-up.

C. These AHPs Offered Lower Deductible Plans for the Same Level of Coverage Offered Through "Individual" and "Small Group" Market Plans

The average deductible for a single plan in the "individual" and "small group" markets is over \$4,000⁹ and \$3,000,¹⁰ respectively. However, individuals and employees who were covered by an AHP during the 2019 plan year enjoyed *lower* deductibles for the same level of coverage as they would receive under an ACA-compliant "small group" or "individual" market plan.¹¹

D. These AHPs Developed "Actuarial Fair Premiums"

These AHPs also were priced at an "actuarially fair premium" for both young and old AHP participants. This was achieved through developing rate-bands based on age that did *not* exceed a 5 to 1 ratio. Alternatively, composite rates were developed by the average age of the employer member (not to exceed a 5 to 1 ratio among employer members), and then every employee of a particular employer member participating in the AHP was charged the same premium regardless of age.

Importantly, a health plan sponsored by a labor union (which is similar to an AHP because the union aggregates small employers together and offers a "large group" plan to these small employer members) *ALSO* develops premium rates based on a 5 to 1 age band or based on the average age of the employer member (not to exceed a 5 to 1 ratio among employer members). Why? Because the union is advised to do so by their actuaries, and the law currently allows unions to engage in this practice.

The Federal Employees Health Benefit Program ("FEHBP") also develops premiums based on a 5 to 1 ratio. Why? Because based on a study cited by the Congressional Budget Office, actuaries conclude that older individuals utilize health care 4.8 times more than younger individuals, and a 3 to 1 age ratio – as opposed to a 5 to 1 age ratio – "encourages older people to enroll and discourages younger people, and because the costs of the former are greater, average premiums rise."¹²

⁸ *A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications*, Congressional Budget Office, April 2021, page 7-8 at <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf>.

⁹ *How Much Does Individual Health Insurance Cost?*, eHealth, January 21, 2022 at <https://www.ehealthinsurance.com/resources/individual-and-family/how-much-does-individual-health-insurance-cost>.

¹⁰ *What Is the Average Cost of Small Business Health Insurance?*, eHealth, January 11, 2021 at <https://www.ehealthinsurance.com/resources/small-business/average-cost-small-group-health-insurance>.

¹¹ As stated, an AHP is a "large group" employer plan. Kaiser Family Foundation indicates that the average deductible for a single employer-sponsored plan was \$1,945 in 2020, which is consistent with our Coalition member's AHPs offered during the 2019 plan year. See *Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance for Single and Family Coverage* at <https://www.kff.org/other/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/?currentTimeframe=0&sortModel=-%7B%22colId%22:%22Location%22:%22sort%22:%22asc%22%7D>.

¹² *Private Health Insurance Premiums and Federal Policy*, Congressional Budget Office, February 2016, page 22 at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

E. Data Shows that AHPs Can Offer Lower Costing Plans While Providing Coverage That Is More Comprehensive Than ACA-Compliant “Individual” and “Small Group” Plans

Data from AHPs providing coverage to (1) employers in *different industries* and (2) self-employed individuals with no employees (which began their operations on or after January 1, 2019) show that there is savings that can be achieved while also covering the ACA’s EHBs and offering broader provider networks and lower-deductible plans.

For example, coverage that was offered to self-employed individuals through an AHP that was established by five different State and Local REALTORS® – the Baldwin County Association of REALTORS® in Alabama, the Greater Las Vegas Association of REALTORS®, the Kansas City Regional Association of REALTORS®, the Nevada REALTORS®, and the Tennessee REALTORS® – produced savings relative to ACA “individual” market plans.

Specifically, participants in the Kansas City Regional Association of REALTORS® AHP averaged savings between 5 percent and 50 percent, while participants in the Tennessee REALTORS® AHP experienced 25 to 50 percent savings. The Nevada REALTORS® AHP participants saw savings from 2 percent up to 32.5 percent, while participants in the Baldwin REALTORS® AHP realized savings ranging from \$150 to \$15,000 per year. Unfortunately, these AHPs have been discontinued due to the legal uncertainty surrounding the DOL’s 2018 final regulations.

Similarly, an AHP offered by the Nebraska Farm Bureau to self-employed farmers produced savings of up to 25 percent relative to “individual” market rates in Nebraska. This AHP has also been discontinued.

Another AHP jointly sponsored by the Small Business Association of Michigan and the Michigan Business and Professional Association – called Transcend AHP – covered both small employers and self-employed individuals. Although this AHP has been discontinued as of December 31, 2019, below are some statistics showing savings during the 2019 plan year:

- 22 employee investment manager – 35% savings - \$100,000/year and composite rates.
- 15 employee architecture firm – \$3,700 savings and composite rates.
- 27 employee managed service provider – 27% savings - \$53,000/year.
- 3 employee law firm – 5% savings from comparable BCBSM “small group” plan.
- Sole proprietor, health insurance agent – 17% in savings - \$2,400/year in savings vs. an ACA Exchange plan.
- 16 employee light manufacturer – 11.3% savings - \$16,000 a year and lower deductible.
- 7 employee refrigeration company – \$2,400/year savings and composite rates.
- 15 employee manufacturer – 27% savings - \$59,500/year savings.
- Sole proprietor, investment manager – 10% savings and a more robust plan design vs. an ACA Exchange plan.
- 16 employee small municipality – 10% savings - \$18,400/year.
- 24 employee construction company – 8.66% saving and cut deductible in half to \$1,000.
- 9 employee credit union – 18.5% savings - \$15,600/year in savings and a lower deductible.

V. AHPs Are Not the Same As Short-Term Health Plans; AHPs Provide Comprehensive Coverage As Required Under the ACA, ERISA, HIPAA, COBRA, and State Law

It is important to emphasize that AHPs are *not* the same as short-term health plans. We believe it is paramount to make this distinction because the media and critics of these health care arrangements have inaccurately explained the rules applicable to AHPs. In short, the media and these critics have conflated AHPs and short-term health plans, and they have described these health plans as being one-in-the-same. AHPs and short-term health plans are *vastly different*.

A. Short-Term Health Plans Are Exempt from the ACA, While AHPs Are Subject to the ACA's Coverage Requirements

Under existing law, short-term health plans are *not* considered “health insurance” offered in the individual insurance market,¹³ and therefore, short-term health plans are *not* subject to the Affordable Care Act’s (“ACA’s”) insurance and coverage requirements.¹⁴ As a result, short-term health plans *can* deny a person coverage with a pre-existing condition (because the ACA’s pre-existing condition protections do *not* apply). Also, a short-term health plan *can* develop premiums based on a person’s health condition (because the prohibition against developing premiums based on health status does *not* apply). And, a short-term health plan *can* impose annual and lifetime limits on benefits and medical services covered under the plan (because the prohibition against imposing annual and lifetime limits does *not* apply).

On the other hand, AHPs – as a “group health plan”¹⁵ – *are* subject to the ACA’s coverage requirements.¹⁶ Again, this distinction is important to understand because – under current law – AHPs (1) *cannot* deny a person coverage if they have a pre-existing condition, (2) *cannot* develop premiums based on a participant’s health condition, and (3) *cannot* impose annual and lifetime limits on the EHBs covered under the plan.

According to the ACA, a fully-insured “large group” and self-insured AHP – as a “group health plan” – *must*:

- Eliminate all pre-existing condition exclusions for all plan participants.¹⁷
- Stop imposing annual and lifetime limits on the “essential health benefits” covered under the plan.¹⁸
- Provide coverage for certain preventive health services with no cost-sharing.¹⁹

¹³ Section 2791(b)(5) of the Public Health Service Act section (“PHSA”), providing that the term “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

¹⁴ Section 1551 of the Affordable Care Act (“ACA”) incorporates the definitions under the PHSA – including PHSA section 2791(b)(5) – into the ACA’s insurance and coverage requirements.

¹⁵ ERISA section 733(a)(1) and PHSA section 2791(a)(1) provide that a “group health plan” is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents...directly, or through insurance, reimbursement, or otherwise.

¹⁶ ERISA section 715 incorporates by reference the ACA’s coverage requirements applicable to a “group health plan” into ERISA.

¹⁷ See PHSA section 2704.

¹⁸ See PHSA section 2711.

¹⁹ See PHSA section 2713.

- Cover “adult children” up to age 26.²⁰
- Stop rescinding coverage absent fraud or misrepresentation.²¹
- Include new internal and external appeals processes (and provide notice).²²
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.²³
- Provide direct access to emergency services.²⁴
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.²⁵
- Limit the plan’s cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account (“HSA”) rules for 2014.²⁶
- Eliminate waiting periods that exceed 90 days.²⁷
- Cover the cost of clinical trial participation.²⁸
- Provide participants with a summary of benefits and coverage.²⁹
- Provide annual reports describing the plan’s quality-of-care provisions.³⁰

B. Consumer Protections Under ERISA, HIPAA, and COBRA Apply to AHPs

Under ERISA, there are specific notice and disclosure requirements that a fully-insured “large group” and self-insured AHP must comply with.³¹ In addition, ERISA’s fiduciary responsibilities apply,³² requiring the AHP and its employer members to act in the best interest of the plan participants. AHP plan participants also have a private right of action to sue the AHP if there is wrong-doing,³³ and there are detailed procedures for filing health status.³⁴

According to COBRA, a plan participant terminating coverage under an AHP has a right to continuation of coverage,³⁵ and according to HIPAA, premiums for an AHP participant *cannot* be developed based on the participant’s health condition.³⁶

C. State Benefit Mandates Apply to Fully-Insured “Large Group” AHPs

Another important layer of coverage requirements that is often times overlooked by critics of AHPs is this: A fully-insured “large group” AHP will be subject to State benefit mandates. State benefit mandates require an insurance contract sold within a particular State to cover specified benefits and medical services. The State benefit mandates applicable to fully-insured “large group” plans in

²⁰ See PHSA section 2714.

²¹ See PHSA section 2712.

²² See PHSA section 2719.

²³ *Id.*

²⁴ See PHSA section 2719A.

²⁵ See PHSA section 2705.

²⁶ See PHSA section 2707(b).

²⁷ See PHSA section 2708.

²⁸ See PHSA section 2709.

²⁹ See PHSA section 2715.

³⁰ See PHSA section 2717.

³¹ ERISA, Title I, Subtitle B Part 1.

³² ERISA, Title I, Subtitle B Part 4.

³³ ERISA section 502.

³⁴ ERISA section 503.

³⁵ ERISA, Title I, Subtitle B Part 7.

³⁶ ERISA section 702.

most States are as good as the ACA's EHBs. Even in States where their benefit mandates do not cover all of the ten medical services that make up the EHBs, the drafters of the ACA observed that most if not all fully-insured "large group" plans were already covering the EHBs, which led Congress to exempt fully-insured "large group plans" from the EHB requirement entirely.

D. State MEWA Statutes Apply to Self-Insured AHPs

In the case of a self-insured AHP, this arrangement is by definition a "multiple employer welfare arrangement" ("MEWA").³⁷ In the case of a self-insured MEWA, Congress specifically amended ERISA's preemption provision to give States the explicit authority to regulate self-insured MEWAs operating within the State.³⁸ Since that time, many States have enacted their own State MEWA laws with varying degrees of regulation – ranging from restrictive to permissive. These laws often times impose specific coverage and/or premium rating requirements on self-insured MEWAs. In addition, State MEWA laws typically impose the same solvency – or reserve – requirements that apply to insurance companies operating within the State. Other States outright prohibit self-insured MEWAs. States that have yet to enact a State MEWA statute are not prohibited from doing so in the future. In addition, States with existing State MEWA statutes are free to amend those statutes to impose specific coverage, rating, and/or solvency requirements on self-insured AHPs.

E. A Regulatory Framework Has Been Put In Place Over Time to Combat Fraud and Abuse; Our Coalition Pledges to Work With the NAIC and Congress to Fight Against Fraud and Abuse

It is important to point out that an AHP can take the form of either a fully-insured or a self-insured arrangement. This is a crucial distinction when it comes to the issue of fraud and abuse. For example, fully-insured AHPs are under-written by insurance companies, which are themselves subject to significant State regulation. In addition, States impose specific requirements on agents and brokers who sell insurance, imposing significant penalties on agents/brokers that engage in the fraudulent sale of insurance products. As result, there have been very few cases of fraud and abuse in fully-insured AHPs. And based on the current regulatory environment, it is unlikely that any fraud will occur in the context of fully-insured AHPs in the future.

While self-insured AHPs have in the past been more vulnerable to fraud and abuse, this history prompted Congress to act. Before 1983, self-insured AHPs resisted efforts at State regulation by arguing that such State regulation was pre-empted by ERISA. However – as stated above – Congress amended ERISA to give States the exclusive authority to regulate self-insured AHPs in any manner the State may choose.

Therefore, since 1983, the States have been free to regulate self-insured AHPs as they see fit, and they have exercised that authority through the enactment of State MEWA laws. Currently, a number of States – including California, Illinois, and Washington – flatly prohibit the establishment of any new self-insured AHPs. However, most other States have enacted MEWA laws that set forth comprehensive certification and approval processes that an organization seeking to operate a self-insured AHP in the respective State must satisfy. Any such certification/approval must come directly from the State's Insurance Commissioner, and any such certification/approval will only be provided by the Commissioner if all of the State's MEWA law requirements are satisfied.

³⁷ See ERISA section 3(40).

³⁸ ERISA section 514(b)(6)(A)(ii).

More extensive oversight has also come at the Federal level through the enactment of the ACA. Specifically, Congress expanded and strengthened the DOL's authority over MEWAs – and thus over AHPs – through a multi-pronged approach to eliminate MEWA/AHP abuses. These new requirements include improvements in reporting, together with stronger enforcement tools, and expanded required registration with the DOL prior to operating in a State. This additional information enhances the State and Federal governments' joint mission to prevent harm and take enforcement action. The ACA also strengthened enforcement by giving the Secretary of Labor the authority to issue a cease and desist order when a MEWA/AHP engages in fraudulent or other abusive conduct, and to issue a summary seizure order when a MEWA/AHP is in a financially hazardous condition.

This detailed State and Federal regulatory framework – which was not in place at all prior to 1983, and which has been built up over the years – provides safeguards that will largely prevent fraud and abuse, and, where such misconduct does occur, will significantly mitigate its effects. The Coalition has also pledged to the National Association of Insurance Commissioners (“NAIC”) that we are ready, willing, and able to work with the State Insurance Commissioners to build on the current regulatory framework. In addition, the Coalition seeks to work with members of Congress to provide additional funding for the DOL's enforcement activities – as established under the ACA – as well as to fund State enforcement efforts.



STATEMENT FOR
U.S. HOUSE OF REPRESENTATIVES
EDUCATION AND LABOR SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR,
AND PENSIONS

HEARING ON
EXPLORING PATHWAYS TO AFFORDABLE, UNIVERSAL COVERAGE

February 17, 2022

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the over 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to working to ensure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come.

Employer-sponsored coverage has been the backbone of our nation's health system for nearly eight decades. Employers of all sizes contribute vast resources to employees and their families through the employer-sponsored system. Employers have a vested interest in health care quality, value, and system viability. Employers have been on the leading edge of health delivery innovation and modeling for decades.

Benefits offerings and coverage plans in the employer-sponsored system are as diverse as employers and employees themselves. With self-insured coverage under the Employee Retirement Income Security Act (ERISA), employers tailor coverage to meet their workforce's specific needs across state lines, pay all health claims and bears the financial risk, and utilize a third-party administrator (insurance carrier) for daily plan management. Through the fully-insured state regulated insurance market, employers purchase a prescribed benefit insurance product sold in a state from an insurance carrier and do not bear the full financial risk of claims.

Employers have led the way in benefits design and innovation for decades and will continue to do so for decades to come. There is no one-size-fits-all employer health plan nor should the federal government enact or implement laws that stifle an employer's ability to develop benefits offerings that meet the needs of their specific workforce. All levels of government should work constructively with private sector employers to ensure that employers have the tools and flexibility to foster benefits design and innovations that provide employees with benefits that are crucial to the wellbeing of themselves and their families.

The foundation of the employer-sponsored coverage system is rooted in workforce policy and business operations. Employers of all sizes offer coverage for employee recruitment and

Partnership for Employer-Sponsored Coverage
 February 17, 2022
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retention, and the functionality of a business is centered around a productive, thriving, and healthy workforce.

The ability to offer coverage to employees and the capacity to operate a business for its core purpose are not mutually exclusive functions. An employer offer of coverage is not merely a transaction in which an employee fills out paperwork, enrolls in coverage, and receives an insurance card – it is a multifaceted fiscal and operational commitment at the core of any business. As employers are making the decision to offer coverage and determine which type of coverage to offer their employees, a critical aspect of this deliberation is the administrative compliance costs and complexities associated with coverage.

When considering legislative and regulatory policy development and implementation, federal lawmakers and regulators must understand and appreciate the societal and economic commitments employers make to our nation's workforce through the employer-sponsored coverage system. The following policy and implementation questions should be carefully considered in the context of today's hearing and future deliberations.

- What would a single-payer health care system mean for employment? Recruitment and retention of employees?
- How would a Medicare or Medicaid buy-in program be an advantage or disadvantage to employees and employers?
- How would expansion of Medicare/Medicaid through a buy-in program effect current program beneficiaries and resources?
- How would a Medicare/Medicaid buy-in program effect timely access to providers and services for the influx of new beneficiaries?
- How would the employee-employer relationship change by a Medicare buy-in plan? Specifically with regard to working Americans between 50-64?
- What is a Medicare buy-in program striving to accomplish? Cohort of uninsured?
- How would a Medicare/Medicaid buy-in program effect take-up rates for fully-insured employer-sponsored plans? How would it effect other populations of employees?

The Partnership for Employer-Sponsored Coverage opposes the establishment of a single-payer health care system. Dismantling our nation's private sector employment-based health system which provides coverage for the largest percentage of the population would create utter chaos and massive disruptions to the care system for all Americans. We urge Congress to devote its attention and resources toward issues to improve our current health care system such as increasing market competition, providing more coverage choices and access to providers for all Americans, and addressing systematic cost drivers and wasteful spending. Our public principles include:

- Preserving the current tax treatment of employer-sponsored coverage
- Promoting innovations and diversity of plan designs and offerings for employees

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- Providing employers with compliance relief from burdensome regulations
- Repealing the Affordable Care Act taxes on employer-sponsored coverage
- Protecting ERISA

As a coalition representing businesses of all sizes, the Partnership for Employer-Sponsored Coverage has the unique ability to provide operational input across the full spectrum of the employer system – from the smallest family-owned business to the largest corporation. Employers have a great stake in the development and implementation of health care policies.

