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HEALTH INSURANCE COVERAGE IN AMERICA: CURRENT AND FUTURE ROLE OF FEDERAL PROGRAMS

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HEALTH INSURANCE COVERAGE IN AMERICA: CURRENT AND FUTURE ROLE OF FEDERAL PROGRAMS

WEDNESDAY, OCTOBER 20, 2021

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10 a.m., via Webex, in Room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Stabenow, Cantwell, Cardin, Bennet, Casey, Whitehouse, Hassan, Cortez Masto, Warren, Crapo, Grassley, Cornyn, Thune, Portman, Toomey, Cassidy, Lankford, Daines, and Young.

Also present: Democratic staff: Shawn Bishop, Chief Health Advisor; Elizabeth Dervan, Health Counsel; Eva Dugoff, Senior Health Advisor; Peter Fise, Health Counsel; Michael Evans, Deputy Staff Director and Chief Counsel; and Kristen Lunde, Health Policy Advisor. Republican staff: Caleb Graff, Senior Health Policy Advisor; Kellie McConnell, Health Policy Director; Stuart Portman, Senior Health Policy Advisor; and Gregg Richard, Staff Director.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

So many of the major health policy debates happening in the Senate today come down to the same basic challenge: health care is a human right. But without insurance coverage, you cannot exercise that right fully. The emergency room is no substitute for high-quality insurance and a doctor who takes your call.

The committee, handling our Federal health programs and tax credits for health care, is right at the center of the effort to close the coverage gap and move the U.S. closer to universal health coverage. There is a lot of work to be done.

And the fact is, when you look back at the events of the last few years, the historic change, for example, to eliminate discrimination against those with preexisting conditions will always be regarded as a hallmark of public health policy.

Right now, we are working on crucial efforts; for example, to show that we can provide relief to people at the pharmacy counter who feel they are getting mugged, while at the same time promoting innovation. And we are on the cusp of a historic opportunity

to provide coverage to seniors and the disabled through home and community-based services.

So these are all a handful of the particularly promising opportunities for the days ahead. And we are going to start this morning with Senator Reverend Warnock, who has become the conscience of the Senate on the basic question of closing these coverage gaps.

Reverend Warnock was a crusader for health care long before he was a member of the Senate. His home State of Georgia is one of a handful of States where Republican leaders have blocked the expansion of Medicaid. Instead of getting health coverage to many of the most vulnerable people in their State, they are clinging to a decade-old political grudge against the Affordable Care Act.

That is one aspect of the health coverage challenge the committee is going to discuss today. The committee will also talk about building on what worked in the response to COVID–19.

Earlier this year, reversing a Trump policy that restricted coverage to people during the pandemic, President Biden announced a special enrollment period for health insurance. Nearly 3 million people signed up for coverage. As part of the American Rescue Plan that passed in March, Democrats in Congress made signing up for that coverage more affordable. Democrats made coverage more affordable during the eye of the pandemic, and we did it by expanding the ACA's tax credits for health care.

All in all, consumers who updated their health coverage during that special enrollment period saved on their net monthly premiums an average of 40 percent. Nearly two of three consumers could get a plan with zero premium now after tax credits. Extending those improvements, in my view, ought to be seen as a no-brainier, as a way to improve health coverage and put money back in the pockets of Americans.

Now, in addition to expanding coverage, today's hearing is also an opportunity to discuss how to make that coverage more valuable to patients themselves. We Democrats believe deeply in updating the Medicare guarantee, because we know that seniors need dental care and vision and hearing assistance. It is unthinkable that these gaps in Medicare coverage are allowed to persist.

Similarly, as I noted, we are working on a plan to let seniors and people with disabilities get the care they need in the place where they are most comfortable: at home. And Senator Casey, a valued member of the committee, deserves enormous credit for that effort.

Now, before I wrap up, I want to deal with some of the distortions that are offered up with respect to health care. And I am going to deal with one kind of central issue that I think deserves special attention.

None of the plans I have talked about will reduce the solvency of Medicare's hospital insurance trust fund at all—not one bit. Those benefits will have different sources of funding. They will not be part of Medicare Part A, which is what the trust fund covers.

So, let's be clear and make sure the public understands it. None of the plans that we are talking about will reduce by one bit the solvency of Medicare's hospital insurance fund. Furthermore, Republicans trot out this same attack in all the advertisements and campaigns every time Democrats propose a significant improvement to health care—and it is never true. The Affordable Care Act,

for example, extended the solvency of Medicare by 12 years, but Republican political campaigns falsely claimed just the opposite. And they continued to make the claim even after it was fully and repeatedly debunked.

Also, we know that stated concerns by Republicans over Medicare's finances did not stop them from attempting to repeal the ACA, which would have devastated Medicare's finances had they succeeded. The Trump tax law even reduced payments into Medicare's trust fund. Just think about that one. That flawed, horrendous 2017 tax bill actually reduced payments into Medicare's trust fund.

Now, we are all going to work together on the hospital insurance trust fund going forward. We are going to work in a bipartisan way. We are going to extend the olive branch to our colleagues to do that, rather than create another artificial crisis.

The fact is, Democrats here in the Senate have been working constantly to uphold Medicare's finances, while upholding the promise of guaranteed benefits.

So we have a lot to discuss today. We are going to have a lively hearing, I am sure. I want to thank particularly Reverend Warnock for being here to discuss some of these crucial access issues today, and we are looking forward to Q&A.

Senator Crapo?

[The prepared statement of Chairman Wyden appears in the appendix.]

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator CRAPO. Thank you, Mr. Chairman, and welcome to our witnesses. I would like to especially thank Senator Scott for coming today and for highlighting the critical role that States play in our health-care system, as well as how we can work to address affordability issues for all Americans. He has proven that he knows how to do it.

As we look forward to our future in the health-care system, we have a responsibility to enhance care quality, to increase affordability, and to improve access to life-saving services and treatment options, from diagnostics to cutting-edge therapies.

Any reforms we adopt moving forward should build on what works within our current system, in addition to addressing hurdles to high-quality, low-cost health care. We should look to the unprecedented success of Medicare Part D and Medicare Advantage, which empower consumers to choose what works best for them.

In contrast with top-down, bureaucratic health-care models, these programs leverage choice and competition to expand coverage while lowering costs and enhancing care quality. Outside of Medicare, these same core principles have driven a wide range of promising reforms. Employers who provide coverage to roughly half of the population have adopted diverse tools and models to incentivize workers to seek out lower-cost, higher-quality care options.

States have adopted waivers and flexibilities to tailor their Medicaid programs to best meet their needs and strategic goals. Our health-care system has substantial room for improvement, but

these creative and market-based models provide a compelling blueprint for bipartisan reform.

We have seen strong bipartisan backing for proposals to expedite Medicare coverage for cutting-edge devices, to avoid a telehealth access cliff for seniors, and to cap out-of-pocket spending under Part D. I have also worked with multiple members of this committee on both sides of the aisle to ensure Medicare beneficiary access to tests that detect dozens of cancers at an early stage, reducing mortality and allowing for proactive care.

These types of policies have the potential to lower consumer costs while improving health-care outcomes. Unfortunately, some of the proposals currently under consideration risk moving in the opposite direction, with potentially dire unintended consequences for Americans. In addition to exacerbating inflation and weakening our economic recovery, the trillions of dollars in taxing and spending proposed by House Democrats would advance a range of policies that could hinder health-care outcomes and drive up costs, with taxpayers paying the burden.

The proposed drug price controls, imposed under the guise of negotiation, impose a threat to our global leadership in biomedical innovation. A recent University of Chicago study found that the price-fixing policies included in the bill would slash research and development funding by up to 60 percent, reduce the number of new drugs approved in the next 20 years by as many as 342, and trigger a loss of life as much as 20 times what the COVID–19 pandemic has inflicted on our Nation.

House Democrats have also proposed making their poorly targeted Obamacare premium subsidy hike permanent. This proposal does nothing to improve Obamacare plans or to address the underlying health-care costs.

The administration has also taken a series of steps that risk constraining consumer choices, delaying or weakening coverage, and undermining innovation. A number of States that had devoted months, if not years, to crafting comprehensive improvements to their Medicaid programs saw their hard work thrown away overnight as the administration rescinded their waivers, seemingly for political purposes.

This approach undermines the State-Federal partnership at Medicaid's core and creates tremendous uncertainty, in addition to eliminating opportunities for innovation. The administration also announced plans to roll back a popular rule aimed at expediting access to lifesaving medical devices for seniors. This regulation would be a game-changer for patients suffering from cancer, diabetes, and a broad range of other conditions. Disappointingly, it may never go into effect.

I stand ready and eager to work with the administration and members of both parties to pursue policies that improve health-care outcomes, expand access to lifesaving drugs and devices, and drive costs down for both the consumer and the taxpayer. From telehealth expansion to outcomes-based payment arrangements, there are endless opportunities for us to come together on common ground and meet the needs of the American people. We should set aside needless tax hikes and wasteful spending and instead take advantage of these opportunities.

Again, I thank our witnesses for their time, and I look forward to hearing from all of you.

[The prepared statement of Senator Crapo appears in the appendix.]

Senator STABENOW [presiding]. Well, good morning, and thank you very much, Senator Crapo. Our chair, Senator Wyden, has had to step out for a moment, so I will step in in his stead. We are going to hear from two colleagues, as we know: Senator Scott and Senator Warnock. I am going to pass the gavel back to Senator Crapo to introduce Senator Scott.