We stand ready to work with the 117th Congress in a bipartisan manner strengthen and preserve our nation's private sector employment-based health system. We would welcome the opportunity to discuss these issues with you or your staffs. If such a meeting would be of interest to you, please have your staff contact P4ESC's Executive Director Neil Trautwein at eneiltrautwein@gmail.com.

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE
www.p4esc.org

CHCC

CORPORATE HEALTH CARE COALITION

February 17, 2022

Honorable Mark DeSaulnier, Chair
Honorable Rick Allen, Ranking Member
House Education & Labor Subcommittee on Health, Employment, Labor and Pensions
2176 Rayburn House Office Building
Washington, D.C. 20515

Dear Chair DeSaulnier and Ranking Member Allen:

The Corporate Health Care Coalition (CHCC) would like to take this opportunity to comment on the today's subcommittee hearing, "Exploring Pathways to Affordable, Universal Health Coverage."

CHCC is comprised of companies from varying industries that compete in the global marketplace and sponsor health plans for the benefit of our employees and other beneficiaries. Collectively, our plans provide health care benefits for nearly 5 million Americans across every state in the nation.

CHCC companies are committed to providing access to affordable, quality health care benefits. On-site and near-site medical clinics, direct primary care arrangements and providing access to health and mental/behavioral services via telehealth are just a few examples of how our companies are constantly striving to innovate and improve plan participants' health, reduce health care costs for all, and use our leverage as payers to promote payment for value.

The employer-sponsored health care system is the backbone of the U.S. health care system, offering a popular source of health care for nearly 160 million Americans. Any legislative effort to provide additional sources of coverage should build on and improve, rather than dismantle, the current health care infrastructure. According to polling last year by the Alliance to Fight for Health Care, an overwhelming majority of Americans, over 77 percent, give their employer health plan top ratings in terms of innovation in treatment, high quality care and choice in doctors. A majority of those surveyed also preferred that government and business work together to build on what we have today, offering a variety of coverage options.

As you consider policies to help those currently uninsured find coverage, CHCC urges you to strengthen and maintain existing sources of coverage, such as the employer-sponsored health care system. Congress can do that by maintaining adequate risk pools and increasing health care transparency, both critical to employers' ability to offer quality care and manage costs.

CHCC companies and other plan sponsors in the commercial market recognize that there is already a cost-shift we carry and do not want to see it increased. The payment system is a

The Corporate Health Care Coalition (CHCC) is a public policy coalition of large, multi-state, self-insured companies that operate health benefit plans for employees and their families as well as retirees. For more information, please visit corporatehealthcare.org.

balloon; if you squeeze one end, the other expands drastically. Therefore, if providers cannot obtain reimbursement for the true cost of care for patients under a public option (as some proposals have suggested with reimbursement tied to current government program rates), providers will respond by seeking higher reimbursement from private health coverage, further raising costs for millions of Americans.

If employees are permitted to enroll in a public option after receiving an offer of affordable, minimum essential coverage from their employer, employers' risk pools will not be maintained. It could become more expensive to offer employer-sponsored coverage and hence threaten an important source of coverage for close to 160 million Americans, because younger, healthier individuals could seek coverage in the public option, thereby leaving older, sicker individuals in an employer's risk pool. We should be building on the health care system we have, not diminishing a current source of high quality, affordable health care coverage.

CHCC companies also recognize that health care transparency is a vital tool to control costs in employer-sponsored health care. We believe that empowering our health plan participants with meaningful information regarding the cost and quality of services across care categories will enable them to make informed, cost-conscious health care decisions. For employers, access to cost and quality data can help provide the insights we need to continue our efforts to offer employees and their families access to high-quality providers, thereby improving outcomes and lowering health care costs. We encourage Congress to continue to make increased transparency in the health care system a priority.

Thank you again for the opportunity to comment on the future of our health care system and the need to preserve and strengthen the employer-sponsored health care system. CHCC looks forward to an ongoing dialogue with you on this important matter.

Sincerely,

The Corporate Health Care Coalition



**COUNCIL FOR AFFORDABLE
HEALTH COVERAGE**

440 1st St. NW, Suite 430 Washington, DC 20001
o: 202.808.8850 w: CAHC.NET

Chairwoman Patty Murray
Committee on Health, Education, Labor and Pensions
428 Senate Dirksen Office Building
Washington, DC 20510

Chairman Frank Pallone
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Murray and Chairman Pallone,

The Council for Affordable Health Coverage (CAHC) thanks you for the opportunity to provide our comments on the merits of and design considerations for legislation to develop a public health insurance option. CAHC (www.cahc.net) is a broad-based alliance with a primary focus: bringing down the cost of health care for all Americans. Our members include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers who collectively cover millions of lives in the private market.

Universal Coverage

CAHC supports universal coverage. We want all Americans to have access to a health policy they can afford and that meets their individual needs. Fortunately, most Americans (92 percent)¹ do obtain health coverage, which they receive through job-based health benefits, government programs, or charitable care. And most Americans like their health coverage. According to a recent CAHC poll, voters support job-based coverage over government run programs by a 20-point margin.²

The “Public Option”

Because each person has different health circumstances, one-size-fits-some solutions like a public option will never work well for many, making it an unappealing approach. That is why we believe the so-called public option is the wrong path, since it would upend the entire market to advance an ideological agenda to expand government run health care. Worse, a public option effectively removes the competitive forces at work in health markets with government prices set by bureaucrats and formulas rather than real world experience. Under a public plan, the government would be responsible for negotiating reimbursement rates for doctors, hospitals, and pharmaceutical companies. The government typically does not “negotiate.” The government would likely resort to price-setting based on Medicare or use existing government programs as leverage for negotiations, creating similar effects.

In November 2013, the Congressional Budget Office (CBO) examined a proposal to add a public plan to the health insurance exchanges. The public plan would charge premiums that fully covered its costs, including administrative expenses. At the outset, the plan’s payment rates for physicians would be set 5% higher than Medicare’s rates in 2013 and increase to reflect costs in later years. In addition, the public plan would pay hospitals and other providers the same amount that would be paid under Medicare, on average, and would set payment rates for prescription drugs through “negotiations” with drug manufacturers. Low reimbursement rates would not likely encourage provider participation in a public exchange, which would likely lead to longer waits for care and inevitably lead to rationed care. These states may be less attractive to specialists who provide critical care to patients with complex medical conditions. States that choose to offer a public option on the exchange may risk losing their health

¹ [Health Insurance Coverage in the United States: 2019 \(census.gov\)](http://census.gov)

² [CAHC March 2021 Board Presentation \(squarespace.com\)](http://squarespace.com)

care workforce – or at least some of it – if the arrangements offered by the government health plan are not workable.

Experience

The Affordable Care Act included several attempts at creating “public options” including the creation of co-operative health plans or co-ops, multi-state plans run by the Office of Management and Budget, and finally the creation of the CLASS Act to help with long-term care expenses. Millions of dollars and numerous lawsuits later, most of the federally funded co-ops have either become insolvent or ceased to operate as a co-op. The multi-state plan – intended to interject national competition into local markets – was a failure from the outset. The long-forgotten CLASS Act, which was supposed to be a public option for long-term care, was repealed before it was operationalized due to solvency and serious design flaws.

In short, all the federal public options in the ACA have flopped. The programs cost taxpayer money, destabilized insurance markets, and led to higher overall insurance prices as costs shifted to private payers. The imposition of a new public option scheme would be similarly detrimental to optimal health insurance markets and result in increased costs for both taxpayers and consumers.

State-Based Efforts

Efforts in the states have fared no better. Many state insurance codes included requirements to offer a “basic and standard plan” starting in the late 1980’s and early 1990’s. Even prior to the passage of the ACA, the plans were not popular with the public and enrollment was anemic, at best. More recently, Washington state (and Colorado and Nevada passed similar laws this year) has passed and implemented their Cascade Care program. The program includes standardized plan designs and a rigid Medicare-based reference price for insurance plans participating in the program. Despite the advantage in set medical costs, Cascade Care plans were more expensive than plans designed and offered by private insurers at commercial reimbursement rates. In response, this year Washington state passed new changes to the program to limit competition with Cascade Care plans.

Characteristics of Coverage

More than 99 percent of the 333 million Americans have access to health coverage, regardless of their income or medical condition. About 30 million people under age 65 are uninsured, but more than two thirds of those lacking insurance could have obtained subsidized coverage in job-based or government programs but did not enroll in those programs.³ Of the 10 million uninsured, many unsubsidized individuals are present in the U.S. unlawfully, which should be a matter of immigration policy. The remainder of subsidy-ineligible uninsured are in states that did not expand Medicaid, or who have incomes too high to qualify for government programs. In addition, almost three-quarters of those who remain uninsured cite cost as the number one reason.⁴

³ 20 million were eligible for subsidized coverage (5.1 million for Medicaid or CHIP, 5.5 million for ACA, and 9.4 million for employer coverage). 9.8 million of the uninsured are not eligible for subsidized coverage, including 4 million who are unlawfully present, 3.2 million in states that did not expand Medicaid and 2.6 million high income people. [Who Went Without Health Insurance in 2019, and Why? | Congressional Budget Office \(cbo.gov\)](#)

⁴ In 2019, 73.7% of uninsured nonelderly adults said they were uninsured because coverage is not affordable, making it the most common reason cited for being uninsured. [Key Facts about the Uninsured Population | KFF](#)

More targeted policies to address the discrete challenge of the remaining uninsured is a superior approach to the public option. For these reasons, government policy should focus on four key issues:

1. Lowering medical costs relative to income to increase affordability.
2. Expanding currently eligible but unenrolled.
3. Reforming Medicaid to ensure state and individual incentives to maximize program dollars and affordable private coverage; and
4. Expanding private coverage through small business incentives.

Expand Private Coverage

Policymakers should focus on expanding access through the overwhelmingly popular jobs-based insurance market—specifically through small businesses who struggle to provide coverage to their employees and who were hardest hit by government COVID lock downs and capacity limits. Employers, unions, and enrollees place high value on offering and receiving these benefits, giving elected officials of both parties a clear path to success by focusing coverage efforts to increase access where significant gaps in coverage remain.

- Provide a small employer and their employees a tax credit for enrolling in health coverage. The tax credit could be higher for micro groups and slightly lower for larger small groups.
- Provide a shrinking tax credit to assist micro or small employers in offering health insurance to their employees. Micro employers could be provided with a \$500 per year, per employee tax credit to provide insurance for the first year, \$300 per year, per employee in the second year, and \$100 per year, per employee for the 3rd year. The credit could be in addition to the small employer and employee credit.
- Reinsurance has led to direct premium reductions in the individual market and could provide the same advantages in the small group market. Because reinsurance helps address high-cost claims of individuals, they improve market stability and affordability in a virtuous process. Unfortunately, reinsurance programs are not established for small employers, and Congress' focus has been on shoring up ACA markets, not the small business market. Congress should provide states with 50-50 split for the cost of reinsurance up to \$200 million per state. Like the Affordable Care Act 1332 waiver program, the federal government would match state dollars 50-50. A roughly \$200 million reinsurance program could drop premiums rates up to 10% in some states.
- Congress could allow firms to provide gig worker account-based plans and allow one or more employers to provide contributions to the accounts. A 50% tax credit for each dollar provided by employers subsidizing part-time or gig worker health accounts would incentivize contributions and coverage. Gig worker health accounts would not be treated as an employer subsidy for the purposes of health insurance exchanges.

Instead of turning to a government-run solution, we should also focus on ways to promote greater flexibility in insurance exchanges and insurance design to make coverage more affordable and accessible to all Americans. For example, we should:

- Make subsidies portable so that consumers can buy coverage from any exchange website, public or private – or directly from an insurance carrier.
- Create more flexibility in essential health benefit requirements to reduce premium costs.
- Add a new Copper level of coverage to the insurance exchanges, which would be a lower premium catastrophic plan that would pay 50% of covered expenses; and

- Consider benefit designs that engage consumers and encourage access to high-value and appropriate care. This would include HSA-eligible High-Deductible Health Plans, which would provide first-dollar coverage for targeted preventive services that are clinically proven to lead to good health outcomes and prevent chronic disease progression.

Lowering Medical Costs

A far better approach to universal coverage is ensure health costs, which determine premiums, rise more slowly than family income. Currently the U.S. spends almost \$4 trillion annually on health care. Over the next 10 years, the U.S. health sector will take in more than \$50 trillion. Currently, three-quarters of health spending goes toward hospitals, professional services, and prescription drugs, which drive premium and out-of-pocket costs. Since 2010, the medical cost trend has grown by 73 percent, about four times faster than the average wage and five times faster than the Consumer Price Index. Because costs are rising faster than wages, health coverage is becoming less and less affordable. If current trends persist, the typical working family will spend more than 40 percent of its income on health care by 2030.

Health Services

Most hospital markets are highly concentrated, leading to higher prices and costs, and fewer choices. For example, during 2012-2016, commercial inpatient spending per person grew 24.3 percent, even as utilization fell 12.9 percent. (In other words, had prices not gone up, inpatient spending per person might have fallen by 37 percent.) Similarly, outpatient spending grew 17.7 percent while utilization fell 0.5 percent. Importantly, these price increases are imposed by non-profits - more than 80 percent of hospitals are nonprofit or state-run, and thus lack the incentives that motivate for-profit institution efficiency. Government policies and programs also fuel much of the problem by stifling competition.

- **Pay for Value, Safety and Site of Care.** Reforms to taxpayer funded programs should seek to maximize taxpayer value while strengthening incentives to deliver superior patient outcomes. Congress should enact reforms that pay for value, pay for safe care, and seek to pay the same amount for the same services delivered across different sites of care.
- **Incentives for Value.** Repeal MIPS and establish a new voluntary value program in Medicare in which clinicians can elect to be measured as part of a voluntary group; and clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures. Congress should also deregulate the EHR market by eliminating complex rules for use of EHRs in Medicare and Medicaid and allow direct primary care as an option for Medicare beneficiaries. Finally, consumers should be allowed to share in the savings generated by shared savings models. Currently, Medicare ACOs only share savings with providers and taxpayers. If patients could share in efficiencies, they would be more engaged in their care and have incentives to be well.
- **Competition.** Outside of Medicare, Medicaid and other public programs, state and federal policies that inhibit market competition should be phased out. New enforcement tools should be employed to ensure competitive markets remain robust. Where competition fails, new rules should be enacted to ensure consumers are protected from monopolies, and incentives are created to encourage new market entrants. The goal is to enact policies that continuously move to more competitive markets.

Prescription Drugs

Medications are only effective if patients can access and afford them. Too many Americans are forced to make difficult choices between medicines and other necessities. Others are unable to access the most effective or innovative treatments because increasing costs throughout the system have led to draconian measures that limit health providers' ability to address the individual needs of each patient. Our current system is not working for too many patients. Rather than rely on government interference in markets, we support common sense solutions that will bring relief to Americans struggling with rising health care costs. Essential provisions that should be part of any legislative package include:

- **Establish an annual out-of-pocket limit on costs for Part D enrollees and redesign the standard Part D benefit** so that beneficiary initial cost sharing decreases from the current 25 percent, while also restructuring the catastrophic benefit to lower costs
- **Reform pricing models that inhibit value-based arrangements.** Manufacturers and payers are reluctant to enter value-based arrangements, in part, because of the challenge of squaring such innovative approaches with the inflexible complexities of rebate liabilities under Medicaid's "best price" reporting requirements. The result is that many innovative, lower cost arrangements simply are not pursued. We recommend that clear exceptions to Medicaid best price and Average Manufacturer Price reporting be established for value-based arrangements, coupled with clear guidance to reduce current ambiguity about how to capture value-based pricing for reporting purposes.
- **Reform Anti-Kickback and Stark restrictions.** Value-based and care coordination arrangements, which should be allowed safe harbors from both laws to allow for greater care coordination and payment, combined with the changes to Medicaid Best Price, would save up to \$36 billion annually, and \$2.8 billion in federal budgetary savings over the ten-year budget window.
- **Enable medication synchronization programs** to assist patients in filling their multiple prescriptions. We estimate incentivizing medication synchronization programs in federal health programs will save up to \$42 billion in annual healthcare costs.
- **Reform Medication Therapy Management** programs in Medicare Part D to target resources to at-risk beneficiaries based on data driven insights from EHRs.

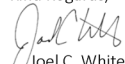
Expand Outreach for those Already Eligible

Rather than enact new government programs, Congress should provide incentives to enroll already eligible individuals into current programs. As noted above, this could reduce the number of uninsured by 3 million or more.

Conclusion

Thank you for the opportunity to comment on this important issue, we appreciate your focus and determination in solving these problems. We at CAHC are committed to working with you to solve them, however we do not believe a public option would solve the problem facing Americans, rather it would make matters worse.

Kind Regards,


Joel C. White
President



June 10, 2019

The Honorable Richard Neal
Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington D.C. 20515

The Honorable Kevin Brady
Ranking Member
House Ways and Means Committee
1102 Longworth House Office Building
Washington D.C. 20515

Dear Chairman Neal and Ranking Member Brady:

As an organization representing the 90 million Americans who work at or own a small business, we have grave concerns about the increasing likelihood of a government takeover of America's healthcare system.

On Wednesday, the House Ways and Means Committee is holding a hearing on "pathways to universal health coverage," which is a pleasant way of saying "a government takeover of everyone's health insurance." The most popular bill to achieve that, the *Medicare for All Act of 2019*, has over 110 House cosponsors, almost half the Democratic Caucus.

Sen. Bernie Sanders, who has introduced his own "universal healthcare" bill, told CBS News that his plan would "get rid of insurance companies." Specifically, he warned those who currently have employer-based insurance "you're going to have to change that" because "all people will be covered by Medicare." The implications of Sanders's statement are undeniable: "Universal healthcare" means the complete abolishment of all private health insurance. That will be devastating for America's small business owners and their employees.

According to a 2015 report from the National Small Business Association, 65 percent of small businesses offer health insurance to their employees. This means that abolishing private health insurance would eliminate healthcare choices for up to 38 million Americans employed by small businesses. Over 200 million Americans, in total, will be impacted.

President Obama famously promised that "if you like your healthcare plan, you can keep it," only to break his pledge when four million Americans lost their plan because of the Affordable Care Act. "Universal healthcare" would impact a vastly greater number of Americans, forcing them into a system that has failed miserably around the world – one where access to care is limited and literally rationed.

Under Canada's "universal" system, nearly one million Canadians are stuck on healthcare wait lists. More than 60,000 Canadian patients flee each year to escape their wait line, mostly going to the U.S.