Senator CRAPO [presiding]. Well, thank you, Madam Chairwoman, and I appreciate that. I think Senator Scott really needs no introduction. The former Governor of Florida has extensive experience in working with these health-care issues, particularly the Medicaid and other issues, and showing how the kinds of solutions I have talked about in my opening statement work on the ground.

So, I want to thank Senator Scott for coming and sharing his expertise and the experiences that Florida has shown us can work.

STATEMENT OF HON. RICK SCOTT, A U.S. SENATOR FROM FLORIDA

Senator SCOTT. Thank you. Thank you, Senator Crapo. Thank you for holding this hearing on the Federal Government's role in our health system. It is an important topic, and one that is deeply personal to me.

Growing up, my family lived in public housing and often failed to have health insurance. My brother had a rare disease, and because my mom did not have health insurance, she had to drive to a charity hospital 4 hours away for his treatment. It was really hard on my mother.

I am a business guy, and everything I do is goal-driven. Everything I do is driven by my mother—by the experience of watching my mom struggle to feed five children. It is with that in mind that I set the following goals for government's role in health care.

We must ensure access to affordable health care. We must ensure families receive quality care. We must ensure that the available services for those truly in need are never inhibited by poor management of government programs. And we must never promise something we cannot afford.

None of us would make promises to our children we could not fulfill. We should not over-promise to the American public. With those goal sets, we also need to abide by some governing principles. Without these guidelines, we cannot measure our success in properly serving the American people.

First, we must acknowledge that more Federal control is never a solution. Our goal is to ensure American families have access to affordable health care that States individually choose.

We believe we must empower patients first with information transparency. Think about how easy it is to find the price of milk or an oil change. Now, how easy is it to find the price of a mammogram or the price of a common blood test?

The biggest fix for our health-care system is price and outcome transparency. Through price transparency, up-front pricing, and service and outcome measurements, consumers would be empow-

ered to choose suppliers that best fit their needs, and providers would be driven to offer services based on price, quality, and service, like any other important amenity.

How do we make choices now? We ask, is it in network? Is it close to our home or work? Those are not factors that drive quality, value, or lower prices. But real price transparency would be a paradigm shift away from providers and insurers to empowered consumers.

Second, for those who are truly in need, we need to achieve better outcomes to target subsidies to the consumer. We already do this through Federal food assistance programs. The government does not run the grocery store or the farm. Stores compete against each other for business, and that competition drives down the cost of food, increases the quality of food, and gives customers the freedom to choose.

Similarly in health care, it is critical that we do not allow government to be the provider or insurer for the American people. That is the role of the private market, and the private market can do it much better than government.

We need more competition and less government control. The core to this is two concepts: consumer choice and price transparency—two concepts completely absent from health care. Of course we need to ensure that those receiving these benefits truly qualify. As with all government programs, I am a strong supporter of requirements that recipients who are not disabled are actively working or looking for work. We cannot allow people to simply ride along on government programs with no qualifiers. It is not fair to the people who are working.

In addition, we cannot make promises to Americans that a country with nearly $30 trillion in debt, and staggering budget deficits, cannot fulfill.

Third, we must preserve Medicare and Medicaid. I believe Medicaid is best when States are allowed flexibility. The Governors should have control over how their States spend their State tax receipts and serve their vulnerable populations.

This is best done through per capita funding. It is a system that ensures total fairness and has complete flexibility. Let each Governor build a plan that reflects their priorities for vulnerable populations. There should be 50 State labs with custom plans for their priorities and populations.

For Medicare, we must ensure that we do not allow this program to go insolvent. Part A is already forecast to go bankrupt by 2026. Part B, which pulls directly from the Treasury, is going to be a larger and larger stress to our Nation's budget.

And let us remember, our Nation cannot meet its existing financial obligations. I have said about Social Security and other critical programs, we cannot allow cuts to the main services. This is just another example of the importance of eliminating reckless government spending and stopping the current path towards unsustainable debt we are on. This is the best way to protect Medicare.

In conclusion, everyone should have access to affordable care. As I said in my opening, everything I do is driven by my mom's experience. We can and must set a course for government to have a productive role ensuring access to affordable care for every American

family—families like mine growing up. But we have to do it by living within our means. Government's role should be absolutely limited. We cannot over-promise or under-deliver.

I look forward to working toward the goals I have outlined here today with each of you, and I thank you for allowing me to speak in front of the Finance Committee. Thank you.

Senator STABENOW [presiding]. Well, thank you, Senator Scott.

We will now turn to our colleague from Georgia. And I will say, since coming to the Senate, that Senator Warnock has given a voice to so many Georgians who lack health insurance coverage, and I know he is here today to speak about the importance of expanding Medicaid in States like Georgia that have yet to expand under the Affordable Care Act.

So welcome, Senator Warnock.

STATEMENT OF HON. RAPHAEL WARNOCK, A U.S. SENATOR FROM GEORGIA

Senator WARNOCK. Well, thank you so much, Senator Stabenow. And thank you for your leadership on so many issues. I am grateful to Chairman Wyden and Ranking Member Crapo for having me here today to talk about health coverage, an issue that is near and dear to my heart.

In my home State of Georgia, there are 275,000 Georgians in the coverage gap—this is an equity issue—47 percent of whom are Black, 9 percent who are Latino; 63 percent are working families. There are still 500,000 Georgians who are uninsured, 646,000 Georgians who would quality for free and affordable health coverage if Georgia joined the 38 other States and the District of Columbia in expanding Medicaid.

So our mission today for me is very clear. Today we have the opportunity to uphold the promise we made 11 years ago when we passed the Affordable Care Act, and provide quality, affordable, and comprehensive health coverage to 4.4 million Americans. And every day that we delay is another day that the least among us continue to suffer, as we debate whether and how to expand health-care coverage here in a State where lives are literally caught in the crosshairs.

We need to remember the faces of those who are affected by the policies we choose to create and not create, the human cost of the policy work we do here in the Senate. There are real consequences for real people when we fail to do what we were sent here to do.

So today I just want to recount a story that I told on the Senate floor not long ago, and I want to lift up the life of a Georgian who fought to expand Medicaid as she and other Georgians lived in the coverage gap.

Every time I talk about this issue, I think about Lorie Davis of Covington, GA. She was one of our heroes, and she spent much of her life serving her neighbors. She was a trauma nurse at the Grady Memorial Hospital, a hospital not far from my home and my church. I have seen the incredible work they do there every day.

But while working as a health-care professional in Atlanta at Grady Hospital, Lorie was diagnosed with pelvic adhesive disease. The chronic pain associated with this condition eventually pushed her to leave the nursing profession. And after that, while also

working to manage her own chronic condition, she struggled to maintain steady employment in restaurants.

During this time, Lorie could not afford health insurance. She made too much to qualify for Medicaid, but not enough to qualify for subsidies and afford other insurance plans. I am hearing a lot of talk about "choice." Choice is an illusion if you do not have the resources.

This left Lorie unable to purchase health insurance because it was financially out of reach. She lived in the health-care coverage gap. And she went without coverage for years, relying on her own medical training and free health-care clinics to treat her chronic condition.

And then in August 2020, Lorrie began feeling ill. Her condition got worse. And fearful of costs, she delayed seeking health-care coverage. Think about that. Lorie, who spent her life treating her neighbors in the Grady Memorial Hospital, living in the wealthiest Nation on the planet, delayed seeking health-care coverage because she could not afford it.

It seems to me that, as members of this body, we should be ashamed that in the richest Nation in the world, and a country with some of the best health-care coverage in the world, some citizens would choose not to seek treatment because they fear they cannot afford it, the price tag of lifesaving care.

So the next month, in September 2020, Lorie was admitted to the hospital with pneumonia. And while there, she learned she had lung cancer, a treatable condition had she received an earlier diagnosis. Put together, it was too much. And on September 17, 2020, Lorie passed away after her short battle with pneumonia.

Lorie's story would have been different, could have had a different ending, if she lived in Oregon, if she lived in Idaho, or most of the other States represented here. Can you imagine Medicare in 38 States? Can you imagine Social Security in 38 States? Conventional Medicaid in 38 States? We cannot imagine it because it is the law of the land.

Well, 11 years later, the Affordable Care Act is the law of the land. This is not about rewarding States with bad behavior. This is not about your State, or my State, a red State, or a blue State. This is about a very basic principle: in the United States of America, access to quality, affordable health care should not depend on where you live. And we should not allow State politicians to undermine that basic principle. Americans are literally dying for lack of health-care coverage. And so, let me be clear, as I wrap up. I am a little bit over time—forgive me, I am a Baptist preacher.

I am not asking for additional benefits for Georgia, or better coverage for those in Georgia, or those in the 11 other non-expansion States. I am asking for basic fairness and equity. I am asking especially that we give the working poor—because largely that is what we are talking about in the coverage gap—give the working poor a chance.

I am asking that every American everywhere in every State and every ZIP code have the same opportunity and the same right to live. Dr. King said that, of all the injustices, inequality in health care is the most shocking and the most inhumane. I believe that

health care is a human right, and in America it ought to look that way in every single State.

Thank you so much.

Senator STABENOW. Well, thank you very much, Senator Warnock.

We will proceed now with today's hearing. We have an excellent panel of witnesses who bring deep, substantial expertise on health-care coverage and Federal programs. I will introduce each one, and then we will proceed with their testimony.