Under the United Kingdom's "universal" system, wait lists have ballooned to 4.1 million people, with the average person waiting 18 weeks for necessary treatment. Applying that number to the U.S. would be the equivalent of having 20 million Americans on wait lists.



Members of Congress must take a stand now. Small businesses are the backbone of the growing economy, creating two out of three new jobs in America.

We urge you to publicly reject “universal healthcare” whether it takes the name of “single-payer,” “Medicare for All,” or any other Orwellian name.

Instead, we urge you to pass market-based healthcare reforms to reduce burdensome regulations that are artificially reducing healthcare supply and inflating prices. For instance, passing expanded association health plan (AHP) legislation, similar to the AHP rule issued last year by the Labor Department, would allow our small business owners and employees to access better health insurance for less cost. Any healthcare reforms should promote choice, lower costs, and empower patients, not the government.

We look forward to your timely response.

Sincerely,

Alfredo Ortiz
President and CEO
Job Creators Network



Committee on Education and Labor
 United States House of Representatives
 Rayburn House Office Building
 Independence Ave SW #2176
 Washington, DC 20515

NAHU is committed to ensuring that every American has access to affordable, quality health coverage, and believe that the free market and public programs can bring down the cost of care and expand access to high-quality care for every American. Instead of considering single-payer healthcare proposals, Congress should focus on bringing costs down for everyone, no matter where they get their insurance. As a member of the Partnership for America's Health Care Future (PAHCF), NAHU works with a coalition of industry stakeholders to promote employer-sponsored health coverage and preserve Medicare, Medicaid, and other existing health programs

NAHU is also dedicated to preserving the private health insurance market amid growing concerns by consumers over increasing instability, premiums, and cost-sharing, and decreasing choices. As frustrations with these conditions continue, it has led to a growing interest in some version of a single-payer healthcare system, either through incremental approaches such as a public option or Medicare or Medicaid buy-in, or a more sweeping federal takeover of the entire healthcare system to implement a single standardized government-run plan.

Legislation to implement a Medicare-for-All system has been introduced in both the House and Senate in past Congressional sessions. Representative Pramila Jayapal (D-WA) and 106 original co-sponsors introduced [H.R. 1384](#) in February 2019 and Senator Bernie Sanders (I-VT) and 14 co-sponsors introduced [S. 1129](#) in April. These proposals would force all Americans into government run plans within two-years (house) or four-years (senate) by expanding Medicare into a government insurance plan, gradually providing comprehensive health insurance coverage to all U.S. residents. The coverage would be available at the end of the first transition year for current Medicare enrollees, people over age 55 and those under 19, and to all Americans by the end of the second year. The plan would be based on an expanded form of Medicare coverage that would also include prescription drugs, dental and vision services, and long-term care, but without co-pays, premiums, or deductibles.

Existing individual and employer-based coverage would be replaced by the plan, and it would be illegal for any private insurance to compete with the government run plan, although limited private coverage would be available for any services not covered by the plan. There would also be an exception for the Department of Veterans Affairs and the Indian Health Service to continue their existing coverage.

The Medicare-for-All legislation followed the introduction of Medicare buy-in legislation introduced in the [House](#) by Representatives Brian Higgins (D-NY) joined by 29 co-sponsors, and in the [Senate](#) by Senator Debbie Stabenow (D-MI) and 19 co-sponsors in 2019. That legislation would have allowed those aged 50-64 to buy into current Medicare coverage. Similarly, Senators Michael Bennet (D-CO) and Tim Kaine (D-VA) introduced [S. 981](#), the Medicare-X Choice Act that would establish a public option plan parallel to Medicare coverage for all Americans to be able to buy-into, including those who already have employer-sponsored coverage.



Leading proposals for a public option would make it available to consumers purchasing coverage through the state or federal marketplaces. The plan would comply with requirements related to other state or federal marketplace plans and offer various level plan options. Premiums would be established according to state or federal marketplace rules. As a public plan it could have the power to dictate prices, provider networks, and provider reimbursements. It could also potentially indemnify itself for unexpected costs, allowing it to offer insurance at below-market costs.

One of our most serious concerns about the public option is its potential to further exacerbate the cost-shift that already drives up health care spending. Cost-shifting is a hidden tax on private payers that occurs when government payment rates are too low and providers shift costs to the privately insured to make up the difference. The public reimbursement rates result in these costs being shifted onto private insurers and plan enrollees, as a study by the actuarial firm Milliman found that annual healthcare spending for an average family of four was \$1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates. A government-run plan reimbursing at the rates could result in a net \$70 billion decrease in provider reimbursements with at least some of those costs shifted directly onto those already privately insured, while drawing consumers away from private coverage and leading to a potential death-spiral and the collapse of the private market.

NAHU strongly opposes these government-run insurance proposals, regardless of whether it is Medicare for All, Medicare buy-in, single-payer or a public option, given the consequences it would have for Americans who already have coverage, including the more than 180 million Americans who receive coverage through their employer.



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February 17, 2022

The Honorable Mark DeSaulnier
Chairman
Subcommittee on Health, Employment, Labor, &
Pensions
U.S. House of Representatives
503 Cannon House Office Building
Washington, D.C. 20515

The Honorable Rick Allen
Ranking Member
Subcommittee on Health, Employment, Labor, &
Pensions
U.S. House of Representatives
570 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman DeSaulnier and Ranking Member Allen:

On behalf of NFIB, I write to share comments in response to the committee's hearing entitled *Exploring Pathways to Affordable, Universal Health Coverage*.

NFIB is the nation's leading small business advocacy association, representing members in Washington, D.C., and all 50 state capitals. Founded in 1943 as a nonprofit, nonpartisan organization, NFIB's mission is to promote and protect the right of its members to own, operate, and grow their businesses. NFIB proudly represents approximately 300,000 members nationwide from virtually every industry and sector of the U.S. economy.

Health insurance is an important benefit that many small businesses offer for the care of their employees and as a tool to recruit and retain a qualified workforce. Research has shown that small businesses are leaders in offering high quality health benefits that often provide a better value to their workforce as compared to their large peers.¹ Unfortunately, small employers continue to face a severe challenge in providing affordable health insurance coverage.

For over 30 years, NFIB members have identified the cost of health insurance as the number one small business problem with 50% ranking it as a critical problem.² This committee acknowledged the seriousness of this issue when marking up H.R. 3200, the predecessor of the Affordable Care Act (ACA), noting that "rising healthcare costs have had a negative impact on business, especially small employers. Over just the last 15 years, the percentage of small businesses offering health insurance dropped from

¹ See Gary Claxton et. al, *Employer Health Benefits 2021 Annual Survey*, KFF, available at <https://files.kff.org/attachment/Report-Employer-Health-Benefits-2021-Annual-Survey.pdf> (noting that 29% of covered workers in small firms are in a plan where the employer pays the entire premium for single coverage, compared to only 5% of covered workers in large firms).

² Holly Wade & Andrew Heritage, NFIB Research Center, *Small Business Problems and Priorities*, 2020, <https://assets.nfib.com/nfibcom/NFIB-Problems-and-Priorities-2020.pdf>.

61% to 38%.³ Unfortunately, since the ACA's passage, the average employee-only premium for employers with less than 50 employees has increased 42%,⁴ the average family policy premium has increased 47%,⁵ and the number of small businesses offering coverage has dropped further to just 31%.⁶

The ACA increased federal regulation and cost burdens on small employers. To make matters worse, the principal ACA provisions to help small employers offer coverage, the Small Business Healthcare Tax Credit and the Small Business Health Options (SHOP) Exchange Marketplace, failed to deliver savings. The SHOP has been extremely unpopular with SHOPS non-operational in more than half of states.⁷ The Congressional Budget Office (CBO) estimated that the Small Business Healthcare Tax Credit would peak at \$6 billion in utilization.⁸ Instead, data on the credit from the IRS shows that utilization peaked at around \$555 million in its early implementation before steadily declining to just \$30 million in the last year data is currently available from Treasury.⁹

The principal solution to affordability proposed by the 117th Congress in the *Build Back Better Act* is increased ACA subsidization of the individual market by extending enhanced Advanced Premium Tax Credits (APTCs) first implemented by the American Rescue Plan. While enhanced APTCs assist those Americans who qualify for the program, this policy does not address the underlying issues that are driving cost growth, nor does it offer help to small business owners who desire to offer employer sponsored insurance (ESI) but cannot afford to do so. Unsurprisingly, CBO projects that this policy will result in a substantial decrease in employer sponsored insurance offer rates, which could further deteriorate the small group market. The *Build Back Better Act* also seeks to address affordability by shifting additional costs to employers in modifying the affordability test for ESI and by allowing additional individuals to obtain Exchange Marketplace subsidized coverage even if they have an offer of affordable coverage by their employer. These policies will likely raise prices on employers, further exacerbate problems in the employer sponsored insurance system, and lead to continue declines in ESI coverage.

Facing ever growing costs and declining offer rates, some propose that the ultimate solution for small businesses in health insurance is to simply jettison ESI and transform the American health insurance system into a single payer model. NFIB members overwhelmingly reject that approach with 75% indicating opposition to a single-payer solution in a recent member ballot.¹⁰ As multiple analyses have

³ U.S. House, Committee on Education and Labor, *Report to Accompany H.R. 3200, America's Affordable Health Choices Act of 2009*, H. Rept. 111-299 (Oct. 2009).

⁴ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), *Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics, 2010 to 2020*, available at <https://datatools.ahrq.gov/meps-ic>.

⁵ *Id.*

⁶ Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), *Percent of private-sector establishments that offer health insurance by firm size and selected characteristics: United States, (2020)*, https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2020/tia2.htm.

⁷ See Vanessa C. Forsberg, Congressional Research Service, *Overview of Health Insurance Exchanges*, (updated Feb. 16, 2021) (noting for plan year 2021 "there are no insurers offering medical plans in SHOP exchanges in more than half of states.").

⁸ Congressional Budget Office, Letter to the Hon. Nancy Pelosi, *An Estimate of the Direct Spending and Revenue Effects of H.R. 4872*, (March 20, 2020), <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf>.

⁹ Internal Revenue Service, *Small Business Health Care Tax Credits Filed in Tax Years 2010-2016*, <https://www.irs.gov/pub/irs-soi/17acasmallbusiness.xls>.

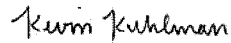
¹⁰ NFIB Member Ballot, vol. 575, "Should Congress create a federal, single-payer health insurance system?" (Yes: 13% No: 75% Undecided: 12%) (August 2019).

confirmed, single payer would be financially unsustainable for the federal government and lead to a costly tax system that small business owners cannot afford.¹¹

Rather than double down on the existing ACA structure or seeking to transition to a single payer system, Congress should continue to work towards innovative approaches to lower health costs to benefit small businesses and all Americans under the existing model of private health insurance. This should include work by this committee to level the playing field between large self-funded employers operating under the Employee Retirement Income Security Act (ERISA) and small businesses who face excessive ACA and state mandates. Congress should work to provide innovative payment solutions for small businesses, such as enhancing the ability of businesses to offer Health Reimbursement Arrangements that offer predictable costs and give employees the opportunity to choose the health insurance plan of their choice. Moreover, Congress should build upon the important work of increasing price transparency in medical services and insurance, while combatting provider consolidation and other cost drivers in the health insurance system.

In short, NFIB appreciates the committee's willingness to tackle affordability in today's hearing. We stand ready to assist Congress in the important task of helping to provide affordable coverage for small business owners and their employees.

Sincerely,



Kevin Kuhlman
Vice President, Federal Government Relations
NFIB

¹¹ See, e.g. Kenneth E Thorpe, *An Analysis of Senator Sanders Single Payer Plan* (Jan. 27, 2016), <https://www.healthcare-now.org/296831690-Kenneth-Thorpe-s-analysis-of-Bernie-Sanders-s-single-payer-proposal.pdf> (finding Senator Sanders' Medicare for All Plan would require up to a 14.3% payroll tax, as well as a 5.7% income-related premium a combined 20 percent tax on income).



U.S. Chamber of Commerce

1615 H Street, NW
Washington, DC 20062-2000
uschamber.com

February 17, 2022

TO THE MEMBERS OF THE U.S. HOUSE OF REPRESENTATIVES:

The U.S. Chamber of Commerce strongly opposes legislation that would create or lead to a national, single-payer, government-run healthcare system, including “Medicare for All” proposals and “Medicare Buy-In” proposals. These proposals would limit access, increase costs for employers and workers, and inhibit innovation.

Medicare for All would eliminate privately funded health plans, including the employer-sponsored coverage enjoyed by over 160 million Americans. Medicare Buy-In would erode the employer-sponsored system by disrupting insurance pools and increasing the level of cost-shifting onto private healthcare that already occurs under the existing Medicare system.

Both Medicare for All and Medicare Buy-In would limit access as providers struggle with the artificially low reimbursement rates under Medicare. It is worth noting that for this reason, the Affordable Care Act did not attempt to impose Medicare rates on insurance provided through the exchanges. Expansion of Medicare rates would also reduce resources available for medical innovation.

Rather than pursuing a government-run, single-payer healthcare system, policymakers should work to address the problems in our current system by taking the following steps:

- Help reduce costs for all Americans by moving towards a more value-based system that rewards outcomes and limits costs;
- Help Americans with out-of-pocket costs through expansion of Health Savings Accounts and Health Reimbursement Arrangements;
- Expand coverage options through mechanisms like Association Health Plans;
- Solidify the ACA’s exchanges through the use of risk corridors and funding cost-sharing reduction payments.

The Chamber looks forward to working with Congress on legislation that improves access to and reduces the cost of healthcare, and which preserves the employer-sponsored system.

Sincerely,

Neil L. Bradley
Executive Vice President, Chief Policy Officer, and
Head of Strategic Advocacy
U.S. Chamber of Commerce



The Unanswered Questions of Medicare for All

By Charles Blahous

February 2019

The single-payer health insurance proposal known widely as Medicare for All (M4A) cannot be enacted without first answering certain questions. Foremost among these is whether the public would support shifting more than \$32 trillion in M4A's first 10 years from private health spending, over which consumers retain some discretion, to federal health spending, over which consumers do not. A related open question is whether the federal government can adequately finance this amount of spending without triggering significant adverse economic effects. Other unanswered questions include M4A's effects on health providers, the prescription drug market, and private health insurance. M4A would add further to national health cost growth unless provider reimbursements are cut more sharply than lawmakers have been willing to do historically. Yet the consequences of enacting such payment cuts simultaneously with a substantial increase in health service demand are unpredictable.

The Medicare for All (M4A) cost estimate I published with the Mercatus Center last year (Blahous 2018) intensified an already vigorous national debate on whether to replace current US health insurance with a single-payer system. The study achieved its central informational goal, in that hardly an article about single-payer health care now appears without noting that such a system would cost at least \$32.6 trillion in new federal spending over its first 10 years (Alonso-Zaldivar 2018). Yet without my intending it, the study ended up revealing much more. Policy advocates' diverse reactions to the cost analysis illuminated a striking lack of national consensus on fundamental value judgments that must be made in the course of crafting future health care policy.

While rhetorical slogans such as "Medicare for All!" can be voiced without confronting any difficult trade-offs, legislating health care policy nevertheless

requires making such trade-offs. Americans approach these trade-offs differently, as the widely divergent reactions to the study make clear. To enact M4A, or indeed any other fundamental change to national health policy, legislators must find common ground on answers to certain critical policy questions.

Costs and Consequences

First and foremost among these considerations is the unavoidable issue of cost. The aim of my research was purposely narrow: not to opine on the merits or demerits of single-payer health care itself, but to estimate its effect on the federal budget. Apart from the many other important policy considerations in play, knowing this budget impact is essential because it largely determines Congress' legislative procedures. Any legislation

with such far-reaching fiscal consequences will require a Congressional Budget Office (CBO) cost estimate in order to be considered. Both skeptics and proponents of M4A need to know its federal budget effects, yet no up-to-date, official score existed.

My study calculated a lower bound for additional federal costs under M4A of \$32.6 trillion over the first 10 years, ranging up to \$38.8 trillion depending on assumptions about provider payment rates and drug prices. Importantly, these figures do not represent the total cost of M4A, merely its incremental addition to federal spending above current federal programs such as Medicare, Medicaid, the Affordable Care Act (ACA), and the tax preference for employer-provided health insurance. M4A's total costs over its first 10 years would be much higher, in the range of \$54.6–\$60.7 trillion. Dollar amounts so large are difficult to place in any familiar context. As my study noted, financing even the lower-bound cost estimate of \$32.6 trillion would require more additional federal revenues than could be collected by doubling all currently projected individual and corporate income taxes.

Cost is M4A's existential issue, because if federal lawmakers are not willing to impose M4A's cost on taxpayers, no other aspect of the framework will enable its enactment. Americans therefore face a fundamental threshold value judgment as to whether it is acceptable for the federal government to expand to the extent required to deliver M4A.

We simply have no instructive experience with permanent government expansions of that magnitude. M4A's additional federal costs start somewhere in the range of 10.7–12.3 percent of gross domestic product (GDP), rising within the first decade to 12.7–15.1 percent of GDP. For context, consider that the net deficit impact of the 2017 tax cuts, decried by many as fiscally irresponsible, amounted to less than 1 percent of GDP per year. In other words, the fiscal impact of M4A would be over 15 times that of the 2017 tax cuts. For comparison, Social Security, the largest existing federal program, will have taken more than 80 years to grow to 5 percent of GDP by 2020. Congress has simply never seriously considered enacting legislation with such transformative effects as M4A would have on the economy and the size of government.

The additional federal costs of enacting M4A, unlike the initial costs of establishing Social Security,

must be borne on top of the federal government's obligations to Social Security, Medicare, Medicaid, and its other preexisting spending commitments. The federal government currently lacks a viable plan to finance these obligations even before considering M4A's costs (CBO 2018). It remains an open question whether all who are favorably disposed to M4A in a conceptual sense would also favor expanding the federal government and increasing their tax burdens to the unprecedented levels required to bring M4A into existence.

One of the more interesting divides exposed by the study is a wide divergence in attitudes about the significance of replacing so much private health spending with federal spending. Some M4A advocates have suggested that the federal cost increase is not the pertinent metric, focusing instead on M4A's potential effects on total national—including current federal, state, and private—health spending (Scott 2018). Specifically, these advocates believe M4A to be a good policy choice if it achieves universal health coverage while containing national health spending, irrespective of the new federal cost obligations it would create.

Cost is M4A's existential issue, because if federal lawmakers are not willing to impose M4A's cost on taxpayers, no other aspect of the framework will enable its enactment.

M4A supporters are correct to observe that Americans already pay for the vast majority of health spending that would occur under M4A and that most of M4A's costs are therefore not “new” to the national economy. Specifically, my study projected that M4A would not qualitatively change total national health spending. Instead, national health spending under M4A would be somewhere within the range of 96–107 percent of current projections by 2031, depending on the specific assumptions. Yet this does not necessarily imply that it is trivial or benign to shift all or even most private health spending to federal spending. After all, Americans spend vast amounts of money on

many things, including health care, housing, food, and state and local government services. This does not suggest that it would be simple or uncontroversial for the federal government to assume responsibility for providing these various goods or services to every person in America.

Two of the most important facets of such a shift are its vast magnitude and the transfer of decision-making from individuals and businesses to the federal government. Depending on the specific assumptions, the initial additional federal obligations would be in the ballpark of \$10,000 annually per person. Even if M4A fully liberated Americans from all their current personal health care expenses, including all spending by employers and deducted from workers' wages, a family of four might still strongly object to having to send an additional \$40,000 to Washington each year on top of their current tax burdens. The sheer magnitude of this resource transfer and the difficulty of crafting an equitable means of allocating the costs might be a bridge too far for many Americans.

Then, too, the factors of personal choice and control cannot be summarily dismissed as irrelevancies. Many Americans are satisfied with employer-sponsored insurance and prefer to continue with it. Beyond that, not all Americans will want to yield their purchasing decisions involving health care, food, or any other deeply personal expenditure to the federal government—even if they are already spending that amount of money and the government promises to lower the total tab by a few percentage points. Instead, these Americans may place significant value on being able to choose whether and how to allocate those resources. Moreover, they might not trust the government to produce the promised cost savings or maintain the full range of existing purchasing choices, while worrying about potential consequences of the government's cost-containment methods.

In sum, we cannot assume that Americans generally regard federal spending as functionally equivalent and interchangeable with their own personal spending. We therefore cannot assume Americans will broadly support shouldering M4A's costs through their federal taxes, even if it relieves them of all the other ways they currently pay for health care.

How the federal government would finance this enormous cost expansion is an especially important variable. US health care is currently financed via a wide variety of methods, including premiums paid by individuals and their employers, individual payments out of pocket, and spending at various levels of government. If nearly all this spending is shifted to the federal ledger, the federal government would need to decide how to collect the revenue necessary to finance it. These decisions are central to the economic consequences and the political viability of a single-payer health care system.

Marc Goldwein has noted that “it would be almost impossible to raise \$32 trillion of taxes (or finance it with extra borrowing) and not create some negative GDP effects and deadweight loss.” Goldwein guesses that US economic losses could “easily exceed \$2 trillion over a decade” (Goldwein 2018)—in other words, more than the M4A's realistic potential to lower US health care costs. Economic losses of this magnitude under M4A seem virtually certain. Even given all the inefficiencies that currently exist in private health insurance, current premium payments create fewer deadweight losses than the possibilities on the table for financing M4A.

Not all Americans will want to yield their purchasing decisions involving health care, food, or any other deeply personal expenditure to the federal government.

Specifically, with M4A adding roughly \$10,000 per American in additional annual federal costs, the federal government is unlikely to find it politically feasible to require every American, rich or poor, young or old, to fully pay for their own per capita share of the federal cost increase. Legislators would more likely seek to finance M4A with assessments that are at least proportional to the payer's income and more likely via proportionally higher assessments on higher-income households. Indeed, the financing mechanisms suggested by M4A proponents—such as increased estate taxes, income taxes, and “wealth” taxes—would together still not be adequate to

finance its full costs, and they confirm that sponsors intend to rely on progressive taxes that would significantly reduce total US economic output (Sanders 2017).

In sum, national health spending under M4A is more likely to rise than to fall, but even if it falls slightly, deadweight loss would likely more than offset any potential savings, leaving Americans poorer on average. It is far from clear that Americans would be willing to pay the massive additional federal taxes required only to produce this problematic combination of outcomes.

How and What Would Providers Be Paid?

Another threshold question concerning M4A is how and what health care providers—including hospitals, physicians, nurses, and others—would be paid. The M4A bill introduced by Sen. Bernie Sanders (I-VT) specifies that providers would be paid at current-law Medicare reimbursement rates, which are substantially lower than those paid by private insurance (S. 1804, §611). The proposed cuts to providers now working through private insurance would be severe. According to data from the Centers for Medicare and Medicaid Services (CMS) actuary, payment cuts for these treatments would start at roughly 40 percent for hospitals, growing gradually larger over time. For physicians, the cuts for treating those currently with private insurance would be closer to 30 percent in the first year of full implementation, but per current-law Medicare payment schedules the cuts would quickly grow larger—to 42 percent within the first 10 years and becoming much more severe after that.

Before the Sanders bill was introduced, experts generally assumed that provider cuts of this magnitude could not and would not be imposed under M4A. A widely cited Urban Institute analysis preceding the bill's introduction noted that Medicare payment rates were well below hospitals' reported costs; therefore, assumed M4A hospital payment rates would be set higher than current Medicare rates to enable hospitals to break even and thereby continue operating (Holahan et al. 2016). An analysis by Emory University Professor Ken Thorpe also assumed higher M4A hospital payment rates (5 percent

higher than the Urban team's assumptions) (Thorpe 2016).

Three critical questions about M4A provider payment rates necessitate answers: *Would* provider cuts similar to those in the Sanders bill actually be implemented? *Should* they be implemented? And what would be the *consequences* if they were implemented? It is important to distinguish among these questions. An analytical conclusion that such cuts are unlikely to be implemented does not necessarily imply that they should not be. Similarly, a policy opinion that such cuts should occur does not equate to a projection that they actually will.

Would Proposed Provider Payment Cuts Be Implemented? Whether M4A would successfully implement provider payment reductions on the order of the Sanders bill is a critical question for several reasons, including the fundamental one of costs. Without such provider cuts, M4A's coverage expansion would drive national health spending higher than currently projected, undoing a foundational premise of the case for M4A (Blahous 2018). But there are strong reasons for skepticism that such cuts would actually take effect. One of them is Congress' legislative track record on provider cuts of comparable or lesser magnitude.

The cuts in the Sanders M4A bill would sharply reduce provider reimbursements for treatments now covered by private insurance, which represent a substantially greater (more than 50 percent larger) share of national health spending than does Medicare. Federal lawmakers have historically proved unwilling to uphold many smaller payment cuts affecting relatively fewer Medicare treatments. For example, lawmakers repeatedly overrode Medicare physician payment reductions specified under the previous statutory Sustainable Growth Rate (SGR) formula, overriding those cuts when they would have been just 4–5 percent, continuing when they had accumulated to more than 25 percent, and finally repealing the formula altogether (Hahn 2014, 6–7). For comparison, the provider cuts in the Sanders bill would start at about 30 percent for physicians and 40 percent for hospitals and would apply to the more numerous treatments now covered by private insurance. In other words, the provider cuts required to keep M4A from exacerbating our national health

cost problem are far steeper than statutory reductions that federal lawmakers persistently balked at implementing.

Even if lawmakers were willing to gradually lower private insurance provider payments by 40 percent cumulatively, they are still highly unlikely to do so all at once and thereby risk sudden disruptions in health service supply. In 2015, federal lawmakers replaced the SGR physician payment schedule with the Medicare Access and CHIP Reauthorization Act (MACRA) schedule, which also aims to constrain payment levels, but on a more delayed schedule. Furthermore, the ACA's current Medicare provider payment constraints are devised to produce substantial savings over the long run, but only gradually (accumulating 1.1 percent per year) (Boards of Trustees 2018, 6). As a general rule, whenever belt-tightening has been deemed too sudden, even its authors have been unwilling to implement it. Other examples include the various Obama administration waivers and postponements of the ACA's Medicare Advantage cuts and coverage mandate penalties (Blahous 2016).

Indeed, it remains an open question whether even the ACA's current and relatively gradual Medicare payment growth constraints will be sustained, irrespective of whether M4A is enacted. The CMS Office of the Actuary issues an annual memorandum questioning whether Medicare's physician payment schedule under MACRA, or the ACA's provider payment constraints, will be maintained in future decades (Shatto and Clemens 2018). CMS's alternative projection scenario assumes that the ACA's Medicare payment constraints will be phased out starting in 2028, based on the actuary's finding that to do otherwise would render most hospitals' finances untenable (Heffler et al. 2018). None of these highly uncertain aspects of current law are nearly as severe as the more dramatic provider payment reductions in proposed M4A legislation.

All these considerations feed into the question of whether M4A would deliver on its advocates' hopes for bringing national health spending growth under control. Unless lawmakers are willing to impose far more sudden and potentially disruptive provider payment reductions than they have historically been willing to implement, M4A's coverage expansion should be expected to further increase national health spending growth.

Should Proposed Provider Payment Cuts Be Implemented? The preceding evidence, however, tells us only that M4A is unlikely to dramatically reduce provider payments. It does not answer an equally important question: How *should* provider payment levels be set?

In a well-functioning market, policymakers are generally excused from making value judgments about how much a seller of services should be paid. Prices arise from the intersection of what consumers are willing to pay and what sellers are willing to accept for their services. The accepted role of government is not generally to impose a price structure, but to ensure that the market operates fairly and transparently.

Few seem willing to contend that our current patchwork system of paying for health care efficiently or transparently determines provider payment levels. There is widespread belief that various health goods and services cost more than they should and more than they would cost in a well-functioning market. A study by Jeffrey Clemens and Joshua Gottlieb found that, whenever Medicare overpays for health services, the effects spread throughout the health market by fueling even larger price increases in private insurance (Clemens and Gottlieb 2013; Whoriskey and Keating 2013). Anecdotal horror stories abound, for example, of hospitals charging upward of \$25 for a single aspirin (Alkire 2012).

Analysts and advocates, however, derive different conclusions from current US health care market dysfunction. Some experts point to government's role in distorting the health market, fueling excess cost growth by subsidizing millions of Americans' health insurance and with the federal tax preference for employer-provided health benefits over other forms of worker compensation (Finkelstein 2005). From this vantage point, solutions lie in the direction of corralling these drivers of excess cost growth. Single-payer represents a diametrically opposed approach: harnessing the full power of government to control health costs and prices, irrespective of where a well-functioning market might set them.

Both market advocates and single-payer advocates might agree that health care services are overpriced, even as they disagree on the causes of and solutions to the problem. But of these opposing perspectives, only the single-payer approach forces lawmakers to

make normative judgments on how to set provider payment rates.

Unfortunately, data offer only a murky picture of what optimal provider payment rates would be in a single-payer system. The American Hospital Association reports that Medicare reimburses hospitals at only 87 percent of costs, whereas private insurance reimburses at 145 percent of costs (AHA 2018, Chart 4.4). Taken at face value, this would mean that hospitals currently take Medicare patients despite losing money when treating them and then make up the loss (and then some) by private insurance reimbursing at far more than hospitals' costs.

One interpretation of the data is that hospitals manage their finances based on their overall case mix, which would mean that those with private insurance are subsidizing hospital services for those on Medicare and Medicaid. An alternative interpretation is that hospitals would not take Medicare (or Medicaid) patients if they truly experienced losses whenever they did, thus hospitals' reported costs must be somewhat overstated relative to their true ones. Yet another theory is that hospitals' current excess capacity allows them to make beds available to Medicare and Medicaid patients at below-cost rates. These and other alternative interpretations lead to different conclusions as to how much a single-payer system could reduce provider payments without substantially reducing the quality or timeliness of health care services.

Providers' administrative costs are a particular analytical sticking point: Specifically, how much administrative cost savings potential could a single-payer system offer? Many single-payer advocates cite private insurance profit and administrative overhead as drivers of unnecessarily high health spending (Irwin 2017). But multiple studies, including mine (Blahous 2018) as well as an Urban Institute study (Holahan et al. 2016), found that the potential savings on insurance administration under M4A are not nearly as large as the health spending increases it would induce. In implicit recognition of these realities, some single-payer advocates shift their emphasis to the potential for savings in providers' own administrative costs, beyond savings in the actual costs of insurance.

Some single-payer advocates believe M4A would eliminate the need for much of providers' current administrative expenses, thereby allowing the dramatic reductions in provider payment required to decelerate national health spending under M4A. Hospitals themselves appear to disagree (Leonard 2018). "Many hospitals wouldn't be able to keep their doors open," the president of the Federation of American Hospitals has stated (McCaughey 2019). While hospital associations should naturally be expected to lobby for higher payment rates, they should also be expected to lobby for lower administrative costs and a net improvement in their own financial position. The hospitals' opposition to M4A's provider cuts does not necessarily mean that payments should not be cut, but it is a telling indicator that hospitals are skeptical that their own administrative savings under M4A would offset their revenue losses from lower reimbursements.

What Would Be the Consequences? The biggest unanswered question about provider payment rates—more unpredictable than whether provider payment cuts proposed under M4A would or should be implemented—is what would be the consequences of implementing the cuts. Demand for health services would rise substantially under M4A, not only because of covering the currently uninsured, but also because the currently insured would attempt to consume more services as M4A provides more generous coverage. A substantial body of economics literature demonstrates that the higher the percentage of one's health purchases that are paid by insurance, the more services (both effective and ineffective) one tends to consume. My study estimated that total national demand for health services would rise by roughly 11 percent under M4A (Blahous 2018).

It is unclear whether the supply of US health services would expand under M4A, let alone expand sufficiently to meet this additional demand without causing disruptions to timely access to health care. It is even less clear that supply could fulfill the increased demand if the suppliers of health services are simultaneously subject to substantial reimbursement reductions. While part of that demand increase would be the result of a positive change—that is, giving the previously uninsured greater access to health services—some of the supply crunch would

arise from M4A's more generous coverage incenting additional unnecessary and ineffective care.

Experts have published general warnings that M4A would trigger health access disruptions, but we lack reliable projections of their extent. The CMS actuary projects that this year over 80 percent of hospitals will lose money treating Medicare patients, suggesting that many hospitals will go into the red if payments now made through commercial insurance are reduced to Medicare rates (Heffler 2018). The Urban Institute projects that under single payer "not all increased demand could be met because provider capacity would be insufficient," despite assuming higher provider payment rates than in the Sanders bill (Holahan et al. 2016). The extent of these health care access disruptions and how policymakers would respond are among the largest unanswered questions about M4A. The only near certainty is that the combination of a substantial increase in demand and a sharp diminution in suppliers' reimbursements would cause some such disruptions.

Finally, the provider efficiency gains required to prevent M4A from adding still more financial strain to our nation's health care system, for whatever reason, have not been achieved to date. While some may believe that only a single-payer system can deliver these productivity improvements, this is far from certain. In this respect, the adoption of a single-payer system is essentially a multitrillion-dollar bet on a long-shot outcome.

Effects on Other Health Markets

The list of unanswered questions about single-payer health care is long and includes questions about how it might affect drug prices, as well as other effects of eliminating (or dramatically reducing the role of) private health insurance.

The Sanders M4A bill would instruct the secretary of Health and Human Services to directly negotiate drug prices, specifically to promote the use of generic drugs where possible, while granting the secretary flexibility to establish copayment formulas pursuant to maximizing generic penetration. Although an objective of these provisions is to reduce drug prices, it is unclear how they would be applied in practice. It should not necessarily be assumed that the federal government would

prioritize cost-containment more than private insurance does, relative to maximizing the availability of prescription drugs to constituent beneficiaries. While government would wield enormous negotiating power under a single-payer system, no one can say with certainty that government would deploy that power on behalf of taxpayers more than on behalf of health care consumers. To the extent that M4A follows the historical political dynamics of Medicare, the political power of participants as beneficiaries may outweigh their political power as taxpayers, pushing costs higher rather than lower.

The adoption of a single-payer system is essentially a multitrillion-dollar bet on a long-shot outcome.

Further complicating the picture, the US has by far the biggest and most powerful drug industry of any nation in the world, with the result that lower drug prices do not represent the unalloyed financial gain for the US that they might for other nations lacking a comparable pharmaceutical industry. It is widely noted that the US has higher drug prices than other nations (Sarnak 2017). It is less often noted that other nations with large pharmaceutical industries (such as Switzerland) spend more per capita on drugs than the levels single-payer advocates believe can be achieved through M4A. While my study (Blahous 2018) showed potential for substantial savings in drug costs if M4A succeeds in replacing most brand-name drugs with their generic equivalents, it is highly doubtful that a single-payer system could knock one-third off the prices of US drugs as advocates have projected without impairing the pace of pharmaceutical innovation or undercutting the viability of much of the existing US pharmaceutical industry (Friedman 2013, 3).

Policymakers would also need to determine whether private health insurance would continue to have a role under single payer and, if so, what it would be. In particular, they would need to decide whether private insurance would be allowed to finance health services beyond those covered by the single-payer system or to provide expedited

access to the same services. The Sanders bill does not envision a significant continuing role for private health insurance, as it expressly prohibits private insurance from offering the same benefits as the single-payer system, in addition to offering a single-payer system so expansive that it would render supplemental coverage largely superfluous (S. 1804).

The effective demise of private health insurance upon the enactment of a single-payer system is riddled with sensitive political pressure points. Political advertising during the 2018 congressional campaigns highlighted patients' fears about eliminating employer-provided insurance in favor of single-payer health care (NRCC 2018). The Sanders bill would create a fund to assist workers in the health insurance industry displaced by the shift to single payer. On a national level, welfare gains by those who receive enhanced health insurance would be somewhat offset by the economic losses associated with effectively eliminating the private health insurance business. This by itself does not

argue for or against a single-payer health system, but demonstrates that some Americans' economic losses would need to be balanced against others' gains.

In sum, much about the consequences of single-payer health care remains unknown, either because it is difficult to project or because legislators have yet to confront and resolve important policy trade-offs. Among the things we do not know are whether the federal government can absorb the costs of M4A, how these costs would be financed, how steeply providers' payments would be cut, whether health spending growth would slow or accelerate, whether US health care supply would be sufficient to meet demand, and whether the US pharmaceutical and health insurance industries would survive the transition. All these questions and more need to be answered before serious consideration can be given to pursuing the rhetorical vision of Medicare for All.