First, Frederick Isasi, who is the executive director of Families USA, a leading nonprofit, nonpartisan health-care advocacy organization providing a voice for consumers, focused on improving access to affordable health care in America. Mr. Isasi previously served in roles at the National Governors Association and the Advisory Board Company. Prior to that, he served as Legislative Counsel on Health Care for Senator Jeff Bingaman, a former member of this committee. And he holds a juris doctorate from Duke University School of Law, a masters in public health from the University of North Carolina, and a bachelor of science from the University of Wisconsin. So, welcome.

Next we will hear from Dr. Douglas Holtz-Eakin, who is the president of the American Action Forum. From 2003 to 2005, Dr. Holtz-Eakin served as the Director of the Congressional Budget Office. He also has previously served on the Financial Crisis Inquiry Commission, as well as serving as the Paul A. Volcker Chair of International Economics at the Council of Foreign Relations. He earned his Ph.D. in Economics from Christian University and his bachelor of arts in economics and mathematics from Denison University. Welcome.

Then we will hear from Dr. Sara Collins, who is the vice president for health-care coverage and access at the Commonwealth Fund. Dr. Collins directs the Fund's program on coverage and access, and has led several multiyear national surveys on national health insurance. Prior to joining the Commonwealth Fund, she served as associate director and senior research associate at the New York Academy of Medicine. Dr. Collins received her Ph.D. in economics from George Washington University and her bachelor's degree in economics from Washington University.

And finally, we will hear from Dr. Linda Blumberg. Dr. Blumberg is an institute fellow in the Health Policy Center at the Urban Institute. Dr. Blumberg is an expert on private health insurance coverage, health-care financing, and health systems reform. Her recent work includes analysis of the implication of congressional proposals to repeal and replace the Affordable Care Act, as well as analysis of strategies to improve the ACA, and other policy proposals to expand health insurance coverage. Dr. Blumberg received her Ph.D. in economics from the University of Michigan—go Blue—and her bachelor of arts in economics from the University of Illinois.

So let us start first with Mr. Isasi, and we welcome you.

STATEMENT OF FREDERICK ISASI, J.D., MPH,
EXECUTIVE DIRECTOR, FAMILIES USA, WASHINGTON, DC

Mr. ISASI. Thank you very much, Senator Stabenow, Ranking Member Crapo, and members of the Finance Committee. Good morning, and it is an honor to speak with you. My name is Frederick Isasi. I am the executive director of Families USA. For over 40 years we have been a leading national nonpartisan voice for health care for consumers here in DC, in States, and State capitols.

I have been asked to testify on the current State of health insurance and health-care affordability across the country. Let me start by saying, looking back over the last 15 years, we have made some real gains, with much more work left to do.

For example, after the Affordable Care Act passed in 2010, 20 million people gained health insurance, many for the first time in their lives, either through new Medicaid access or through health insurance marketplaces. Over the next 6 years, coverage numbers continued to go up until 90 percent of our Nation was insured.

Then, in 2017, the Trump administration began slashing programs to help families find coverage, and authorized the sale of junk health insurance. All told, at least 2 million people lost coverage because of President Trump's policies. Most sadly, for the first time in over 20 years we watched as children lost coverage. Three-quarters of a million children became uninsured.

And then the COVID–19 pandemic hit our Nation so very hard. As millions of Americans lost their jobs, about 6 million people lost their employer-sponsored coverage. Almost three-quarters were able to secure coverage through Medicaid or the marketplaces. In fact, the only measurable increase in the uninsured occurred in the States that have refused to extend Medicaid to their poorest residents.

And let me describe to you what this experience is like for so many millions of Americans. Let me tell you about a very courageous woman named Della Young. In 2004, Della was diagnosed with lupus. This can be a really painful illness in which the immune system starts attacking the body. Patients are left with terrible weakness and fatigue, which without medical care worsens over time, and can even lead to organ failure or death. Because Della lives in Rhode Island and New York, she was able to access the critical services she needed through Medicaid and Medicare. Eventually, when her immune system attacked her kidneys, she was even able to receive an organ transplant.

However, in 2015, this all changed. Della moved to Georgia to be with her mother battling cancer. Georgia is one of the 12 States that has refused to extend Medicaid coverage to its poorest people. To help support herself, Della took a part-time job that included walking 4 miles, taking a train and two buses, so she could work her 4-hour shift.

Unbelievably, despite being far below the poverty level, Della was ineligible to receive Medicaid because her income was over the State allowance by less than $100. Let me say that again. Despite being far below the poverty level, less than $100 stood between Della and her ability to continue to receive health care.

So, what happened? Tragically, but predictably, Della could not afford to pay for the expensive medications, and she lost her kid-

ney. Della was forced to return to a life of costly and exhausting dialysis. She has even less ability to work, and as each day passes she goes deeper and deeper into medical debt. Della's mom lost her battle with cancer, and Della is now relying on a GoFundMe page to finance her care.

Simply put, it is a national disgrace. Nearly half of the adults in our Nation report they do not seek medical care when they need to because of cost. One-third indicate the cost of medical care interferes with their ability to secure basic things like food, heat, and housing. And a third, nearly 80 million people, skip doses or cut medication because of cost. And let us not forget, despite spending so much more than other wealthy nations, just about $4 trillion, our moms and babies die at much higher rates, live shorter lives, and our health-care system is much more likely to fail us, leading to a patient's death.

There is more to say, and it is good news. The American Rescue Plan you passed earlier this year made critical investments and improved the affordability of health care for hardworking families. As a result, nearly 3 million people signed up for coverage in the marketplaces, and, incredibly, average premium costs for these families were cut in half.

And now, the Build Back Better legislation gives all of you an opportunity to finish the job you started. You can deliver for our Nation's families. Making premium subsidies permanent, ensuring kids have 12 months of eligibility in Medicaid, and authorizing a Federal Medicaid fallback, are three critical ways to deliver for our families.

Tackling the outrageous and abusive prices charged by drug companies is also essential to making health care affordable, as is creating new dental, vision, and hearing benefits in Medicare. These are interrelated policies, and they are the greatest opportunity in at least a decade to help our Nation's families achieve health and economic well-being.

On behalf of Della and the tens of millions of Americans struggling with health-care affordability, let us get this done. Thank you very much for the opportunity to testify on behalf of our Nation's families, and I really look forward to your questions.

[The prepared statement of Mr. Isasi appears in the appendix.]

Senator STABENOW. Thank you so much.

We would now like to turn to Dr. Douglas Holtz-Eakin, and we appreciate your testimony.

STATEMENT OF DOUGLAS HOLTZ-EAKIN, Ph.D., PRESIDENT, AMERICAN ACTION FORUM, WASHINGTON, DC

Dr. HOLTZ-EAKIN. Senator Stabenow, Ranking Member Crapo, and members of the committee, thank you for the privilege of being here today to discuss health insurance coverage. I hope to make three brief points in my remarks, and I look forward to your questions.

Point number one is that the vast majority of Americans are covered by insurance. Over half, 54 percent, have employer-sponsored insurance. About 18 percent each are in Medicare and Medicaid. And 10 percent are covered by the individual market.

The second major point is that, with the onset of the pandemic, we saw government programs serve as a very effective safety net. With the coronavirus arrival on the North American continent, there were predictions of large-scale losses in employment. As we have seen, the overall uninsured rate has barely budged over that time. This is really attributable to both the fact that a lot of the job losses were concentrated in sectors of the economy where employer-sponsored insurances are more scarce—and so they were not covered to begin with—but also that Medicaid did its job and picked up some of those who lost their ESI.

Then the third point, and the one I want to really emphasize, is that for about the past 15 years we have had a conversation about health-care reform, the need for affordable coverage for Americans, and for lower-cost, higher-quality care. And for the past 15 years, I think the coverage discussion has dominated the thinking about government programs. And I would like to urge you to shift the focus somewhat to make sure that those programs deliver high-value care; that we see cost controls and improvements in quality in the programs that are so important to Americans.

For example, Medicare Advantage has been a great success story. About 41 percent of seniors are in MA, and it is forecast to be the majority of Medicare beneficiaries in the near future. It provides incentives for cost control because of its capitated features. Plus, with the improved quality metrics, especially outcome measures for high-quality care, MA can provide a vehicle for driving a better delivery system in the United States. MA offers individuals lots of choices for which plan they choose, and it is different in every part of the country because population and health care differs across the country. It is an excellent vehicle for driving high-value care in the U.S., and I urge you to focus on that.

As was mentioned in his opening remarks by the ranking member, Part D is a fantastic program, but it is now 15 years old and could use some additional reforms and improvements. There have been a lot of proposals to redesign the Part D benefits to accomplish really two big objectives.

The first would be to have a genuine cap on out-of-pocket cost and insulate our seniors from catastrophic costs from their prescription drugs. And the second would be to rearrange the reimbursement so that the taxpayers are no longer responsible for costs in the catastrophic region—that is about 80 percent of the cost of Part D right now—but instead, have insurers and manufacturers of prescription drugs liable for the cost in that region. That would give them an incentive to negotiate and develop cheaper drugs that didn't drive people into the catastrophic region, and also for prescription drug plans to manage seniors so that they did not have utilization that landed them in the catastrophic region.

That would enhance the basic features of private negotiation that have made the Part D program our most successful entitlement. Since Part D is also about 25 percent of drug spending in the United States, this would have spillover benefits across all of the economy and be a step in the right direction for preserving innovation, but reducing the cost of prescription drugs.

And lastly, we have seen a lot of success in managed care organizations in Medicaid in many States across the country. A system

of competition among Medicaid care organizations as a foundation for the future of Medicaid would offer the same promises as the system of competition in the MA plans and deliver higher-quality, higher-value care to the less affluent Americans.