About the Author

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Preview Of The Coming Medicare For All Debate

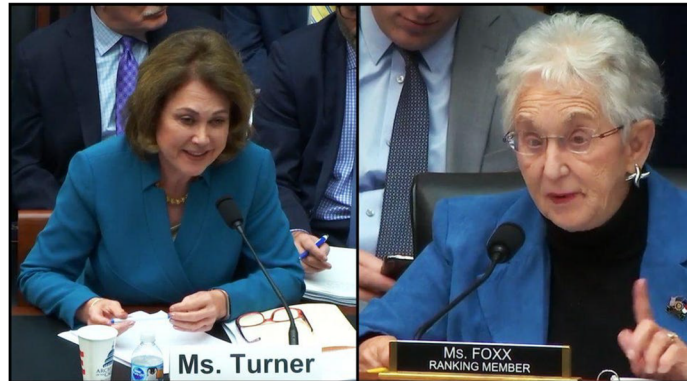
**Grace-Marie Turner** Contributor

Policy

Focusing on free-market ideas for health reform

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Grace-Marie Turner testifies before congressional committee | PHOTO: HOUSE COMMITTEE ON EDUCATION AND LABOR

The pre-existing condition scare tactics continue.

I testified yesterday—as the sole witness called by the Republican minority—during a House Education and Labor Committee hearing on “Examining

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ask questions. (The hearing lasted for three and a half hours!)

I continually stressed the guarantees that already exist to protect people with pre-existing conditions, and members on the Republican side underscored their commitment to making sure these protections remain.

Ranking Member Virginia Foxx, R-NC, said in her [opening statement](#), “Americans with pre-existing conditions need health insurance. This is a fact and a value that Congress and the President have affirmed countless times.

“It’s also the law,” she affirmed.

“Insurance companies are prohibited from denying or not renewing health coverage due to a pre-existing condition. Insurance companies are banned from rescinding coverage based on a pre-existing condition. Insurance companies are banned from excluding benefits based on a pre-existing condition. Insurance companies are prevented from raising premiums on individuals with pre-existing conditions who maintain continuous coverage.” She cited existing protections under the [Health Insurance Portability and Accountability Act](#) (HIPAA) and Republican support for additional protections in the House-passed [American Health Care Act of 2017](#).

The Democrats focused on the district court decision in Texas v Azar that struck down the individual mandate and with it, the Affordable Care Act, including the law’s guarantee of pre-existing condition protections. The decision has been appealed and could wind up before the U.S. Supreme Court by next year.

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Chairman Scott [said](#) consumers would lose not only these protections but also would face annual and life-time limits on coverage and lose cost-sharing subsidies and guaranteed preventive services. He and others continually criticized short-term limited duration plans and association health plans, two new consumer-friendly options allowed under Trump administration regulatory authority.

The hearing was a preview of the coming debate over Medicare for All, including the belief of many members that neither the private sector nor the states can be trusted to provide protections. Member after member on the Democratic side implied that if *Texas v Azar* were upheld, people throughout the health sector could lose their coverage if they have pre-existing (i.e., chronic) health conditions.

First, that is not the case, and second, the commitment in Congress to provide continued protections, whatever the outcome, is unquestioned.

In my testimony, I highlighted:

- the central role that employer-sponsored health insurance plays in

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- bipartisan support for pre-existing condition protections and the need for further improvements

Here are the links to:

[Webcast of my five-minute testimony](#)

[The Full Webcast of the hearing](#)

[My written testimony](#)

I relied heavily on Doug Badger's [latest paper](#) on employer-sponsored health insurance (ESI) where he describes the central role that ESI plays in underpinning the larger health sector.

Here are some points I highlighted:

The Value of ESI: Nine out of 10 workers are employed in the U.S. by companies that offer health insurance, a system that provides coverage for nearly 173 million people. These benefits are tax free both to workers and companies—a generous benefit but one that leverages nearly \$3 in spending by private companies for every \$1 in federal revenue losses.

Employers and employees want the best value for their health care dollars—balancing both quality and cost. Long before the ACA mandates, employers offered preventive services because they know that addressing health issues before they become a crisis leads to better outcomes and minimizes costs.

ESI Supports Public Programs: These employers also play a vital role in supporting the overall health sector. Physicians and hospitals are paid

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Leading proposals to expand Medicare coverage to all Americans would extend these public reimbursement rates universally, diminishing quality and access to care.

New Options: The Trump administration is offering several options through its regulatory authority to help individuals and employees with more affordable coverage:

- Association Health Plans, for example, allow small firms to group together to buy coverage with the economies of scale of larger companies. *The Washington Post* reports a new study shows that AHP benefits are comparable to most workplace plans, and plans aren't discriminating against patients with preexisting conditions.
- States also have new flexibility under Section 1332 of the ACA to lower costs and increase access to coverage. Several states have received waivers to create risk-mitigation programs.
 - They separately subsidize patients with the highest health costs, which leads to lower premiums and increased enrollment.
 - In Alaska, premiums for the lowest-cost Bronze plan fell by 39 percent in 2018.
 - Maryland is seeing an even larger cost drop this year.

Putting the sickest people in the same pool with others means premiums are higher, often much higher, especially for those without subsidies. Virginia State Sen. Bryce Reeves told us of an email from a constituent in Fredericksburg: He made a good living and tried to provide for his family but said his insurance premiums cost \$4,000 a month! "That's

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Protection for the vulnerable. There is strong bi-partisan support to maintain pre-existing condition protections. The ACA assures that people cannot be turned down or have their policies cancelled because of their health status, and these protections are still in place. The American Health Care Act, passed by the House of Representatives in 2017, maintained pre-existing condition protections as did legislation that was considered in the Senate.

Need for reform: People with chronic health conditions are vulnerable and need protection. But a woman with serious health problems provided us with a testimonial about why changes are needed.

Janet reports that in 1999, she was diagnosed with Hepatitis C. She lives in Colorado and applied for coverage in the state's high risk pool and was accepted.

Her premiums in 2010 were \$275 a month. Then her liver failed, and she needed a transplant. The \$600,000 bill was covered 100% with a \$2,500 out of pocket maximum, she told us.

Colorado's high-risk pool was closed when the ACA took effect, so she moved into the marketplace. Her premiums rose to \$450. By 2018, they were \$1,100 a month with a deductible of \$6,300. But her anti-rejection meds weren't covered.

She said, "almost everything I needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the care I needed.

"Those of us who are self employed but make more than the threshold for tax credits wind up footing the whole bill ourselves," she said. "I have to spend \$19,500 before my insurance pays anything, and it still doesn't cover

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Preview Of The Coming Medicare For All Debate

Democrats and Republicans are committed to the goals of better access to more affordable coverage and better protection for those with pre-existing conditions. It was all-in-all a civilized hearing, but we must first start with a commitment to maintain consumers protections and work together to solve the problems of access to care and costs of coverage.

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Grace-Marie Turner is president of the Galen Institute, a nonprofit research organization she founded to promote an informed debate over... [Read More](#)

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Mercatus Working Paper

The Costs of a National Single-Payer Healthcare System

July 30, 2018

Authors: Charles Blahous

The leading current Senate bill to establish single-payer health insurance in the United States is that of Senator Bernie Sanders (I-VT). It's called the Medicare for All Act, or M4A. The desirability and practicality of this kind of healthcare system will depend in large measure on cost—on what American taxpayers would have to pay for it.

Charles Blahous puts a price on Sanders's proposed legislation in "The Costs of a National Single-Payer Healthcare System." These are his key findings.

M4A Would Place Unprecedented Strain on the Federal Budget

By conservative estimates, this legislation would have the following effects:

M4A would add approximately \$32.6 trillion to federal budget commitments during the first 10 years of its implementation (2022–2031).

This projected increase in federal healthcare commitments would equal approximately 10.7 percent of GDP in 2022. This amount would rise to nearly 12.7 percent of GDP in 2031 and continue to rise thereafter.

These estimates are conservative because they assume the legislation achieves its sponsors' goals of dramatically reducing payments to health providers, in addition to substantially reducing drug prices and administrative costs.

A doubling of all currently projected federal individual and corporate income tax collections would be insufficient to finance the added federal costs of the plan.

M4A's Dramatic Federal Cost Increase Arises from Several Factors

First and foremost, the federal government would become responsible for financing nearly all current national health spending, including individual private insurance and state spending.

M4A would increase federal health spending on the currently uninsured as well as those who now carry insurance by providing first-dollar coverage of their healthcare expenditures across the board, without deductibles or copayments.

M4A would expand the range of services covered by federal insurance (for example, dental, vision, and hearing benefits).

M4A would dramatically expand the demand for healthcare services, consistent with economics research findings that the more of an individual's health costs are covered by insurance, the more services they tend to buy, irrespective of the services' efficacy and value.

We Do Not Know How Much M4A Would Disrupt the Availability and Quality of Health Services

M4A would markedly increase the demand for healthcare services while simultaneously cutting payments to providers by more than 40 percent relative to private insurance rates, reducing payments to levels that are lower on average than providers' current costs of providing care. It cannot be known how much providers will react to these losses by reducing the availability of existing health services, the quality of such services, or both.

Note: this summary has been updated to clarify that the projected 40% reduction in provider payments is relative to private insurance rates.

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ISSUE BRIEF

National Taxpayers Union Foundation

Medicare for All: Buyer Beware

Issue Brief #181
September 12, 2018
By Demian Brady

Introduction

There is wide agreement that health care costs are too high in the United States. The policy debate revolves around how these costs can best be controlled. One plan recently has garnered a lot of media coverage: a so-called “Medicare for All” (M4A) program, proposed in Congress by Senator Bernie Sanders (I-VT). A poll released at the end of August by Kaiser Family Foundation [found](#) that about six in ten adults would favor Sanders’ idea.

However, there are substantial costs for the program that will require the government to raise a lot of new revenue to pay for it. And while the backers of the plan insist that the new taxes to finance national health care will fall on the wealthy, make no mistake, the costs are so enormous that taxpayers at all income levels will be forced to pay more. Medicare for All would be an unprecedented expansion of outlays, taxes, and government power.

The Cost of Medicare for All

Think tanks across the political spectrum have produced cost estimates for Senator Sanders’ Medicare for All proposal. Though they each include different assumptions, the analyses are all in agreement that the plan will add trillions to the federal budget.

If implemented, a \$30 trillion Medicare for All plan would cost more than twice as much as projected defense spending for the next decade.

Sanders himself has admitted that the plan will be costly, [disclosing](#) during the 2016 campaign that M4A “has been estimated to cost \$1.38 trillion per year.” This estimate was based on an analysis by Gerald Friedman, an economics professor at the University of Massachusetts at Amherst.

More recently, Charles Blahous of the Mercatus Center at George Mason University released an analysis of Sanders’ plan and estimated that it would cost [\\$32.6 trillion](#) over ten years – over

twice as much per year as Sanders' estimate. The left-leaning Urban Institute [completed](#) its own analysis of M4A in 2016 and its numbers were in line with Mercatus's. Urban Institute's scholars projected that the plan would cost \$2.5 trillion in the first year and \$32 trillion over a decade. In case there are any lingering doubt regarding the astronomical costs of M4A, other organizations and scholars have also produced similar estimates:

- The Committee for a Responsible Federal Budget: [\\$2.8 trillion](#) per year.
- Kenneth Thorpe of Rollins School of Public Health of Emory University: [\\$2.4 trillion](#) per year.
- The Center for Health and Economy (CHE): between [\\$3.5 trillion and \\$4.8 trillion](#) per year.

The reports may have some differences in methodology, but there is no doubt that enacting this program would result in a monumental expansion of the size and scope of the federal government. Taking the average of the independent estimates (with CHE's low-range cost), Medicare for All would add just over \$3 trillion in new annual spending.

Budgetary Context of \$3 Trillion in Higher Spending

The Congressional Budget Office (CBO) [projects](#) that the federal government will spend \$4.5 trillion in FY 2019 and \$56.6 trillion over the next ten years. Medicare for All would become by far the largest single federal program. The cost of Sanders' plan would be enormous, dwarfing the costs of the Affordable Care Act:

- If fully-implemented in FY 2019, outlays would see a 70 percent hike, boosting outlays as share of GDP from 21 percent to 35 percent. Only during the height of World War II, between 1943 and 1945, has spending ever [exceeded 24.4 percent](#) of GDP, much less 35 percent.
- \$3 trillion would exceed the FY 2019 projected outlays for Medicare, Social Security, Medicaid, and all other mandatory entitlement programs combined (\$2.7 trillion).
- This would be tantamount to adding 16 Departments of Veterans Affairs to the budget (FY 2018 outlays of [\\$176.8 billion](#)).
- Adding \$30 trillion in new spending would expand the ten-year budget by over 50 percent.
- If implemented, a \$30 trillion Medicare for All plan would cost more than twice as much as projected defense spending for the next decade (\$14.4 trillion).
- Adding \$30 trillion in mandatory spending would nearly double currently-projected mandatory spending over the next decade of \$35 trillion.
- A single year of the program exceeds the [combined cost](#) since 2000 for the Departments of Commerce, Education, Energy, Interior, and Justice (\$2.6 trillion).
- The ten-year cost would exceed total combined outlays since 1962 for Medicare, Medicaid, and the Children's Health Insurance Program ([\\$21.8 trillion](#), in constant FY 2009 dollars).

There is good reason to believe that the actual figures, if the massive new entitlement program were ever enacted, would be on the higher end of the range of cost estimates. In fact, one need

look no further than the existing Medicare program to identify the potential for runaway cost escalation. After all, if “Medicare for some” is on track to break the federal bank absent significant reforms, it’s fair to expect that “Medicare for all” will suffer from the same flaw on an even larger scale.

Paying for Medicare for All

Sanders’ latest legislative version (introduced in the Senate as [S. 1804](#)) of M4A does not include any details on financing his program, but his 2016 campaign platform laid out a [list of taxes](#) to finance the massive new program (the figures below in parenthesis are estimates from Sanders’ 2016 campaign):

- A new 6.2 percent payroll tax on employers (\$630 billion per year).
- A new 2.2 percent income-based premium paid by households (\$210 billion per year)
- A massive hike in income tax rates, including the following new brackets (\$110 billion per year):
 - 37 percent on income between \$250,000 and \$500,000.
 - 43 percent on income between \$500,000 and \$2 million.
 - 48 percent on income between \$2 million and \$10 million.
 - 52 percent on income above \$10 million.
- Higher rates on capital gains (\$92 billion per year).
- An enormous increase in the death tax (\$21 billion per year).
- A new limit on deductions for individuals earning over \$250,000. (\$15 billion per year).
- An elimination of tax breaks for employer-provided health insurance (\$310 billion).

In total, the taxes that Sanders proposed in 2016 to finance Medicare for All would impose a \$1.3 trillion annual burden. The taxes would roll back the relief provided Tax Cuts and Jobs Act that has already contributed to an expanding economy. And even before considering the dynamic impact of enacting such massive levels of taxation, the revenues

would fall short of covering the full cost of providing universal coverage through Medicare. To be fully-financed, upwards of \$3 trillion in tax increases would be needed.

Taxes needed to pay for Medicare for All would spike U.S. tax receipts from one of the lowest in the OECD to one of the highest – surpassing the burdens in Germany, Canada, Spain, and the United Kingdom.

Budgetary Context of \$3 Trillion in Higher Taxes

- A \$3 trillion tax hike would nearly double total federal revenues projected by CBO for FY 2019 (\$3.5 trillion).
- CBO’s baseline forecasts that revenues will comprise 16.5 percent of GDP in FY 2019. Hiking taxes to pay for the full annual cost of Medicare for All would boost revenues to over 30 percent of GDP. By contrast, since World War II, revenues as a share of GDP has

exceeded 20 percent only [twice](#), in 1944 and 2000. Revenue has never topped 20.5 percent of GDP.

- According to the most recent data compiled by the Organization of Economic Cooperation and Development (OECD), the United States' total federal, state and local tax receipts comprised 26 percent of GDP, below the OECD [average](#) (34.3 percent). Adding the new Medicare for All taxes would spike U.S. tax receipts to 40 percent of GDP, bumping the U.S.'s ranking from 31st to 9th highest among OECD nations, surpassing the tax burdens suffered in Germany, Canada, Spain, and the United Kingdom.
- This would pile on \$30 trillion in higher taxes over the next decade – two-thirds higher than CBO's [revenue baseline](#).
- As Brian Riedl of the Manhattan Institute [notes](#), repealing the 2017 tax cuts would cover just \$1.8 trillion of the cost for M4A. Fully-financing the program would require piling on “a new 31 percent payroll tax on top of the current 15.3 percent tax; imposing a 72 percent value-added tax (like a national sales tax); or raising income-tax rates by 35 percentage points across the board.”

The dynamic impact would also have to be considered. Sanders' estimates presume optimistic forecasts of the revenue that would be raised from M4A's tax hikes. In reality, the burdensome tax hikes would lead to lower growth, wages, and ultimately, fewer tax receipts. Higher rates to compensate for the “lost” revenues would only exacerbate the fiscal gap, sending the deficit and economy into a downward spiral. Furthermore, any attempts to broaden the price controls inherent in single-payer schemes would drive many top-quality doctors out of the system. Medicare's Trustees have already [warned](#) about the likelihood of this happening in the current system - piling on the kinds of price controls for Medicare For All would exacerbate the situation.

Conclusion

Supporters claim that a single-payer system would on paper lead to efficiencies that would save money. The reality under a single-payer system is that politicians and unelected bureaucrats would establish damaging price controls, leading to longer wait times and fewer treatment options. In recent years, the prohibitive costs have led to the demise of single-payer plans in several states.

The public is being sold a bill of goods through Medicare for All, but *caveat emptor*: be sure to read the fine print for the costs, and consider the ramifications on the federal budget, tax burdens, and the expansion of the government's regulatory power. A better remedy to ensure affordable health care would be to find ways to increase market forces that foster competition and stimulate innovation.

About the Author

Demian Brady is the Director of Research for the National Taxpayers Union Foundation.



February 15, 2022
For Immediate Release
Contact: [Tara Bradshaw](#)

Message to Congress: Fix Health Care Costs

New poll highlights reducing health care costs is top priority among Americans

The **Alliance to Fight for Health Care**, a broad-based coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups, and other stakeholders that support employer-provided health coverage, today released a Morning Consult National Tracking Poll on health care coverage issues.

"We appreciate all of the actions Congress has taken to help make health care more affordable for Americans during the COVID-19 pandemic," said **James A. Klein**, president of the **American Benefits Council**. "As this public health emergency lingers on, voters' message to Congress is clear: *address high health care costs*. With prices soaring everywhere, we urge Congress to take up bipartisan, common-sense measures to drive down health care costs."

The Morning Consult National Tracking Poll sponsored by the Alliance and conducted between January 14-16, 2022, finds insured Americans are satisfied with their employer-provided coverage but are concerned about high costs. The poll finds:

1. **Insured adults who have employer-provided health care coverage are more likely to rate their care positively than those with Marketplace coverage.** Those with employer-provided health coverage rate their care 19% more positively than those with coverage through the marketplace. Moreover, those with employer coverage are also 31% more likely to rate their care more positively in comparison to the health care system overall. Furthermore, a majority of those who receive their care through the marketplace report they would be likely to switch to an employer-provided plan if they had the opportunity.
2. **Most insured adults are concerned with the cost of health care, prescription drugs, and the ability to pay for a major health event.** To this end, when asked what should be made the single most important priority when it comes to health care reform, a majority of insured adults agreed that it should be reducing health care costs.
3. **Insured adults believe that the U.S. health care system is struggling with respect to matters of cost.** Insured adults find the U.S. health care system inspires *innovation*, *provides a choice in care*, and *offers high quality treatment* but finds that it is underperforming areas such as *affordability and transparency*.
4. **Nearly two-thirds of insured adults feel the U.S. should take "modest" action to fix and improve the health care system rather than large scale changes.** A majority of Democrats, independents, and Republicans all agree that the U.S. should take "modest" action.



5. **Three quarters of insured adults support affordable telehealth.** A majority of Democrats, independents, and Republicans all agree that Congress should extend a law that provides flexibility for employers to offer telehealth visits to employees without having to pay their deductible. In addition, more than half of insured adults would seek virtual/online mental health care if it were free.
6. **Same service—same price:** 72% of insured adults feel the price of health care services should be the same no matter where it is received and 89% of insured adults, across key demographics, feel it is important for regulators to address how patients are charged when receiving a prescription through a hospital clinic rather than a doctor's office.

[Link](#) to **polling deck**

[Link](#) to The **Alliance to Fight for Health Care's** policy priorities that will help reduce premiums and help consumers afford care.

The **Alliance to Fight for Health Care** is a broad-based coalition comprised of businesses, patient advocates, employer organizations, unions, health care companies, consumer groups and other stakeholders that support employer-provided health coverage. Together, we are working to ensure that employer-provided coverage remains an available and affordable option for working Americans and their families. The coalition, previously working as the **Alliance to Fight the 40**, led the successful effort to repeal the so-called 40% "Cadillac Tax" on health care coverage.

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MEMORANDUM

TO: INTERESTED PARTIES
 FROM: GLEN BOLGER & JARRETT LEWIS, PUBLIC OPINION STRATEGIES
 CC: AMERICANS FOR PROSPERITY
 DATE: FEBRUARY 4, 2022
 SUBJECT: KEY FINDINGS – HEALTH CARE NATIONAL SURVEY

METHODOLOGY

On behalf of Americans for Prosperity, Public Opinion Strategies conducted a national online survey of 1,000 Registered Voters, January 20-24, 2022. Results from the survey have a credibility interval of ± 3.53 percentage points.

KEY FINDINGS

1. **Voters are divided about the current structure of the U.S. health care system, but a majority believe we should strengthen free market competition rather than increase government control and subsidies.**
 A slim majority (52%) of voters believe the U.S. health care system is built mostly on government mandates and control, while 48% say the U.S. health care system is built on free market competition. However, when it comes to making changes to the system, a strong majority of voters support a free-market approach. Six-in-ten voters agree that changes to the health care system should *strengthen* free market competition instead of increasing government control and subsidies (40%), including majorities of Independents (68%), seniors (66%) and suburban voters (65%).
2. **Voters believe the U.S. health care system is expensive, convoluted, opaque, and unpredictable.**
 Cost continues to be the main concern for voters when it comes to health care. More than nine-in-ten (93%) agree the cost of health care is too high, with 64% strongly agreeing. When asked what kind of health care costs concerned them most, a strong majority (61%) selected out-of-pocket costs not covered by insurance. Further, fully 40% of voters say either they or someone in their household have delayed medical care in the last two years because of cost.

 Beyond cost, there is a real belief the health care system is too complex and confusing. Majorities of voters agree that the health care system is filled with too much bureaucracy and paperwork (89% agree), it is far too difficult to know the cost of medical care ahead of time (89% agree), and that there are too many surprise medical bills in the health care system (85% agree).
3. **More than three-quarters of voters believe the U.S. health care system is in a state of crisis or has major problems, and voters overwhelmingly want candidates to have specific plans to address health care costs.**
 - ✓ When asked to best describe the state of the U.S. health care system, fully 23% say it is in a state of crisis, while 55% say it has major problems.
 - ✓ Some 91% of Americans want candidates to have a plan to lower health care costs.
4. **However, voters reject more government as the solution to improve the health care system.**
 - ✓ Two thirds of voters say there should either be less government control of our health care system (41%) or that the current level of government control is about right (25%) – just 34% say they want more government control of our health care system.

- ✓ By 65-35%, Americans believe that “giving Americans more choice and control over their own health care” is a better way to reduce health care costs than “increasing the government’s role in regulating and subsidizing health care.”

5. Personalizing health care resonates with voters, especially when contrasted against a government led solution.

More than six-in-ten (62%) voters believe the best way to reduce health care costs is to lift government restrictions that prevent Americans from choosing the health care options that are right for them, compared to 38% who believe the best way, to reduce costs are to end private coverage and replace it with a single government-run system.

Further, more than two-thirds of voters agree (68%) that health care is personal, and people should be able to choose the coverage that is right for them compared to 32% who believe health care is a public responsibility and every American should be enrolled in the same government plan.

6. Voters continue to support the personal option over Medical for All and the Public Option.

Survey respondents were shown the following proposals and asked to choose between the personal option and Medicare for All and between the personal option and the Public Option:

“A ‘personal option’ plan in which the government allows for more choices, like tax-free Health Savings Accounts and short-term renewable plans, that let people select affordable options that are right for them, without adding new taxes.”

“A ‘Public Option’ plan in which the government offers all Americans the option to purchase a public health insurance plan like Medicare, with subsidies for low-income Americans.”

“A ‘Medicare for All’ plan that would end private health insurance coverage and move every American into a government-run health insurance plan.”

Voters support the personal option over the Public Option by 59%-41% and support the personal option over Medicare for All by a 64%-36% margin.

- ✓ % Supporting personal option Over Public Option: Majorities of Republicans (75%), suburban voters (73%), women (63%), Independents (59%) and moderates (57%).
- ✓ % Supporting personal option Over Medicare For All: Majorities of Republicans (82%), suburban voters (67%), Independents (66%), women (65%) and moderates (65%).

7. When it comes to specific improvements for the U.S. health care system, voters support reforming the Food & Drug Administration (FDA), expanding the availability of Direct Primary Care and Health Savings Accounts, and expanding access to telehealth.

- ✓ A majority of voters (69%) believe the FDA needs to be reformed, including Independents (72%), women (70%) and Republicans (69%).
- ✓ After reading a brief description of Direct Primary Care (DPC) arrangements, fully 71% of voters support DPCs, and 71% support legislation to expand the availability of DPC arrangements.
- ✓ Nearly 90% of voters support Health Savings Accounts (HSA), and the same amount support legislation that would allow any American to open an HSA.
- ✓ Expanding access to telehealth services is extremely popular. Fully 85% of voters back the option of having “virtual” doctor’s appointments or health assessments rather than going to a doctor’s office.

BOTTOM LINE

Voters believe the U.S. health care system has problems. They believe it is too expensive, convoluted and opaque, and more than three-quarters believe it is in a state of crisis or has deep problems. Yet despite all the health care system's warts, voters reject more government authority and control over the sector as a solution. A majority believe more competition and personalizing the system are the right ways to improve it.

Voters continue to support the personal option. They support the personal option over the Public Option by 18 points and they support the personal option over Medicare for All by 28 points. Voters react very favorably to multiple components of the personal option, including increasing the availability of Direct Primary Care, Health Savings Accounts, and Telehealth. But while the components of the personal option are popular, the key ingredient of the plan is the personalization and control – which voters *strongly* support when it comes to their health care.



APRIL 23, 2019

Public Opinion on Health Care Policy

Elizabeth Fender and Marie Fishpaw

Health care remains a top priority for Americans (69 percent of U.S. voters),¹ who are concerned about cost, access² and choice.³

Many current health care proposals shift control and decision-making to the government—and do not provide what Americans want.

- A majority of Americans oppose a plan that would, under a Medicare for All health care system, decrease access, increase costs, and decrease choices by:⁴
 - Creating “[l]onger wait times to receive health care treatment” (82 percent)
 - Imposing “[m]andatory waiting periods for care” (79 percent)
 - Providing “[f]ewer options for health care providers...and treatments” (76 percent)
 - “Elimin[ating] Medicare” (75 percent)
 - “Increasing taxes” (69 percent)
 - “Elimin[ating] Medicaid” (68 percent)
 - “Elimin[ating] private insurance” (62 percent)

Public opinion is in flux, and malleable based on how the debate is framed.

- According to pollster Dr. Whit Ayres, founder and president of the North Star Opinion Research Corporation: “The numbers that you are going to see...are not in any way cut in stone. They are just a starting point for talking about health care, and they will move all over the place depending on which side is more persuasive in getting its points across. ... [I]f those in Congress leave the field without concrete health policy alternatives, forfeiting

that game only hands victory to those who are campaigning for a single-payer plan.”⁵

Americans support plans that lower costs, give them access to high quality of care, and put them in the driver's seat.⁶ Americans agree:

- America's health care system should be the best in the world. It should offer lower costs and higher-quality care than it does today. (97 percent)
- Health care policy should empower people—not government bureaucrats or insurance companies—to make decisions for their themselves and their own families. (94 percent)

Almost all Americans are likely to support a health care plan that increases access, lowers costs, and improves choice. They want a plan that will:

- “Encourage health care innovations and options” (96 percent)
- “Use proven tools to help people with pre-existing conditions get care without raising costs for other Americans” (96 percent)
- “Lower health insurance premiums for individuals by as much as 32 percent” (94 percent)
- “Allow more people access to personalized private coverage over government-run health programs like Medicare” (85 percent)

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Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

APRIL 23, 2019

Health Care Should Empower Patients and Ensure Access to Quality and Choice

A healthy America is a strong America. Our health care system should be the best in the world. It should offer more personal choice, more access to doctors, lower costs, higher-quality care, protections for people with pre-existing conditions, and open avenues for innovation.

97% AGREE

Health care plans should remove health care decision-making from Washington, D.C., bureaucrats and insurance company executives and give it to the states, small businesses, nonprofits, and families.

84% AGREE

Health care policy should empower people—not government bureaucrats or insurance companies—to make the best decisions for their families.

94% AGREE

Americans should have more choices for their health care.

91% AGREE

Patients—not bureaucrats—should choose how health care is provided.

90% AGREE

Likelihood of Supporting Plan Proposals

Use proven tools to help people with pre-existing conditions get care without raising costs for other Americans.

TOTAL LIKELY: 96%

66% VERY

30% SOMEWHAT

Lower health insurance premiums for individuals purchasing insurance on their own by as much as 32 percent.

TOTAL LIKELY: 94%

58% VERY

36% SOMEWHAT

Encourage health care innovations and options.

TOTAL LIKELY: 96%

58% VERY

38% SOMEWHAT

Allow more people to choose personalized private coverage over government-run health programs like Medicaid.

TOTAL LIKELY: 85%

48% VERY

37% SOMEWHAT

SOURCE: Survey conducted March 1, 2019, among 1,344 respondents with a margin of error of $\pm 3.1\%$.

 heritage.org

Endnotes

1. Pew Research Center, "Public's 2019 Priorities: Economy, Health Care, Education and Security All Near Top of List," January 24, 2019, <https://www.people-press.org/2019/01/24/publics-2019-priorities-economy-health-care-education-and-security-all-near-top-of-list/> (accessed April 11, 2019).
2. "Healthcare System," Gallup, <https://news.gallup.com/poll/4708/healthcare-system.aspx> (accessed April 18, 2019).
3. By comparison, access and cost rank as 25% and 22%, respectively.
4. Morning Consult and *Politico*, "National Tracking Poll No. 181238," December 18–19, 2018, https://www.uschamber.com/sites/default/files/singlepayer_results_mc.pdf (accessed April 11, 2019).
5. Robert E. Moffit, Christopher Pope, and Whit Ayers, "The National Debate Over Government-Controlled Health Care," Heritage Foundation Lecture No. 1305, February 19, 2019, pp. 8–12, <https://www.heritage.org/sites/default/files/2019-02/HL1305.pdf>.
6. All remaining results based on an online survey using a national representative sample of 1,344 U.S. voters conducted March 1, 2019, with a margin of error of ± 3.1 percent.

Mr. ALLEN. Okay. Well listen, I want to thank the witnesses. We had some great discussion. Frankly, nobody at this hearing knows what it costs to take care of a patient. We know that healthcare is a partnership between your physician, and the patient. That is the problem, and frankly I think that is the problem with any type of Federal program is taking away that relationship.

It is a real problem out there, and you know if we like Obama Care. We promised the American people you can keep your doctor, and we were going to reduce the cost. Look what happened. We are here talking today about the explosive costs, but less outcomes.

We are talking about more government programs. I am deeply concerned with the enthusiasm with my democratic colleagues in their support for Medicare for All, or single payer options. More government intervention will not improve quality of care. It will only increase the cost of healthcare, which we have seen since the government got in this business.

According to the Mercada's Center Medicare for All will cost roughly 32.6 trillion over the next, over the first 10 years of implementation, which would require more than doubling all Federal, individual and corporate income taxes. I mean we cannot even pay for our Medicare today. It is running out of money.

The non-partisan Congressional Budget Office has said that a single payer option would reduce the amount of care supplied, and also reduce the quality of care. Over 155 million Americans get their health insurance from their places of work, and the vast majority of them are pleased with their coverage, and their care on these employer sponsored health plans.

In fact, a poll from the Alliance to Fight for Healthcare, found individuals with employer sponsored health insurance ranked their care 19 percent higher than those on Obama Care. Congress should be looking for ways to improve this system. Let us get the real data out there.

Let us find out—let us peel the onion back, find out who is getting the money here, and rather than replacing this with a more expensive, and less effective system like Medicare for All. As we have discussed today there are many options to real healthcare reform.

For example, Association Health Plans would allow small businesses and sole proprietors to offer lower cost health insurance, saving workers upwards of 50 percent of healthcare costs. I look forward to working on these solutions to expand access and improve the quality of employer sponsored health coverage.

Thank you again to all the witnesses and Mr. Chairman, it has been a real pleasure to be with you today and thank you for conducting this great hearing. With that I yield back.

Chairman DESAULNIER. Thanks, Rick. I appreciate it, and forgive my not paying attention to my cursor, and prepare for closing comments. I apologize. Again, I just want to thank you. This has been a terrific hearing. I want to thank all my colleagues. The subcommittee I have been very proud to be chair of and be a member of. We have our differences of opinion, but we work in a way that I think that Congress should work, to try to find where our commonalities are, and mostly—and this subject is probably the—no it is the most important one.

How do we make the system work better knowing that we have different perspectives, and not biases, but different perspectives. To the Republican witness, Mr. Blase, we would like to followup in a conversation with you Mr. Allen and Mr. Fitzgerald. Professor Keith, I thought the dialog between you and the Chairman was a good one.

If we wanted, I really worry about small businesses having spent 35 years in the restaurant business and having many dear friends still in that business coming out of COVID. They are so important. Small businesses are important. I was a member of the California Restaurant Association for a long time, one of the Board members used to refer to me as their communist member, but I took that as a badge of honor.

There is got to be a way that we can help small businesses, and they need that help to be efficient and effective, whether it is through associations or not, I would say I am not a supporter as we currently are talking about, but I thought that exchange was a good one.

If we keep our eye on the ball if we want to help Americans, in this case the small business owners come out of COVID, come out of it successfully, this is a big, big issue for small business. I personally think it should be non-partisan.

I also want to comment on the conversation of prescription drugs just because it is personal to me. This drug keeps me alive. We have had hearings on I think both Elijah Cummings, because we have many conversations about this when I was diagnosed almost 8 years ago with stage four leukemia.

Elijah and I, and now Chairwoman Maloney, we have had hearings about this and brought the CEO here. This drug that keeps me and a lot of people with chronic lymphocytic leukemia alive, costs \$150,000 a year. In Europe it is less than half of that. In Australia, a fully loaded rather than \$150 a day, it is \$40 a day.

Clearly, when I look at that particular drug and the history of it as much of the research started in the Department of Defense. It started in World War I actually with blood cancers. Then the American Cancer Institute, so trying to figure out where the base level of research on drugs like this came from, and the benefit we get.

The Wall Street Journal did a couple of interesting stories on this drug, and it just talked about upper income—imagine poor Americans making life decisions. Dr. Benjamin talked about families sharing drugs. This is frequent on this particular drug. Why does it have to be that way?

These American taxpayers are risking their lives, dying because of our system on prescription drugs, and it is fixable. Even more and I would think my Republican colleagues would agree with that, clearly we are subsidizing other countries on this drug in particular, so I would love to have further conversation about that.

Just last, since I mentioned Elijah and somebody else said this. As he used to say, “We’re better than this.” This subcommittee on this subject, we are better than this. Americans pay way too much for what they get, and I can speak with experience, and I can speak with experience about bureaucracy and government bureaucracy in my experience.

This system saved my life. Two years ago, my sons were told by ICU doctors at George Washington after they flew across the country that I would die within the next 48 hours. I am here because of the health care system in Providence, but we can do better. We can do much better, and Republicans and Democrats can do better.

With that, I would really like to thank everybody. I look forward to continuing to work together. This is not the ending this is a beginning for this subcommittee. Mr. Allen and Representative Foxx, let us work together. We can save people's lives and provide a system that we can all be proud of, and particularly for lower income Americans wherever they live.

Trying to get the resources they need is really unthinkable in the wealthiest country in the history of this planet. I look forward again to working with all of you. Thank you again the witnesses, and if there is no further business, without objection this subcommittee stands adjourned, thank you.

[Whereupon, at 2:19 p.m., the subcommittee adjourned.]

[Additional submissions from Chairman DeSaulnier follows:]



Statement for the House Health, Employment, Labor, and
Pensions Subcommittee

February 17, 2022

Exploring Pathways to Affordable, Universal Health Coverage

Submitted by
National Association of Health Underwriters



I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize health plans of all types.

The health insurance agents and brokers that NAHU represents are a vital piece of the health insurance market and play an instrumental role in assisting employers and individual consumers with choosing the health plan or plans that is best for them. Eighty-two percent of all firms use a broker or consultant to assist in choosing a health plan for their employees¹ and eighty-four percent of people shopping for individual exchange plans found brokers helpful -- the highest rating for any group assisting consumers.² Additionally, premiums are 13 percent lower in counties with the greatest concentration of brokers.³ Consequently, the NAHU membership has a vested interest in ensuring that consumers enjoy affordable health coverage that is the correct fit for their clients.