So I applaud you for having this hearing. Coverage remains something that people care a lot about, and appropriately so, but what that coverage delivers in the way of the value of health care, I think should be an increasingly large focus of the committee and the Congress as a whole.

Thank you.

[The prepared statement of Dr. Holtz-Eakin appears in the appendix.]

Senator STABENOW. Thank you very much for your testimony.

And we will now hear from Dr. Sara Collins, who I believe is with us electronically.

STATEMENT OF SARA R. COLLINS, Ph.D., VICE PRESIDENT, HEALTH CARE COVERAGE AND ACCESS, THE COMMONWEALTH FUND, NEW YORK, NY

Dr. COLLINS. Thank you, Madam Chair, members of the committee, for this invitation to testify on the current status of employer health insurance coverage. My comments will focus on trends in enrollment, worker costs of employer insurance, and policy options to improve workers' coverage.

Employer health insurance is the backbone of the U.S. health insurance system, and it proved to be resilient during the pandemic. More than half the population under age 65, about 163 million people, get their health insurance through an employer.

This has changed very little over the last decade. Nearly all companies with 200 or more workers offer insurance to their employees. Small firms and employers in some sectors of the economy, including food services and retail, are far less likely to offer coverage.

Only about 6 percent of working-age adults reported that they lost employer coverage during the pandemic. This is because the hardest-hit industries were the least likely to offer coverage, and many companies who furloughed workers continued to pay at least part of their workers' premiums.

The Affordable Care Act's coverage expansions provided a safety net for people who lost employer coverage. The safety net was enhanced by Federal relief efforts such as the American Rescue Plan Act, enhanced marketplace subsidies, and marketplace special open enrollment periods. Two-thirds of workers who lost employer coverage gained other coverage. Still, nearly three in 10 became uninsured, which reflects ongoing holes in our coverage system and a lack of awareness of options.

The key issue for many workers with employer coverage is affordability. The U.S. has a health-care spending problem in commercial insurance plans, and many people with employer coverage are paying the price. New data out this month indicate that per-person spending in employer plans grew by nearly 22 percent over 2015 to 2019, outpacing bills, inflation, and GDP growth.

The data show that prices paid for health-care services and prescription drugs were the primary drivers, and accounted for nearly two-thirds of overall growth. These high prices are associated with

higher employer premiums. And, because employers share their premium costs with their workers, worker premium contributions and deductibles are also rising. Worker premium contributions and deductibles in employer plans together accounted for 11.6 percent of median household income in 2020, up from 9 percent in 2010.

Across the country, premium contributions and deductibles were 10 percent or more of median income in 37 States in 2020, up from 10 States in 2010. High deductibles are a barrier to care and leave millions of people underinsured and exposed to medical bills.

The Commonwealth Fund estimates that about one-quarter of people on employer plans have such high out-of-pocket costs and deductibles relative to their incomes that they are effectively underinsured. Across the country, average deductibles in employer plans relative to median income were 5 percent or more in 22 States. A deductible that is 5 percent or more of income is our threshold measure of someone who is underinsured.

In a 2020 Commonwealth Fund survey, more than one-third of adults with a deductible of $1,000 or more said they had not gotten needed health care due to costs. In the same survey, 40 percent of adults with a deductible of that size reported they had experienced problems paying medical bills, or paying off medical debt over time.

In a 2021 Commonwealth Fund survey among adults in employer plans who had problems paying medical bills or were paying off debt over time, 40 percent said they had received a lower credit score because of their medical bills; 40 percent had taken on credit card debt to pay their bills; and 35 percent had used up most of their savings to pay their bills.

Medical bill problems are endemic to our health-care system and are ruining many families' financial health. There are several actions that could help workers burdened by employer premiums and deductibles. They include making the American Rescue Plan Act marketplace subsidies permanent; providing comprehensive and affordable coverage for people eligible for Medicaid in the 12 nonexpansion States; increasing awareness among workers of their options to enroll in marketplace plans and Medicaid; fixing the Affordable Care Act's family coverage glitch, which is preventing millions of family members from accessing marketplace subsidies; and lowering the ACA's employer premium affordability threshold from 9.8 to 8.5 percent.

With this, if combined with the fix to the family coverage glitch, no one would have to spend more than 8½ percent of their income for health insurance, lowering deductibles and out-of-pocket costs in marketplace plans. In addition to the historic No Surprises Act, imposing stronger consumer protection rules for people struggling to pay their medical bills, addressing the high commercial provider prices that are the primary driver of employer premiums and deductibles, and finally, developing an auto-enrollment mechanism, would help people enroll and stay enrolled in comprehensive coverage.

Thank you.

[The prepared statement of Dr. Collins appears in the appendix.]

Senator STABENOW. Thank you very much. We very much appreciate your testimony.

And finally, we will hear from Dr. Linda Blumberg. Welcome.

STATEMENT OF LINDA J. BLUMBERG, Ph.D.,
INSTITUTE FELLOW, URBAN INSTITUTE, WASHINGTON, DC

Dr. BLUMBERG. Thank you for inviting me to address current issues related to health insurance in the U.S. While I am an employee of the Urban Institute, the views expressed in this testimony are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

Research has demonstrated that the Affordable Care Act has increased health insurance coverage in the U.S. among the nonelderly by more than 20 million people. The enhancements of premium tax credits provided by the American Rescue Plan Act have increased coverage further, albeit temporarily given the limited duration of the enhanced credit period. These have also improved affordability of insurance coverage and increased access to care for millions of Americans.

As a result, the U.S. health insurance system provided a stronger safety net during the pandemic and economic downturn than in prior recessions. According to the Urban Institute's Health Monitoring Survey, the number of non-elderly adults with employer-based insurance fell by approximately 5½ million people between March 2019 and April 2021. Yet, unlike prior recessions, the number with Medicaid increased even more.

As a consequence, the number of uninsured held steady, instead of increasing nationwide. However, while nationwide data is encouraging, the number of uninsured rose in non-expansion States because smaller shares of people who lost employer coverage were eligible for Medicaid. Still, nationwide the private non-elderly insurance marketplaces are by all indications fundamentally stable.

In 2021, the national average benchmark premium fell for the third year in a row, with average decreases in 43 States, only one State where the increase was more than 6 percent, following very large premium increases in 2018. In addition, insurer participation in the marketplaces has increased since 2017 in many population centers. However, in areas with lower insurer participation and/or consolidation among health providers, premiums and premium growth tends to be higher.

Even recognizing the successes, significant gaps remain in the health insurance system, for more than 3 million people living below the poverty line, and 1.2 million near-poor people, are uninsured and ineligible for any financial assistance because they live in States that have not expanded Medicaid eligibility

In addition, ARPA services temporarily increased our marketplace subsidies. My Urban Institute colleagues estimate that the number of uninsured nationally will reach 30 million in 2022. Conversely, they estimate that making the ARPA subsidies permanent and extending them to lower-income people in non-expansion States would decrease the uninsured by another 7 million people at a net Federal cost of $27.7 billion in 2022 dollars, or $333 billion over 10 years. In addition, these estimates indicate that such policies would increase marketplace enrollment while decreasing marketplace premiums by 18 percent on average, because of the relatively better average health of the new enrollees.

Taking lower premiums and out-of-pocket costs into account, the average per-enrollee health-care cost for those insured through the marketplaces would be over $1,100 lower per year.

While such opportunities exist with this coverage, further action also must be considered, because the ending of the national public health emergency will also end the requirement that States keep people enrolled in Medicaid. And this transition poses future challenges for coverage.

Urban Institute estimates indicate that Medicaid enrollment could decrease by as many as 15 million people during 2022, once the PHE-related maintenance requirement ends, including 8.7 million adults and 5.9 million children. These numbers are partly offset by the projection that one-third of those adults who qualify for subsidized private health coverage are in the marketplaces. About two-thirds of the children would be eligible for assistance, much of it through CHIP.

However, others have postulated that the number losing Medicaid coverage at the end of the PHE could exceed 15 million people, given the difficulty of contacting still-eligible people to reverify and renew enrollment when they have not been in contact with the Medicaid system for close to 2 years. Thus, the risk of a significant increase in the number of people uninsured following the end of the PHE is substantial, and such risk merits legislative and administrative consideration.

As I have outlined, permanent enhanced premium tax credits should encourage more people to move from Medicaid to the marketplace once they lose Medicaid eligibility. Further, aggressive outreach and enrollment efforts at the State and Federal levels, in addition to streamlining Medicaid redetermination and enrollment processes, are among viable options available to address the potential for a near-term increase in the number of uninsured Americans.

Thank you for the opportunity to share information with you on these important issues, and I would be happy to answer any of your questions.

[The prepared statement of Dr. Blumberg appears in the appendix.]

Senator STABENOW. Well, thank you so much to all of our witnesses, and we will now proceed with comments and questions from the committee.

First let me start by saying that whenever we have a discussion—and I have been involved in the committee now for a long time, and in health-care coverage policy for a long time—there really is a fundamentally different view between Democrats and Republicans about health care and about, is it a fundamental right? Is it about privilege if you have a job that has insurance, if you are able to afford health care? There is just a fundamentally different view that gets the same kind of arguments coming out all the time about whether or not we should act and move forward on things.

Fifty-five years ago, only about half of the seniors over age 65 had health insurance that would cover a stay in the hospital. And far fewer had insurance that would cover surgery or outpatient physician visits. And at the time, the private insurance industry could just refuse to cover higher-risk, older people. They would get

sick. They would get dumped from their insurance plan, and it was likely if you got sick, you could end up in bankruptcy, which means that the elderly were the group most likely in the United States to be living in poverty. That is what was happening then. And many hospitals around the country were rigidly segregated as well.

We believe, as Democrats, that it was critical to expand access to quality, affordable health insurance. And after decades of fighting for it, in July 1965 it finally happened with President Lyndon Johnson signing Medicare and Medicaid into law.

In the decades since, we have continued to fight for expanded coverage and benefits. And as we have talked about, in 2010 the Affordable Care Act, the biggest improvement to health care since the creation of Medicare and Medicaid, brought insurance to 31 million Americans. And that includes 14.8 million Americans through the expansion of Medicaid coverage. In my State, that is about 950,000 people who are now covered. And I should say, this was a bipartisan effort in Michigan, which I appreciated very much.

I share Senator Warnock's concerns for the millions of Americans left without health care because of the refusal of Republicans in 12 States to expand Medicaid. So, expanding Medicaid is the right thing to do. It is the smart thing to do. It also saves money in Michigan, because people are not going to emergency rooms who do not need it, who just need to see a doctor. So we have seen hundreds of millions of dollars in savings.

But this year then, if I could say a bit more, we addressed health care again in the American Rescue Plan, lowering health-care premiums in insurance exchanges by about 40 percent—a pretty big cut. And we created an option to provide 12 months of post-partum coverage under Medicaid.

And I will say, as we have been going through this, that one bright light I appreciate so much is the bipartisanship that we have done together on behavioral health. Mental health and substance abuse treatment should be viewed as health care, funded as health care. I appreciate Senator Blunt and my colleagues on this committee who have been working together to make progress on that.

But the bottom line is, there is just a fundamental difference in how we view health care moving forward.

Mr. Isasi, what do you think are the biggest gaps right now in the Medicare program? And what should we be doing about them?

Mr. ISASI. Thank you so much, Senator Stabenow. The three main things that I would point to—first, let us be really clear. We have heard this over and over again. Right now the biggest crisis in American health-care coverage is price. We cannot currently negotiate fair drug prices. We have got to tackle the abuses of drug companies. It is very popular. The American people want this across the political spectrum. We have got to get this done.

Second, Medicare does not cover essential services like dental, vision, and hearing benefits. It does not make any sense. These are core to the needs of Medicare beneficiaries, in particular seniors. We have got to solve that problem.

And then finally, I agree strongly with my colleague, Dr. Holtz-Eakin. Currently the way that we are paying for health care

incentivizes waste, and it incentivizes high-margin, high-profit services over actual health. We have got to change the way that we pay for health care.

I do want to say, Medicare Advantage is not the answer. We know that, underneath Medicare Advantage payments, what we see is just traditional fee-for-service volume-based payments. We have to actually make sure that the new incentives are reaching the doctors, the nurses, the hospitals, and making sure the people who are actually improving health, maintaining health, and solving health problems do well under the system, and the people who are just driving towards volume and high price fail.

Thank you very much, Senator Stabenow.

Senator STABENOW. Well, thank you very much.

And our distinguished chairman has returned, trying to be two places at once. I think we need to figure out how to do "beam me up, Scotty" so we can all do that at the same time. But, Senator Wyden?

The CHAIRMAN. In fact, Senator Crapo, if we could reverse it and you could start with questions, and then I would go, just for purposes of breath-catching——

Senator CRAPO. I would be glad to let you catch your breath, Mr. Chairman.

Dr. Holtz-Eakin, I want to start out with what is a big threat to the ability of our country to be able to deal with the cost of health care, and that is the impact of some of the proposals before Congress for some massive new taxation and spending that is going to have macroeconomic impacts on everything, including the health care that we are talking about today.

In addition to numerous and major expansions of government into health markets, the administration's Build Back Better plan contains many concerning tax proposals that threaten the economic recovery in the short term, and threaten economic growth and American competitiveness in global markets in the long term.

Your organization provided results in April from economic models to assess the macroeconomic implications of the Build Back Better plan, including the tax provisions. The tax proposals in the plan appear from that analysis to have significant negative macroeconomic implications.

Can you discuss those findings, please?

Dr. HOLTZ-EAKIN. Certainly. We heard during the course of the campaign for the Presidency about the Build Back Better plan, so in the aftermath of the election we commissioned this study so that it was done by some scholars at Rice University using models that are essentially identical to the Joint Committee on Taxation's macro models.

So we have some idea of what the implications of those proposals would be. The basic findings are that imposing trillions of dollars in new taxes is a severe headwind to economic growth and would diminish it considerably. I think there was a lot of consensus on that. But what we heard from the other side was that the spending programs are going to be so effective that they are going to outweigh that, and we will get better economic growth.

So we had them literally modeled, taking all the money and spending it—no deficit finance—spending it entirely on productive

infrastructure and R&D, the highest return things that they could identify in the research literature, and the net effect was negative for the economy over 10 years.

And so, if you compare that modeling exercise—lots of tax increases, highly targeted and effective spending—with what is actually in the legislation, the spending is far less targeted on productive infrastructure and R&D. And so the impacts are going to be even more negative than our model indicated.

Senator CRAPO. All right; thank you. And I think it is very important to understand that we have to stop the injuries to the economy if we want to deal with helping people afford health care.

Let me move again, Dr. Holtz-Eakin, with you, to drug pricing. Driving down premiums and expanding coverage requires us to tackle not just the price of insurance products, but also the underlying cost of care. When we look at the key drivers of health-care spending growth, there is no doubt that certain specialty prescription drugs have a substantial impact, at least when they first come to market. That said, the nonpartisan Congressional Budget Office has repeatedly noted that medications can also play a crucial role in reducing costs elsewhere in the health-care system, including at more expensive sites of care.

Moreover, once products go off patent and their exclusivities expire, the prices generally drop dramatically. And I would note that currently, more than 90 percent of all prescriptions are filled with generic drugs, not patent-protected brand-name products.

The House Democrats' proposed drug pricing controls, unfortunately, would undermine the current balance, drastically reducing the number of new treatments coming into the market and deterring innovative R&D.

In your view, Dr. Holtz-Eakin, what impact would the House drug pricing proposals have on health-care access and quality? And what types of policies do you see as the right ones? I know you touched on this, talking about Part D in your statement, but would you just respond to that generally?

Dr. HOLTZ-EAKIN. Certainly. I am quite concerned about the proposals that were in H.R. 3 and are now in the Ways and Means-passed legislation. Those proposals essentially—the international reference price is a price control. The supposed negotiation with the Secretary of HHS is really not a negotiation. The threat is a 95-percent sales tax on domestic sales. It is not deductible for income tax purposes, so the effective rate is over 100 percent.

So essentially, you know, you have the Secretary in the position of being judge and jury. It is just demanding the price they want. We know from looking at other countries that, while prices are lower, access to medicines is much more limited. In many cases, the most innovative therapies do not arrive for 2 and 3 years, if they arrive at all. In many cases, they do not.

In the U.S., 90 percent of innovative therapies are on the market in 3 months, if people have access to care. So, while it looks like those other countries are not paying much, they are paying for it in less high-quality care, less access to the most innovative therapies. And I think the reforms that I outlined on Part D would be a very good starting point.

They are bipartisan in nature. They have been in legislation proposed by Democrats, legislation proposed by Republicans. Presidents have supported them. They would improve the negotiation incentive in Part D, and thus lower prices broadly going into the commercial markets as well. And they would protect seniors from catastrophic costs, and that is overdue.

So, I think that is a good place to start. It does not threaten innovation in the system. It does promise access to high-quality drugs for seniors.

Senator CRAPO. Thank you.

The CHAIRMAN. Thank you, Mr. Chairman, and thank you for the fact that, whenever we have to juggle in the morning, you are always trying to help out.

I want to make sure we get a quick and accurate accounting of the Medicare ledger, because we have heard, back and forth, various kinds of analyses.

Dr. Collins, you have been an expert in this, and I want to have you lay out for us, on the record, a direct response to the key question. And the key question is, would proposals like a public option or a dental, vision, and hearing benefit in Medicare Part B have a negative impact on the Medicare Part A trust fund?

I would like you to give us a "yes" or "no" answer to that question, and then if you could, amplify why that is the case. Because I think that is absolutely central to our discussion going forward. And I had mentioned, colleagues, that we are kind of looking back a little bit today to the accomplishments of the Affordable Care Act. And I said, if nothing else had been done in the Affordable Care Act other than finally ending the insane proposition that you discriminate against people with preexisting conditions, that would have been an incredible accomplishment. And you listed others.

So we are talking about looking back, and we are talking about looking forward. And I see our friend, Senator Casey, who is a huge part of looking forward, because he has got us on the cusp of an incredible change with respect to seniors and the disabled, frankly one I have dreamed about since the days when I was codirector of the Oregon Gray Panthers.

So, exciting days are coming up. And part of what we want to make sure we are clear on today is where we stand on some of these key issues like the Medicare Part A trust fund. So my question for you, Dr. Collins, apropos of just briefly restating it: would these proposals like a public option, or dental, vision, and hearing benefits in Medicare Part B, have any negative impacts on the Medicare Part A trust fund?

Dr. COLLINS. No, they would not, because they are financed out of other revenue sources. So the trust fund would not be affected because it is for Part A benefits.