Approximately 156 million Americans, nearly half of the country's total population, are enrolled in health insurance coverage from their employer. Recent surveys indicate that most adults are satisfied with their current health coverage, with those enrolled in employer plans the most satisfied.⁴ For those who qualify for Medicare, 96 percent of Medicare Advantage beneficiaries are satisfied with their quality of care, as are 95 percent of those covered by traditional Medicare.⁵ This means that employer-sponsored insurance and Medicare are some of the most popular forms of health coverage in the United States.

Because many people have a positive opinion of Medicare, the word "Medicare" has frequently been used by those who advocate for a greater role for the government in health care delivery, such as a single-payer system. Since beneficiary satisfaction rates for Medicare and Medicare Advantage are generally high, using the word "Medicare" or using Medicare as a starting off place for changes often draws the attention even of those who otherwise would say they aren't interested in a single-payer health care system. However, public polling indicates that most Americans do not support such a shift in our system. While most Americans believe the federal government can do more to help provide health insurance and believe in the idea of universal health coverage, once they learn more about how a single-payer system would work, support for such an idea drops dramatically. For example, 60 percent of consumers oppose any major shift that would threaten the current Medicare program.⁶ Because of this and the high level of satisfaction in

¹ Kaiser Family Foundation. [Employee Health Benefits Annual Survey](#). October 2013.

² Blavin, Fredric, et al. [Obtaining Information on Marketplace Health Plans: Websites Dominate but Key Groups Also Use Other Sources](#). Urban Institute. June 2014.

³ Karaca-Mandic, Pinar, et al. [The Role of Agents and Brokers in the Market for Health Insurance](#). National Bureau of Economic Research. August 2013.

⁴ Collins, Sara. [What Do Americans Think About Their Health Coverage Ahead of the 2020 Election? Findings from the Commonwealth Fund Health Insurance in America Survey, March–June 2019](#). Commonwealth Fund. Sept. 2019.

⁵ Jacobson, Gretchen, et al. [Medicare Advantage vs. Traditional Medicare: How Do Beneficiaries' Characteristics and Experiences Differ? Commonwealth Fund](#). 14 October 2021.

⁶ Kaiser Family Foundation. [Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage](#). 16 October 2020.



both the current Medicare program and in employer sponsored coverage, care should be taken to ensure that any future proposals aimed at increasing Americans' access to affordable health coverage not jeopardize the employer-sponsored market or the Medicare program as they are currently structured.

Some proposals envision new government programs such as a public option competing with private coverage in order to increase market competition. Unfortunately, these proposals may do just the opposite. In order for market competition to work in any market, the market rules must be the same for all market participants. When the government offers a product that competes with private coverage, it plays by a different set of rules, because it can mandate the level of healthcare provider payments. This creates an unlevel playing field in the insurance market where it is offered, since private plans must negotiate the best rates they can but are unable to force providers to accept lower rates. Medicare sets reimbursement rates lower than private payers and the costs are shifted to the private market; since Medicare pays providers an average of 80 percent of the cost of care delivered,⁷ and some rate differentials are even higher. Providers routinely make up for this shortfall by charging private plans more.⁸ Since medical expenses are the biggest part of any premium dollar by law, this means that the competing plan offered by the government will be priced artificially lower than private coverage. Eventually these government plans would push private coverage out of existence.

Some provisions to extend federal healthcare programing, including lowering the eligibility age for Medicare, would create a comparable imbalance in the current individual market because of this unequal pricing ability. It creates a similar problem in the employer market because, under current proposals, employees in employer-sponsored plans would be able to opt out of employer coverage in favor of buying into Medicare. Additionally, in the employer market, this opt-out ability would create adverse selection in the employer market as those opting out of employer coverage in favor of Medicare would likely be most attractive to employees who were younger and healthier since Medicare benefits are less generous than those found in most employer sponsored plans. This would leave those remaining in the employer coverage likely to be older and sicker, potentially damaging the viability of the pool of covered individuals in the employer plan.

On top of the unlevel playing field it would create, lowering Medicare's eligibility age would not significantly increase the number of people with insurance. Almost two-thirds of the more than 20 million people between the ages of 60 and 64 already have private health coverage, with 25 percent obtaining public coverage through Medicaid or other government programs. And 11 percent purchase plans on the individual market, including through the ACA's exchanges. Less than 10 percent of people in this age group are uninsured. In other words, expanding Medicare would simply replace the soon-to-be seniors' existing coverage, which is typically private, with publicly funded coverage.

Additionally, Medicare scarcely has enough money to cover the costs of its current beneficiaries. According to the latest report from its trustees, Medicare's hospital insurance trust fund will be exhausted by 2026.⁹ At that point, the program will not be taking in enough in tax revenue to pay claims. The federal government may have to unilaterally cut rates to

⁷ Centers for Medicare and Medicaid Services. [How to Use the Searchable Medicare Physician Fee Schedule \(MPFS\)](#). March 2021.

⁸ Milliman. [Why hospital cost shifting is no longer a viable strategy](#). June 2010.

⁹ Stewart, Jackie. [Medicare Part A Funds to Run Out in 2026](#). *Kiplinger*. 31 August 2021.



providers, which would undermine patients' ability to access care. With insolvency looming for Medicare, expanding the program is not prudent nor fiscally appropriate.

While lowering Medicare eligibility and creating a single-payer system or public option would undoubtedly threaten the Medicare program and private markets, there are other proposals that also threaten the system as is. One of the most important structures in the health insurance market is the barrier between employer-sponsored health coverage and the individual market, commonly referred to as "the firewall." The firewall prevents employees who have an offer of affordable minimum value job-based coverage from receiving premium tax credits in the marketplace; this is one ACA provision that has been most useful in limiting disruption to individuals already enrolled in employer-sponsored coverage. Any proposal that seeks to eliminate or significantly weaken this firewall threatens the viability of the employer-sponsored market and could result in crowding out. High levels of crowd-out could encourage employers to drop coverage, causing many of those who previously had access to employer plans to search for a new plan or go uninsured.

ACA premium tax credits are helpful for consumers who receive individual market coverage from the ACA Marketplace. Due to the passage of the American Rescue Plan Act in 2021, premium tax credits were extended to those with incomes above 400 percent of the federal poverty level, reducing premium contributions significantly for those who purchase coverage on the individual market. This change to premium tax credit policy resulted in a record-breaking 14.5 million Americans receiving health coverage through one of the ACA marketplaces during the 2022 open enrollment period. NAHU supports expanding and building upon the ACA in this fashion, as opposed to any sweeping changes to the Medicare program that could jeopardize the entire system. However, these expanded subsidies are only effective when there is a clear line between the individual market and employer-sponsored market. For these reasons, any future proposals impacting health insurance must maintain the ACA's firewall.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee. If you have any questions about our comments or if NAHU can be of assistance as you move forward, please do not hesitate to contact me at either (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
CEO, National Association of Health Underwriters

[Questions and responses for the record by Dr. Benjamin follows:]



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March 2, 2022

Georges C. Benjamin, MD
Executive Director
American Public Health Association
800 I St. NW
Washington, DC 20001

Dear Dr. Benjamin:

I would like to thank you for testifying at the Subcommittee on Health, Employment, Labor, and Pensions hearing entitled "*Exploring Pathways to Affordable, Universal Health Coverage*," held on Thursday, February 17, 2022.

Please find enclosed additional questions submitted by Committee Members following the hearing. Please provide a written response no later than Wednesday, March 9, 2022, for inclusion in the official hearing record. Your responses should be sent to Clerk of the Committee at E<estimony@mail.house.gov and Daniel Foster (Daniel.Foster@mail.house.gov) of the Committee staff.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Health, Employment, Labor, and Pensions Hearing
“Exploring Pathways to Affordable, Universal Health Coverage”
 Thursday, February 17, 2022
 12:00 p.m. (Eastern Time)

Representative Andy Levin (D-MI)

OK, let's switch gears in the time I have left. In addition to the conversation about the fundamental reform we need, I think it's also important we do not lose sight of the progress we have made so far.

I am proud that congressional Democrats passed, and President Obama signed, the Affordable Care Act (ACA) into law. The ACA, while not perfect, has been a success. Thanks to it, 20 million Americans now have health coverage. And much more recently, of course, I was proud to vote for the American Rescue Plan, which strengthened the ACA and provided much-needed relief for those facing the subsidy cliff.

Thanks to the ACA and the ARP, we've inched closer to universal, affordable health coverage for all Americans. Lower- and middle- income people have more affordable options, people with preexisting conditions are protected from discrimination, among many other improvements.

- 1) Dr. Benjamin, could you briefly discuss how some of the reforms made by both the ACA and Rescue Plan have expanded access to affordable coverage?
- 2) Why is it so important that we extend the Rescue Plan's premium subsidies beyond 2022?



March 9, 2022

The Honorable Robert C. Scott
Chairman
U.S. House Committee on Education and Labor
2176 Rayburn House Office Building
Washington DC 20515

Dear Chairman Scott:

Thank you again for the opportunity to testify on behalf of the American Public Health Association at the Feb. 17 hearing, *Exploring Pathways to Affordable, Universal Health Coverage*. APHA believes we must continue to work to transform our nation's fractured health insurance system into a system of universal health care coverage that provides quality and affordable health coverage for all.

Below are my responses to the additional questions submitted for me after the hearing by Rep. Andy Levin.

Question 1: Dr. Benjamin, could you briefly discuss how some of the reforms made by both the ACA and Rescue Plan have expanded access to affordable coverage?

Answer:

The Affordable Care Act expanded coverage through the Medicaid program by making it the coverage of choice for lower income individuals without access to other forms of insurance coverage. It also expanded coverage for about 9 million individuals by providing premium support through the federal or state-run health exchanges (Marketplaces). This made coverage more affordable and therefore more available. In addition, allowing dependent children to stay on their parents plans until age 26 also filled a well-known coverage gap that occurs when children make the transition from home to college, their first significant employment or living on their own. Since its passage the ACA has been successful in expanding coverage for millions of uninsured people. It has also served as a buffer for job loss during the COVID-19 pandemic providing coverage stability for many people during this difficult period.

Purchasing health insurance coverage is complicated and can be overwhelming for many people. The Marketplaces created a more efficient mechanism (one stop) for people to shop for coverage either online or with the assistance of enrollment brokers. The ACA exchanges and support systems have dramatically improved the ability of people to shop for insurance and in many communities increased options to choose. Regrettably, there are communities where there is limited choice or a single insurer. The state insurance commissioners do have the authority and ability to incentivize insurers to expand coverage options and reduce premium and out of pocket costs through regulatory and enforcement action. The elimination of pre-existing conditions

denials, and the provisions that provided for first dollar coverage for proven preventive services promoted prevention and wellness.

One of the most important features of the ACA is it addressed cost of coverage for the individual and families. One important mechanism was by providing federal premium support through the health exchanges thus limiting the individual contribution to coverage as a percent of income. This addressed a major barrier to ensuring health insurance coverage – its costs.

The American Rescue Plan Act built on the strengths of the ACA and further addressed the growing challenges with out-of-pocket costs by temporarily expanding the premium tax credits (subsidies) to further make insurance more affordable. The Kaiser Family Foundation estimated in March of 2021 that “1.4 million uninsured people became newly eligible for subsidized Marketplace coverage under ARPA.”

Question 2: Why is it so important that we extend the Rescue Plan’s premium subsidies beyond 2022?

Answer:

The ACA made health insurance more affordable by providing federal premium support which made coverage more available to millions of Americans. However, millions of eligible people still remained uncovered because of unaffordable premium costs. The ARPA provided substantial relief for the existing participants of the program and additional supports for eligible people who remained priced out of the market. A March 2021 report from the Kaiser Family Foundation estimated that 3.7 million more people, who had remained uninsured because of costs, were eligible for a subsidy from the ARPA (A 20% increase). ARPA was successful in addressing this coverage gap for these people as well as for people who lost insurance coverage due to no fault of their own because of job loss related to the pandemic. If these very successful ARPA premium subsidies are not continued several million people are at risk of acutely losing coverage because of the sudden increase in premiums when the subsidies end. For some, premium costs could double. This is a particular concern as the increases would be greatest amongst the lowest income enrollees. The entire marketplace will be in turmoil because of the sudden impact of cost shifting that will occur in the insurance market.

Importantly, ARPA also provided support for states to expand Medicaid coverage to individuals with incomes up to 138% of the federal poverty level. The Urban Institute estimates that the sudden loss of fiscal support coupled with the end of the emergency declaration could result in as many as 15 million people suddenly losing coverage under the Medicaid program. This would be devastating for lower income people and their families.

The public health and medical implications would be significant as well as people, many of whom will be under medical care, will suddenly find themselves without the financial ability to afford their insurance coverage and will be forced to delay or skip needed medical or surgical care. These individuals, and our health system as a whole, will ultimately pay more because delayed care is always more costly and often less effective when we have to treat people at a later more serious stage of disease.

It is my view that the ARPA subsidies were so effective that they should be made permanent.

Thank you for sharing these additional questions and for holding this important hearing on the topic of achieving universal health coverage in the United States.

Sincerely,

A handwritten signature in black ink, appearing to read "Georges C. Benjamin". The signature is fluid and cursive, with the first name "Georges" being more prominent.

Georges C. Benjamin, MD
Executive Director

[Questions and responses for the record by Ms. Keith follows:]



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VACANCY

March 2, 2022

Ms. Katie Keith, JD, MPH
Visiting Professor and Director of the Health Policy and the Law Initiative
O'Neill Institute for National & Global Health Law,
Georgetown University Law Center
308 Upshur St. NW
Washington, DC 20011

Dear Ms. Keith:

I would like to thank you for testifying at the Subcommittee on Health, Employment, Labor, and Pensions hearing entitled "*Exploring Pathways to Affordable, Universal Health Coverage*," held on Thursday, February 17, 2022.

Please find enclosed additional questions submitted by Committee Members following the hearing. Please provide a written response no later than Wednesday, March 9, 2022, for inclusion in the official hearing record. Your responses should be sent to Clerk of the Committee at E<estimony@mail.house.gov and Daniel Foster (Daniel.Foster@mail.house.gov) of the Committee staff.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Health, Employment, Labor, and Pensions Hearing
“Exploring Pathways to Affordable, Universal Health Coverage”
 Thursday, February 17, 2022
 12:00 p.m. (Eastern Time)

Representative Bobby Scott (D-VA)

1. In 2018, the Trump Administration finalized a rule entitled *Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans*.^[1] In 2019, a federal judge found that the rule was an unlawful “end-run around the [Affordable Care Act]”^[2] and remanded the rule to the Department of Labor for further consideration.
 - a) Could you explain the holding in this decision and why many feel that association health plans undermine the *Affordable Care Act*? For example, are association health plans required to cover essential health benefits?
 - b) What is the history of insolvencies with respect to multiple employer welfare arrangements? Could the expansion of association health plans as advocated by the Trump Administration raise similar concerns for state and federal regulators?
 - c) Do association health plans present a risk of adverse selection? If so, what impact could this have with respect to premiums across the market?
2. In 2019, the Trump Administration finalized a rule entitled *Health Reimbursement Arrangements and Other Account-Based Group Health Plans*. This rule created a new type of account-based health plan called the Individual Coverage Health Reimbursement Arrangement (ICHRA).^[3]
 - a) Are premium tax credits under the *Affordable Care Act* available under these arrangements?
 - b) What are the distributional effects of ICHRAs? Are certain groups more likely to benefit than others?
 - c) Do ICHRAs present a risk of adverse selection? If so, what impact could this have with respect to premiums across the market?

^[1] 83 Fed. Reg. 28912 (Jun. 21, 2018).

^[2] *State of New York v. United States Department of Labor*, No. 1:18-cv-01747-JDB (D.D.C. Mar. 28, 2019) at 2.

^[3] 84 Fed. Reg. 28888 (Jun. 20, 2019) (Final Rule establishing individual coverage health reimbursement arrangements and excepted benefit health reimbursement arrangements).

Ms. Katie Keith
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Subcommittee on Health, Employment, Labor, and Pensions
“Exploring Pathways to Affordable, Universal Health Coverage”
 U.S. House of Representatives Committee on Education & Labor
 Thursday, February 17, 2022

Additional Questions for the Record

Katie Keith, J.D., M.P.H.

Visiting Professor and Director of the Health Policy and the Law Initiative
 O’Neill Institute for National & Global Health Law | Georgetown University Law Center

Representative Bobby Scott (D-VA)

1. In 2018, the Trump Administration finalized a rule entitled *Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans*.¹ In 2019, a federal judge found that the rule was an unlawful “end-run around the [Affordable Care Act]”² and remanded the rule to the Department of Labor for further consideration.
 - a) Could you explain the holding in this decision and why many feel that association health plans undermine the *Affordable Care Act*? For example, are association health plans required to cover essential health benefits?
 - b) What is the history of insolvencies with respect to multiple employer welfare arrangements? Could the expansion of association health plans as advocated by the Trump Administration raise similar concerns for state and federal regulators?
 - c) Do association health plans present a risk of adverse selection? If so, what impact could this have with respect to premiums across the market?

Answer: The association health plan rule was issued in response to an executive order from President Trump³ and tried to exploit a narrow exception in federal law regarding when multiple employers may join together in a group or association that will be treated as the “employer” sponsor of a single multiple-employer plan for purposes of offering health insurance coverage under the Employee Retirement Income Security Act of 1974 (ERISA). In particular, the Department of Labor interpreted the word “employer” under ERISA in a way that relaxed a long-standing “commonality of interest” requirement that associations must exist for a reason other than offering health insurance and allowed self-employed “working owners” to enroll in association health plan coverage. In doing so, the rule would have made it easier for associations that offer coverage to small businesses and self-employed individuals to qualify as a single ERISA-covered plan, leaving enrollees without key consumer protections and increasing the risk of market segmentation.

Single ERISA-covered association health plans are treated as large group plans under federal law. As large group plans, association health plans under the 2018 rule had to comply with *some* Affordable Care Act protections, such as the law’s ban on preexisting condition exclusions and coverage of preventive services without cost sharing. But large group plans do not have to comply with the Affordable Care Act’s most significant protections, such as community rating requirements

¹ 83 Fed. Reg. 28912 (Jun. 21, 2018).

² State of New York v. United States Department of Labor, No. 1:18-cv-01747-JDB (D.D.C. Mar. 28, 2019) at 2.

³ See Executive Order 13813, 82 Fed. Reg. 48385-87 (Oct. 12, 2017).