And to your point on the Affordable Care Act, those three important provisions extended the Medicare trust fund solvency and reduced the scheduled updates to Part A providers, reducing the Medicare disproportionate share payments and also, importantly, increasing the payroll tax for upper-income households. So the Affordable Care Act had a very positive impact——

The CHAIRMAN. Dr. Collins, just one other point on that, because I have already said that we are all in a position—and Senator

Crapo and I have worked on so many big issues in a bipartisan way, and in fact Senator Grassley and I teamed up on the prescription drug issue. I think we ought to be teaming up again on the question of the Part A trust fund going forward.

And just so we are clear, Dr. Collins, I think you said, had the Affordable Care Act been repealed—as there was an effort to do in the Senate—that would have hurt the Medicare Part A trust fund further. Is that correct?

Dr. COLLINS. That is correct.

The CHAIRMAN. All right; thank you very much. It is very helpful that we really, colleagues, have an accurate and straightforward accounting of the Medicare ledger by dint of Dr. Collins's comments.

So let me ask you one other question in the short bit of time that I have. And that is, it seems to me that the Affordable Care Act was an extraordinary lifeline to millions of Americans during the pandemic.

We were hit like a wrecking ball with this virus that nobody imagined, and it seems to me that the Affordable Care Act and the American Rescue Plan stepped in and served as a lifeline for families during the pandemic and economic downturn. Families who had a loved one at home were trying to figure out how they were going to deal with all the costs. When job losses mounted, workers not only lost their jobs. The Affordable Care Act marketplaces and Medicaid were there during that pandemic to make sure that millions of families had access to the health care they needed.

So my question to you, Dr. Blumberg, is—you know, I do not think you can just go out and magically recession-proof everything, but I think we would be very much better off if we knew the details of how Medicaid and the ACA premium tax credits for insurance coverage met the needs of American families during the pandemic.

Dr. BLUMBERG. Sure. Senator, this recession related to the pandemic is really the first test of the safety net that was enhanced and strengthened by the Affordable Care Act. And the ARPA subsidies just enhanced that further. So it was the first time in a recession in memory where the number of people uninsured did not increase.

In fact, the only areas in which the number of those without health insurance coverage did increase was in the States that had not expanded Medicaid under the Affordable Care Act. So, while employer-sponsored insurance did fall significantly, as it has in every prior recession on record, the number of uninsured nationally stayed basically constant because some people moved into a marketplace coverage that was there and available to them, and then people who lost much more income were enrolled in the Medicaid program.

So, without it, we would have seen a significant increase in the uninsured, as we have over the years. But ARPA subsidies made that coverage even more affordable to people during this crisis. And so that was also important.

The CHAIRMAN. Thank you. And I thank all our witnesses. We have been working with the leadership and all the members this morning in trying to deal with Build Back Better, and I apologize for being out.

Senator Grassley is next. I am going to go vote. And, colleagues, what we are going to try and do is keep this moving. A number of colleagues on both sides of the aisle have asked that we hold this hearing to kind of start airing ideas for the future. That is the point of it.

Senator Grassley, I am going to run and vote. Thank you for your courtesy. You are next, and let me also give you the list so you have a sense of the order.

Okay; thank you, colleagues.

Senator GRASSLEY. Most of my questions will be to Dr. Holtz-Eakin because of his background being CBO Director. I have worked for 3 years to pass a bipartisan bill to lower prescription drug prices. While Democrats attempt to advance their partisan drug-pricing program, I hope that common sense will prevail and that we will pass a bipartisan prescription drug bill.

I have engaged with colleagues on both sides of the aisle in both the House and Senate. All of the Republicans and Democrats I have contacted have expressed eagerness to find a solution to meaningfully lower prescription drug prices.

Dr. Holtz-Eakin, for decades the Congressional Budget Office, the nonpartisan referee, has said government drug price dictation does not save money unless you restrict access to patients through limiting formularies.

First, is that correct, Dr. Holtz-Eakin?

Dr. HOLTZ-EAKIN. Yes, that is correct.

Senator GRASSLEY. Okay. Also to you: is government drug pricing negotiation a real negotiation? Or is the government dictating prices?

Dr. HOLTZ-EAKIN. It is the government dictating prices. And you cannot do a real negotiation unless you have a restriction on the formula, or a restriction for access in some way. Or, in this instance, another lever, which is a 95-percent tax on sales in the U.S. market. So that is not a negotiation, that is dictating the prices.

Senator GRASSLEY. Okay. I would note that, in 2019, this committee held three hearings on prescription drug pricing, followed by a markup, along with numerous other bipartisan conversations. Given the bipartisan interest in this committee in lowering prescription drug costs—and many questions the American people ought to have answered about the package the majority is now considering—I am very curious if this committee will be holding any hearings on prescription drug pricing in the future.

So getting back to you, Dr. Holtz-Eakin, President Obama's own OMB Director has said this about changes to the noninterference clause, quote: "Negotiating ability alone is largely feckless," end of quote.

Can you save money if you do not limit access, like restricting the formulary, or dictating prices based on domestic or international reference pricing?

Dr. HOLTZ-EAKIN. No. Every CBO Director since the American Modernization Act passed has come to the conclusion that there is no additional genuine negotiating leverage that the Secretary of HHS would have. Prescription drug plans have lots of beneficiaries, but they have market shares, and they have formularies which they can offer as a way to expand their sales, and that is how you

get a lower price. The Secretary of HHS does not have any of those things.

Senator GRASSLEY. Dr. Holtz-Eakin, in your previous testimony you stated that government price dictation would restrict access if you want to achieve savings. Academic research has also confirmed that. Can you expand on how patients will be hurt by the proposed government drug pricing dictation policy?

Dr. HOLTZ-EAKIN. The spirit of these proposals has always been to look to other countries as the reference price as a starting point of dictating the prices. And, if you look at the experience in those countries, the way prices are lowered is, the government is saying "no" to many drugs. And they are not available to their citizens.

As we know—and the ranking member pointed this out; it is an important point—there is not a general drug pricing problem, but we have high prices for some specialty drugs on patent, largely oncology drugs. Those are the most innovative, most effective modern treatments. And their arrival on the market in the U.S. comes in the first 3 months. By and large, they simply do not arrive, and certainly not in a timely fashion, in these other countries.

So we would be saying to our citizens, "We do not want you to have the best care." That is what those proposals would produce.

Senator GRASSLEY. Okay.

I think maybe you have just now answered this question, but let me ask it anyway. If we disincentivize the private sector to produce cures, will we give up our status as the world's leading research and development country?

Dr. HOLTZ-EAKIN. Yes. We are the leading biopharmaceutical innovator on the globe, but that is not our God-given right. It is due to the incentives that are in the system. And if we went ahead with these proposals, there would be less incentive for venture capitalists to fund startups that have generated these advances. Those startups often then sell them to the larger pharmaceutical companies. They would not be interested in buying them because there would be no return. And the innovation would dry up. It is a real threat.

Senator GRASSLEY. Nonpartisan independent analyses show changes to the noninterference clause hurt innovation and cures. CBO says H.R. 3 would reduce the number of drugs created. One CBO report says 38 fewer drugs this decade and next. Another report from the University of Chicago says we could miss out, with 342 fewer drugs in the next 20 years.

Should we be pursuing policies that produce less cures?

Dr. HOLTZ-EAKIN. No. Directionally, everyone agrees there would be fewer cures. The only debate is over how many and how innovative they might be.

Senator GRASSLEY. Thank you.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chair. Let me thank all of our witnesses who are here in our committee room, and those who are with us virtually, for your help on these issues. I appreciate the fact that we have an innovative health-care environment here in America. The question is, are all of our people getting access to it?

And I appreciate that we have a robust pharmaceutical industry in America that we want to keep, but there is something to be said

about competitive pricing. There is something to be said about those that are in this very complicated structure that we have and the profits they are making, and are they giving us value added for the profits that they are making.

So we want to keep the innovative environment here in America, but we also want to pay a fair price. And we recognize that the technologies that are available are not available to all in America.

So I want to ask the question—maybe I will start first with Dr. Collins—and, Mr. Isasi, if you want to add some comments to this, I would appreciate it.

Those who are underinsured, or uninsured, it is a problem for them individually in getting access to our care. But it also presents a problem for our system that causes disruptions and inefficiencies in our health-care system. The Affordable Care Act reduced the number of uninsured in America by about 20 million, if my numbers are correct. We still have uninsured in America, and there are higher percentages in underserved minority communities. We have the underinsured, and that is one of the reasons why the expansion of Medicare to include dental, vision, and hearing becomes an important issue to deal with the underinsured.

My question to you is, can you give us some additional tools that we can use to reach particularly those in underserved communities, minority communities, to make sure that they have adequate third-party coverage? What recommendations would you make for us to be able to deal with that gap we have in our system today?

Dr. COLLINS. Thank you, Senator. One, the Affordable Care Act had a very significant impact on reducing disparities in coverage across racial and ethnic groups. That happened in all States, but the States that saw the biggest improvements in coverage, and the biggest decreases in disparities, were Medicaid expansion States. So expanding coverage in all States would help further reduce those disparities that are endemic—have been endemic to our system—and that the Affordable Care Act has addressed so well.

On the underinsured side, this is an ongoing, chronic problem in employer coverage and in individual market plans for people who are outside of the cost-sharing reduction subsidy threshold. So extending the cost-sharing reductions in marketplace plans further up the income scale would help reduce deductibles in marketplace plans, and allowing more people in employer plans to access those enhanced protections in the marketplaces would also address the underinsured issues that we constantly see in employer-based plans, and which have been growing over time.

Senator CARDIN. Thank you for that.

Mr. Isasi, I want to perhaps expand on that a little bit. Maybe you could share with us the impact from the coming Medicaid redeterminations at the end of the public health emergency, and how Congress can support individuals and States to prevent a significant disruption and coverage loss.

Mr. ISASI. Thank you very much, Senator Cardin, for that really important question. Many folks may be surprised to know that currently, because of the public health emergency, States are under what is called a maintenance factor requirement, which means that they cannot disenroll people from Medicaid because we are in a public health emergency.

When that ends—right now it is just extended until January—but when it ends, States will have to go through a redetermination process. What we know from history here is that when that happens, thousands, and across the country millions of people who are eligible for Medicaid, who should be getting it, lose coverage.

They lose coverage because—really it is a paperwork, administrative burden. All of a sudden they may have moved home. They may have language access issues. They may not have access to the Internet, so they cannot actually maintain their enrollment.

And so it is really important that, as we move into this period where the redeterminations will be made, that we do so thoughtfully and carefully. And one of the most important things we need to do, particularly for kids, is ensure that they have continuous eligibility. It is currently an option for States. We should make sure that all kids automatically have continuous eligibility as the public health emergency ends, and for 12 months—and also consider extending that to adults.

Senator CARDIN. Thank you. I appreciate that.

Thank you, Mr. Chairman.

Senator CRAPO [presiding]. Senator Cornyn?

Senator CORNYN. Thank you, Mr. Chairman.

Dr. Holtz-Eakin, my figures here indicate that about 90 percent of Americans have health insurance coverage. And I know the goal of our friends, and frankly all of us, is to make sure that everybody has access to quality health care. But one of the problems with getting everybody health care is, we have a large non-citizen population here in our country, roughly estimated to be 11 million people who did not come here through the regular legal process.

I believe, and I bet you do too, that legal immigration has been one of the best things we have going in this country, but illegal immigration creates a crisis like we are seeing at the border right now, when we learned this morning that the number of people detained since the Biden administration came into being is about 1.7 million migrants. It is the most since 1986.

The reason I mention that is that the more undocumented, or illegal migrants that come into the country, the worse our uninsured or uncovered population problem is. Do you agree with that?

Dr. HOLTZ-EAKIN. That is correct.

Senator CORNYN. So actually, the policies of the Biden administration are making the problem worse, not better.

Dr. HOLTZ-EAKIN. Certainly that 1.7 million is an extraordinary flow.

Senator CORNYN. Yesterday—you may have missed it because you had other things to do—but we had the nominee for Customs and Border Protection here in front of the committee, and I asked him about the policies of nonenforcement announced by Secretary Mayorkas, where he said that no one will be detained or removed from the United States simply for the offense of illegal entry into the country. And he agreed with me that that was one of the pull factors that encourages people to come to our country.

Would you agree that things that have been proposed by the Biden administration like cash tax credits, things like additional health-care coverage benefits, and other welfare benefits, provide

another part of the pull factors that encourage people to come to the United States by other than legal means?

Dr. HOLTZ-EAKIN. Certainly, the pursuit of a better standard of living, whether it be through illegal employment or benefits from the government, is a big part of the pull factor.

Senator CORNYN. And I guess the solution by our friends across the aisle is just to continue to use tax dollars to encourage and incentivize illegal immigration by providing those benefits. And I bet you believe that we have spent a lot of money, and that our current level of debt as a result of the pandemic is unsustainable, and that additional deficit spending or debt is probably not a great idea. Do you agree with that?

Dr. HOLTZ-EAKIN. I am concerned about that. We entered the pandemic with a structural deficit that would put the U.S. on an unsustainable fiscal trajectory. We have added an enormous amount of debt so that it now exceeds the size of the economy during the pandemic. And the proposed legislation—if all the programs were put in place for 10 years, you would have $5.5 or $6 trillion of spending, and we would have $2 trillion of taxes. That is a structural deficit that is even larger and accelerates the trajectory that is already so dangerous.

So I think that would be a misstep from the viewpoint of macro policy and fiscal policy.

Senator CORNYN. And that is on top of the annual increases in mandatory spending for entitlements, things like Medicare and Social Security, that threaten ultimately the solvency of those trust funds.

Let me ask you about the enhanced premium tax credit that the administration is proposing. CBO says it would lead to a reduction of 1.6 million people with employer-provided coverage. In other words, instead of their employer providing the coverage, then taxpayers would be paying for it.

All of these tax credits are paid to private insurance companies, are they not?

Dr. HOLTZ-EAKIN. Yes.

Senator CORNYN. And in fact the Affordable Care Act was one of the biggest boons to insurance companies that Congress has granted in decades. They benefited enormously, did they not?

Dr. HOLTZ-EAKIN. They certainly did.

Senator CORNYN. Are you aware of the fact that of the people who would be covered by the enhanced premium tax credit, that 65 percent of those would have incomes over 400 percent of the Federal poverty level? Twenty percent would be at 600 percent, which is $159,000 for a family of four. And 10 percent would be at 700 percent of the Federal poverty limit. In other words, families of four making $185,500 would receive this taxpayer subsidy in the form of the premium tax credit.

Would that make our debt problems and our fiscal problems worse, instead of better?

Dr. HOLTZ-EAKIN. Yes. And as a whole, the proposal has that character. These are large increases in the structural deficit that we already have, and are a step in the wrong direction from a fiscal point of view.

Senator CORNYN. Thank you.

Senator CRAPO. Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman. I appreciate having a chance to ask questions of this panel. I want to thank the panel for being here, and for your holding this hearing.

I am glad that we are here to talk about the importance of health coverage and the need to achieve universal coverage, which should be a priority for every member of the U.S. Senate, I think. It has been over 4 years since we had a dedicated hearing on coverages. Unfortunately, at that moment we were in the middle of combating an unsuccessful threat to the Affordable Care Act, and millions of Coloradans who have been affected are deeply grateful that it failed. And on that note, Mr. Chairman, I would ask consent to insert a longer statement into the record highlighting the times that Senator McConnell actually attempted to take away the Affordable Care Act.

Senator CRAPO. Without objection.

[The prepared statement of Senator Bennet appears in the appendix.]

Senator BENNET. Thank you, Mr. Chairman.

I would also like to ask consent to insert into the record a new National Academy for State Health Policy analysis on 13 SBMs (State-based marketplaces) and the impact of enhanced premium support authorized under the ARPA.

Senator CRAPO. Without objection.

[The statement appears in the appendix beginning on p. 60.]

Senator BENNET. Thank you, Mr. Chairman. I appreciate it. Again, this is a real opportunity to highlight the benefits of our work on the ACA and how improvements have increased coverage and reduced the cost to so many families and other folks across the country.

I am glad that earlier this year the American Rescue Plan made some changes to the premium supports for individual marketplace plans that were identical to changes that I proposed in my Medicare-X Choice Act with Senator Kaine.

In Colorado, this made a significant difference. After the law went into effect, there was a 50-percent reduction of premium prices on average. And in fact, the law reduced premium payments entirely for some people.

Nearly three in four customers on the Connect for Health Colorado State exchange received financial support. For example, a barista in El Paso County shared with me that the improved support saved her $115 a month. She is able to purchase a silver level plan and can now afford a crib and other supplies for the baby she is expecting.

An uninsured couple showed up to an enrollment center in Colorado and left in tears when they found out they could obtain high-quality health insurance for $2.38 a month. There are countless stories about how meaningful the support is, and it is critical that this be made permanent.

So, Dr. Blumberg, your testimony had some critical data on this premium support. Could you share with us how these premium subsidies under the ACA, and further expanded under the American Rescue Plan, have improved coverage and reduced cost?

Dr. BLUMBERG. Sure, Senator. By Urban Institute estimates, the ARPA subsidy enhancements reduce the average household spending on health care for families by 23 percent, for those buying in the non-group insurance market. That is about $1,140 per enrollee.

For low-income enrollees, spending is reduced by 32 percent on average. This obviously makes the insurance more accessible for many people, and could decrease the uninsured by, in our estimates, over 4 million people, if made permanent.

And lowering the premium costs through the premium tax credit enhancements also provides them extra funds if families should want to use that to buy coverage that has lower cost sharing requirements than they would otherwise.

Senator BENNET. For the last 19 months we have faced an unprecedented public health and economic crisis. Early in the pandemic, there was deep fear that the uninsured rates would skyrocket. For example, during the economic crisis in 2009, 14,000 people were losing coverage every single day. The uninsured increased by 4.3 million. Although the type of insurance may have changed, the uninsured rate remained steady. And I believe it is a product of the ACA creating a more resilient system.

Dr. Blumberg, I do not have much—and, Dr. Collins, as well—I've only got about a minute left, but I know that both of your organizations have done research on this. Do you agree that the ACA played an essential role in creating this stability?

Dr. BLUMBERG. Absolutely, because prior to the ACA, when people lost their employer-sponsored insurance coverage, very few of them would be eligible for financial assistance or other coverage, and this time it was there through Medicaid and the marketplace.

Dr. COLLINS. And I would agree with Professor Blumberg.

Senator BENNET. Thank you, Dr. Collins, and I will yield back, Mr. Chair, the last 20 seconds to my colleague from Louisiana.

Senator CRAPO. Thank you, Senator.

Senator Cassidy?

Senator CASSIDY. Thank you.