Ms. Katie Keith
Page 2

(which ban rating based on gender and industry, among other factors) or the coverage of essential health benefits.⁴ These and other core consumer protections apply only in the individual and small group markets.

Thus, under the 2018 rule, coverage sold through an association could be marketed to individuals and small employers but would not have to comply with the heightened consumer protections that Congress put in place for coverage sold in the individual and small group markets under the Affordable Care Act. This would result in an unlevel playing field between association coverage and the traditional individual and small group markets.⁵

Association health plans would be able to cherry-pick consumers through eligibility rules, rating practices, and benefit designs that make their plans less attractive to those with health needs.⁶ Association health plans may opt not to, for instance, cover prescription drugs or mental health coverage as a way of keeping premiums low and discouraging enrollment by sicker employers or self-employed individuals.⁷ Since the Affordable Care Act's rating rules do not apply, association health plans could develop premiums based on factors that include no limits on age, gender, industry, and more.⁸ These practices would lead to risk segmentation and higher premiums for those with preexisting conditions in the traditional individual and small group markets as healthier people gravitated towards association health plans.⁹

In addition to concerns about adverse selection, association health plans and other types of multiple employer welfare arrangements are plagued by a long history of fraud, scams, and insolvency.¹⁰ When these plans become insolvent, policyholders and providers are left with millions in unpaid claims and uncompensated care. The Trump administration recognized as much in finalizing the 2018 rule, noting that prior enforcement efforts "often were too late to prevent or fully

⁴ Commenters opposed the 2018 rule because association health plans "would not be subject to the requirement to provide [essential health benefits]." 83 Fed. Reg. at 28933. The Department of Labor acknowledged that association health plans would not be subject to this requirement and explicitly rejected calls to require the coverage essential health benefits under the 2018 rule. *Id.*

⁵ See, e.g., Christina Lechner Goe, Non-ACA-Compliant Plans and the Risk of Market Segmentation: Considerations for State Insurance Regulators (Mar. 2018).

⁶ The 2018 rule prohibited discrimination based on a health factor but did not prohibit underwriting based on other factors (such as age, industry, gender, or geography) even though commenters urged the Department of Labor to do so since non-health factors can be "a pretext for discrimination based on health factors." 83 Fed. Reg. at 28928.

⁷ Some association health plans might *voluntarily* choose to cover the 10 statutorily specified categories of essential health benefits under the Affordable Care Act—a point that proponent of these plans often make. But there is no requirement that they do so. See Kevin Lucia & Sabrina Corlette, It's All About the Rating: Touted "Benefits" of Association Health Plans Ignore Key Facts, CHIRblog (Feb. 2019).

⁸ A comment letter from the BlueCross BlueShield Association noted that association health plans could rate engineers 9 percent lower and taxi cab drivers 15 percent higher than plans in the traditional individual and small group markets. 83 Fed. Reg. at 28945, n. 93. Young men enrolled in association health plans could have rates 40 percent lower while women of child-bearing age could have rates more than 30 percent higher relative to the individual and small group markets. *Id.*

⁹ Katie Keith, Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans, Health Affairs Forefront (Jun. 2018) ("Commenters raised concerns that an uneven playing field ... would result in adverse selection against the [Affordable Care Act] markets").

¹⁰ See, e.g., Goe, *supra* note 5; Mila Kofman, MEWAs: The Threat of Plan Insolvency and Other Challenges, The Commonwealth Fund (Mar. 2004); Mila Kofman et al., Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed, The Commonwealth Fund (Aug. 2003); U.S. Government Accountability Office, States Need More Department of Labor Help to Regulate Multiple Employer Welfare Arrangements and Correct Problems (Sep. 1991).

Ms. Katie Keith

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recover major financial losses” and acknowledging that the 2018 rule will cause “increased opportunities for mismanagement or abuse, in turn increasing oversight demands on the Department and state regulators.”¹¹

In *New York v. Department of Labor*, a federal district court in the District of Columbia held that major provisions of the Trump-era rule on association health plans were unlawful. The lawsuit was filed by a coalition of Democratic attorneys general who argued that the 2018 rule’s interpretation of “employer” was inconsistent with the text and purpose of ERISA and that the goal of the final rule was to undermine the Affordable Care Act. The attorneys general alleged that the 2018 rule increased the risk of fraud and harm to consumers, required states to devote significant resources to preventing that risk, and jeopardized the ability of states to adopt stronger protections.

The court agreed on many of these points and concluded that the 2018 rule failed to reasonably interpret ERISA by defining “employer” to include working owners and groups without a true commonality of interest. The court set aside these parts of the 2018 rule and remanded the rule to the Department of Labor. As a result of the court’s decision, the most significant changes did not go into effect.¹² The Trump administration appealed the decision to the Court of Appeals for the District of Columbia, and oral argument was held in November 2019. A decision has not yet been issued, and the litigation has been held in abeyance since February 2021.

I hope this background provides additional insight into my direct responses to your questions:

a) Could you explain the holding in this decision and why many feel that association health plans undermine the *Affordable Care Act*? For example, are association health plans required to cover essential health benefits?

The court held that major provisions of the Trump-era rule on association health plans were inconsistent with ERISA and thus unlawful under the Administrative Procedure Act. Association health plans undermine Affordable Care Act plans because association health plans do not have to comply with the same consumer protections as coverage offered in the individual and small group markets. Without a level playing field between association health plans and Affordable Care Act plans, association health plans could design their products in a way that causes adverse selection against the Affordable Care Act-compliant individual and small group markets. This would lead to higher premiums for those in Affordable Care Act-compliant plans who need comprehensive coverage. Association health plans as envisioned under the 2018 rule are not required to cover essential health benefits under the Affordable Care Act.

b) What is the history of insolvencies with respect to multiple employer welfare arrangements? Could the expansion of association health plans as advocated by the Trump Administration raise similar concerns for state and federal regulators?

As noted above, there is a long and well-documented history of insolvency and fraud associated with association health plans and multiple employer welfare arrangements. Waves of large-scale insolvencies left policyholders with hundreds of millions of dollars in medical debt

¹¹ 83 Fed. Reg. at 28952, 28953.

¹² See Katie Keith, [DOL Issues Additional Guidance on AHPs](#), Health Affairs Forefront (May 2019).

Ms. Katie Keith

Page 4

and uncompensated care for providers.¹³ Over time, Congress has amended ERISA to give states more regulatory authority over multiple employer welfare arrangements to ensure solvency, require state licensure, and impose financial reporting standards.¹⁴ Although states have had a better track record of addressing fraudulent association health plans than the federal government, fraud and abuse has continued.¹⁵ Given this experience, the expansion of association health plans under the 2018 rule would raise significant concerns for state and federal regulators who, at a minimum, would have to invest new resources in investigations and enforcement.

c) Do association health plans present a risk of adverse selection? If so, what impact could this have with respect to premiums across the market?

Yes, for all the reasons noted above, association health plans present a risk of adverse selection in both the individual and small group markets. These plans do not have to comply with the Affordable Care Act's most significant consumer protections and can thus use eligibility rules, rating practices, and benefit designs to offer lower premiums and cherry-pick consumers. These practices would lead to risk segmentation and higher premiums for those with preexisting conditions in the traditional individual and small group markets.

Federal officials did not quantify the impact of the 2018 rule on premiums, but the Department of Labor extrapolated from quantitative analyses to suggest that individuals that remain in the individual and small group markets could face premium increases of between \$7.7 billion and \$14.1 billion.¹⁶ Among the quantitative analyses cited by the Department, some estimated that individual market premiums would increase by up to about 4 percent and small group market premiums would increase by up to about 2 percent.¹⁷

¹³ See Goe, *supra* note 5 at 12 ("According to the GAO, between 1988 and 1991, multiple employer entities left 400,000 consumers with medical bills exceeding \$123 million. The most recent cycle was between 2000 and 2002, when 144 entities left 200,000 policyholders and providers with \$252 million in unpaid medical bills.").

¹⁴ See Mila Kofman, Association Health Plans: Loss of State Oversight Means Regulatory Vacuum and More Fraud, Georgetown University (2005).

¹⁵ E.g., Susan K. Livio, "Bankrupt N.J. Health Plan Can't Pay Medical Claims and Needs a Bail-Out From Its Members," *N.J.com* (Aug. 20, 2021); Christine Monahan, The MEWA Files: Lifting the Curtain on DOL's Investigation into AHPs and Other Fraudulent Health Plans, CHIRblog (Nov. 2019); Katie Keith, Tennessee Executive Pleads Guilty to Fraudulent Sales of Association Coverage and Limited Benefit Products, Health Affairs Forefront (Mar. 2018); Robert Pear, "Cheaper Health Plans Promoted by Trump Have a History of Fraud," *New York Times* (Oct. 21, 2017).

¹⁶ 83 Fed. Reg. at 28945.

¹⁷ See Keith, *supra* note 9 (summarizing analyses of the proposed rule and its impact on premiums and enrollment).

Ms. Katie Keith

Page 5

2. In 2019, the Trump Administration finalized a rule entitled *Health Reimbursement Arrangements and Other Account-Based Group Health Plans*. This rule created a new type of account-based health plan called the Individual Coverage Health Reimbursement Arrangement (ICHRA).¹⁸
 - a) Are premium tax credits under the *Affordable Care Act* available under these arrangements?
 - b) What are the distributional effects of ICHRAs? Are certain groups more likely to benefit than others?
 - c) Do ICHRAs present a risk of adverse selection? If so, what impact could this have with respect to premiums across the market?

Answer: The ICHRA rule, issued in response to the same executive order from President Trump¹⁹ noted above, expanded the use of health reimbursement arrangements (HRAs) by employers to fund premiums for employees in the individual health insurance market. An HRA is a type of account-based group health plan that allows employers to fund medical care expenses for their employees on a pre-tax basis. As *group* health plans, HRAs have historically not been able to be used to pay premiums for coverage in the *individual* market. The 2019 rule reversed prior federal guidance on this issue by allowing HRAs to be used to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.

a) Are premium tax credits under the *Affordable Care Act* available under these arrangements?

No, an individual covered by an ICHRA is ineligible for premium tax credits through the marketplaces. This is because an ICHRA qualifies as minimum essential coverage under an employer plan during any month when the HRA is considered “affordable.” Under premium tax credit eligibility rules, an employee who receives or is offered an “affordable” ICHRA is generally barred from accessing premium tax credits and cost-sharing reductions.²⁰

Without access to premium tax credits, employees with an ICHRA combine their employer’s contribution with their own premium contribution to pay their premiums in the individual market. This might result in higher (or lower) premium contributions for employees, depending on their prior cost of coverage and their employer’s level of contribution towards premiums.

There is also a risk that employers underfund employee ICHRAs, meaning the employer contribution would not keep pace with individual market premiums. Recognizing that low-income consumers may be better off claiming a premium tax credit than receiving reimbursement under an ICHRA, the 2019 rule allows would-be ICHRA participants to opt out of the ICHRA and instead receive premium tax credits.

b) What are the distributional effects of ICHRAs? Are certain groups more likely to benefit than others?

¹⁸ 84 Fed. Reg. 28888 (Jun. 20, 2019) (Final Rule establishing individual coverage health reimbursement arrangements and excepted benefit health reimbursement arrangements).

¹⁹ Executive Order 13813, *supra* note 3.

²⁰ Consistent with premium tax credit eligibility rules for employer-based coverage, an employee *could* be eligible for premium tax credits if they declined the offer of an ICHRA *and* that ICHRA was considered unaffordable or did not provide minimum value.

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I am not aware of comprehensive data on the distributional effects or impact of ICHRAs but am including a summary of recent data. According to the Kaiser Family Foundation's annual employer survey, there does not appear to be significant take-up by employers at this time.²¹ Of firms that already offer health benefits, only 4% offered ICHRA options to employees in 2021. Of firms that did not offer health benefits, 7% offered ICHRA options to employees in 2021. Low take-up does not seem likely to change dramatically in the near future: only 1% of firms that did not offer ICHRA options in 2021 are "very likely" to do so in the next two years and an additional 7% are "somewhat likely" to newly offer this option.²² Of large firms that currently or intend to offer an ICHRA, nearly half (44%) expect to offer an ICHRA to all employees; others will offer an ICHRA to part-time or seasonal workers or low-wage workers.

A separate study by Avalere estimates that about 2 million employees are enrolled in individual market coverage through an ICHRA, a number that could rise to more than 3 million employees for 2022.²³ And industry-reported estimates suggest even greater take-up with ICHRAs being offered heavily to employees in sectors that include professional services, nonprofits, technology, and health care.²⁴

Limited existing data aside, critics have raised concerns that ICHRAs could be most attractive to employers with less healthy employees—or employers that already offer less generous coverage as a way to contribute even less towards employee health costs.²⁵ Employers could offer an ICHRA in lieu of a traditional group health plan or for some classes of workers, such as part-time employees. The Trump administration expected an estimated 11.4 million people to be enrolled in coverage through an ICHRA by 2029 and a reduction in the number of people with a traditional group health plan by up to 6.9 million.²⁶

c) Do ICHRAs present a risk of adverse selection? If so, what impact could this have with respect to premiums across the market?

ICHRAs, on their own, do not present a risk of adverse selection and have the potential to grow the individual market in a way that helps reduce or maintain premiums. This would be especially true if employers that opt to offer the ICHRA have generally healthy workforces and see value in the availability of comprehensive coverage in the individual market.

But there could be adverse selection in the individual market if employers use ICHRAs to cover high-cost enrollees or if the employers that opt to offer the ICHRA have generally less healthy workforces. Critics have raised concerns that employers might try to incentivize employees with health conditions to move away from a group health plan and into the individual market through an

²¹ Kaiser Family Foundation, 2021 Employer Health Benefits Survey at 49-51 (Nov. 2021)

²² *Id.*

²³ Avalere Health, Impact of Individual Coverage Health Reimbursement Arrangements on Employees with Group Health Coverage (Feb. 2022).

²⁴ See Paige Minemyer, "Willis Towers Watson: Employers Taking an Interest in HRAs," *Fierce Healthcare* (Nov. 17, 2020).

²⁵ JoAnn Volk & Kevin Lucia, Federal Rules Creating New Health Coverage Option for Employers Could Destabilize the Individual Market, The Commonwealth Fund (Jul. 2019); Christen Linke Young et al., Evaluating the Administration's Health Reimbursement Arrangement Proposal, Center for Health Policy at Brookings (Dec. 2018).

²⁶ 84 Fed. Reg. at 28965.

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ICHRA.²⁷ If employers incentivize high-risk employees into the individual market through an ICHRA (with the goal of reducing their own group health plan costs), it could have significant consequences for the individual market risk pool. This could result in worse overall risk profiles and lead to higher premiums, higher federal outlays for premium tax credits, and a higher uninsured rate.

The 2019 rule included safeguards to try to deter employers from steering sicker employees to ICHRAs, such as minimum class size requirements. But some commenters have raised concerns that the safeguards will be insufficient to fully protect the individual market.²⁸ In its own analysis of the 2019 rule, the Trump administration estimated that premiums in the individual market would rise by about 1 percent during the 2020 to 2029 period.²⁹ This is because ICHRA-offering employers were expected to have slightly higher health care expenses than other employers and current individual market enrollees.³⁰

²⁷ Linke Young et al., *supra* note 25.

²⁸ *Id.*

²⁹ 84 Fed. Reg. at 28965.

³⁰ *Id.* (“[E]mployees in firms that would switch from offering traditional group health plan coverage to offering an individual coverage HRA would have, on average, slightly higher expected healthcare expenses than employees in other firms and current individual market enrollees.”).

[Questions and responses for the record by Secretary Reich follows:]



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March 2, 2022

The Honorable Robert B. Reich
Professor
University of California at Berkeley
Box 837
Inverness, CA 94937

Dear Secretary Reich:

I would like to thank you for testifying at the Subcommittee on Health, Employment, Labor, and Pensions hearing entitled "*Exploring Pathways to Affordable, Universal Health Coverage*," held on Thursday, February 17, 2022.

Please find enclosed additional questions submitted by Committee Members following the hearing. Please provide a written response no later than Wednesday, March 9, 2022, for inclusion in the official hearing record. Your responses should be sent to Clerk of the Committee at E<estimony@mail.house.gov and Daniel Foster (Daniel.Foster@mail.house.gov) of the Committee staff.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Health, Employment, Labor, and Pensions Hearing
“Exploring Pathways to Affordable, Universal Health Coverage”
Thursday, February 17, 2022
12:00 p.m. (Eastern Time)

Representative Frank J. Mrvan (D-IN)

1. Despite being hailed as “essential workers” during the pandemic, many health care workers—including home health aides or nursing assistants—are often paid very low wages, subject to unstable hours, and often lack or have low access to benefits like health coverage.
 - a) At a time when health care costs are growing to exorbitant levels, how do you account for the low compensation of some of our most critical patient care providers?
 - b) If the trillions that we spend on health care aren’t being used to provide good wages and benefits to essential workers, where is the money going?

QUESTION from **Representative Frank J. Mrvan (D-IN)**

1. Despite being hailed as “essential workers” during the pandemic, many health care workers—including home health aides or nursing assistants—are often paid very low wages, subject to unstable hours, and often lack or have low access to benefits like health coverage.

a) At a time when health care costs are growing to exorbitant levels, how do you account for the low compensation of some of our most critical patient care providers?

ANSWER: Some claim that the reason many healthcare workers are paid very little, are subject to unstable hours, and often lack health benefits themselves, is that they lack the skills and education necessary to summon higher wages and benefits. I don't buy this. Given the increasing demand for these workers, one would expect them to be paid more and receive better benefits and hours than they're receiving. The reason they're not, in my view, is that the health sector of the economy is not subject to normal market dynamics. It is dominated by a few large hospital systems and for-profit insurers that exert increasing market control and pricing power in their regions and even nationally. They are, in effect, setting the terms of employment.

b) If the trillions that we spend on health care aren't being used to provide good wages and benefits to essential workers, where is the money going

ANSWER: Our healthcare system is increasingly viewed by Wall Street, private equity, and venture capitalist as a profit center. They're investing in hospitals, rehab centers, insurance companies, and pharmaceutical companies for the simple purpose of making the highest return on their investments as possible. This is understandable, given the way our market economy operates. The problem is that health care is not really market based. Consumers of healthcare have no easy means for evaluating the worth of what they're receiving or comparing it to services of other providers. Government is a major player in determining what and how services are provided. The biggest private-sector players are regional monopolies and oligopolies exercising significant pricing power. We end up with the worst of all worlds - a hugely-expensive system that doesn't cover 30 million Americans and provides poor wages and benefits to its workers.