First I want to address—I am sorry she is not here—a couple of things that Senator Stabenow said, making the point that somehow Democrats are for coverage and Republicans are not, and then worming in there something about an association with segregation in hospitals. As a physician who worked in a public hospital for the uninsured and dedicated my life to bringing access to others who did not have it, I take umbrage at that.

I also point out that the segregation in the south was by Democrats who were the ones promoting that, and it was Republican judges who fought back—and, that it was Dwight Eisenhower that passed the first civil rights bill.

So, if we want to say that, oh, my gosh, we can just promise the store and somehow pat ourselves on the back without consequences, or without even regard to sustainability, oh, I will give that to my Democratic colleagues. And if we want to say, oh, my gosh, we were responsible for segregation but somehow we are going to worm that in, insinuating that we were not, I will maybe give that to you. But I am going to let you know that that is not true. That history is wrong. And that history is false.

And by the way, as long as we are speaking about sustainability, Medicare is going bankrupt in 2026. We have a bunch of people who want to expand coverage in Medicare, which will further strain its finances, so that those who are on it are less likely to get it.

Think about this: Medicare is going insolvent in 2026. And when it goes insolvent, by law, it will only pay the providers that which they currently receiving, which will result in roughly a 25-percent decrease in what they shall receive. That will be a crisis of access, and this is a program that the other side is actually wanting to put others on, endangering access to the seniors who are currently on Medicare.

Now again, if folks want to pat themselves on the back for expanding access, let us dig a little big deeper. Republicans are for access, but they are also for sustainability. If you cannot sustain, then you do not have a program. You merely have a talking point for your next election. And in this body, we should be more about sustainability as opposed to a talking point for the next election.

So I wish Senator Stabenow were here to hear that, because I think it is something which I am glad to disagree with.

Now with that said, Dr. Holtz-Eakin, you point out that it is not just about paying for care; it is about lowering the cost and having better quality care, I presume, because otherwise it is not sustainable. Correct?

Dr. HOLTZ-EAKIN. That is right.

Senator CASSIDY. So I was struck that, in Obamacare, there was a big effort to put on the Cadillac tax to otherwise restrain the amount of subsidized health care, because we knew that subsidies of health care drive demand, which overall drives up the cost. Is that a fair analysis?

Dr. HOLTZ-EAKIN. Yes. That is right.

Senator CASSIDY. But, Dr. Collins, you are speaking about how we need to further subsidize health care. That actually seems to go against the principle that the more the subsidy, the more demand, which drives up the cost. And yes, you lower the out-of-pocket to the individual, but for society you drive up the cost, which therefore calls into question sustainability unless you have unlimited dollars.

Dr. Collins, how would you respond to that?

Dr. COLLINS. Well, the new data out from the health-care costs—and, Senator Cassidy, thank you for the question, first—really does show that prices, not utilization, are driving our cost problem in commercial insurance. So increased coverage, that would be the thing——

Senator CASSIDY. Let me ask you—just a second. I have limited time. So prices, not utilization. But there is pretty good data from the Rand Corporation—that is kind of a time-honored study that has been shown elsewhere—that if you ask an ER patient to pay a de minimis amount, you decrease utilization. You decrease utilization without negatively impacting health-care outcomes for those who do not have chronic illnesses.

Now, is it fair to say that, in that case, totally immunizing somebody from the cost of health care indeed increases utilization, and therefore would increase demand and increase total expense?

Dr. COLLINS. I mean, health insurance coverage is the most important——

Senator CASSIDY. But my question right there is, if you totally immunize somebody from any cost-sharing whatsoever, you do increase utilization, therefore demand, therefore total expense. Is that not correct?

Dr. COLLINS. None of our insurance plans, or very few, except for very low-income people, have zero cost sharing.

Senator CASSIDY. In the silverization, so I am told, of the Obamacare exchange policies, there are those who currently do not have any cost share whatsoever. And, of course, I am speaking of the particular of no cost share whatsoever. But at some point cost-share becomes significant enough that somebody—it impacts their behavior. Correct?

Dr. COLLINS. It does. But we know that high cost sharing really discourages people from getting needed care. So the——

Senator CASSIDY. I am not talking about high cost sharing. I am talking about the general principle that the more health care is subsidized, the more demand is generated, and the more people become cost-insensitive to a higher price. The more they are cost-sensitized—and the sweet spot is where it does not discourage needed care—the more it contributes to total global cost. Is that a fair statement?

Dr. COLLINS. I think cost sharing is an important part of health policies, particularly for care that is necessary. But we do want to make sure that people have the right incentives to get the care that they need.

Senator CASSIDY. I am totally in acceptance with that. Really we are talking about sustainability. I am sorry, I am already a minute over my time, but I will just say that if we do not have a sustainable system, everybody patting themselves on the back at the expanded coverage is really just sewing the seeds for a health and economic crisis. I say that because, as a physician in a public hospital, we always ran out of money at the end of the fiscal year. And at that point, we were denying services, or postponing them to the next year.

There has to be sustainability built into whatever we do to expand access. Thank you.

The CHAIRMAN. My understanding is that Senator Hassan may be available now on the web. Is that true?

[No response.]

The CHAIRMAN. Senator Portman, are you out there in cyberspace?

Senator PORTMAN. I am. I am, Mr. Chairman; thank you.

The CHAIRMAN. Wonderful. Go ahead.

Senator PORTMAN. I thank the witnesses for being here today, and for the good information that they have provided. I want to focus on a couple of issues.

One is what is in the reconciliation plan that is being talked about. One thing is expansion of Medicaid. And this is something that I think is important for all of us to take a look at, because States like mine in Ohio did expand Medicaid. We took on a lot of new expenses with that.

My understanding is that this is to create a Federal Medicaid program that essentially will force those States that have not expanded Medicaid to partake in a federally run, federally funded health-care program.

First of all, is that fair to States like Ohio that took on this cost themselves? The Medicaid program now in Ohio makes up a significant amount of our spending every year. Prior to its expansion, we were at about 24 percent of our total State expenditures, and now it is about 38 percent of our expenditures.

So this new program, as I understand, would be paid for by Federal taxpayers, by the Federal Government, and it would go to some of these States that chose not to expand Medicaid, with no benefits for States like Ohio. And also, it is a blatant disregard for State choice, which has been the subject of a number of cases before the Supreme Court—that States have the opportunity under Medicaid to make these decisions.

I guess what I would say is, to Dr. Holtz-Eakin, is this the right way to go: taxpayers being forced to fund an expensive expansion at the Federal level? By the way, the cost is about $323 billion based on CBO, or $635 billion based on other analyses. So between $300 and $600 billion, and again a direct departure from the original intent of the Medicaid program to allow States flexibility, not just to make this choice, but once they have Medicaid under this Federal program, the existing flexibility to test new and innovative ways to deliver care would be gone.

For example, in Ohio we have a big issue with regard to opioids, as many of you know, and so we have a substance abuse disorder demonstration waiver that allows us to have the flexibility to provide essential services like substance abuse disorder treatment services that we use to battle the opioid crisis in Ohio.

Apparently that kind of flexibility would not be permissible. So, Dr. Holtz-Eakin, I know you have looked at this. How would this new proposal inhibit the ability of States to innovate?

Dr. HOLTZ-EAKIN. Well, first of all, Senator, with regard to that range in the numbers, I would just point out that we are responsible for the high end of that range. And the difference between CBO and the Center for Health and Economy is really not in the proposals. It is the fact that CBO has, in its baseline, anticipated expansions in Medicaid.

And so we do not do that. So all of the Medicaid here would be new coverage, whereas CBO would only be doing the increment above the anticipated expansions. And so there is not a great mystery to why that range is there. It has to do with the assumptions about the future in the CBO baseline.

With regard to the structure of the program, this is a dramatic change in Medicaid. Medicaid has always been a Federal-State partnership. And States have always been responsible for the business model that they want to pursue in their State.

And as I mentioned in my opening remarks, there is an enormous track record of success in moving into managed care organizations as a central plank of Medicaid. Competition among them is even better. And that gives the opportunity to have the basic approach of a capitated payment for cost incentives, and quality metrics to make sure that we get high-value care. And to my eye,

there is no guarantee of that strategy in what is being proposed in the reconciliation bill.

Senator PORTMAN. Yes, because it pulls away that flexibility. It is also—do you agree with me that States like mine would be unfairly penalized by this if we have gone ahead and made these decisions, and now the Federal Government comes in in other States?

Dr. HOLTZ-EAKIN. Yes, there is clearly a dissimilar treatment with the Federal taxpayers picking up the entire tab.

Senator PORTMAN. Let's talk about inflation for a minute. Everybody is concerned about it, as we should be. Everything costs more. The food we are buying at the grocery store, gas that has a 42-percent increase this year on average at the gas pump—unbelievable. And inflation is being driven in part by the fact that we have dumped so much stimulus into the economy. That is what economists say. That is what Larry Summers warned about, who was a former Democratic Treasury Secretary. The Federal Reserve Bank of San Francisco just released a report saying that the large spending plan passed, the $1.9 trillion earlier this year, contributed to inflation.

So there seems to be a consensus among economists. Now we are talking about a lot more money, $300 to $600 billion on this Medicaid program, the Medicare expansions, hundreds of billions of dollars depending on what you do. I know there is discussion about various ways to change Medicare.

We talked earlier, I know—and I am a big supporter of the Medicare Advantage programs in Ohio and elsewhere, because they work to provide seniors with choices. But this would be a Federal expansion of hundreds of billions of dollars, and the Affordable Care Act expansion is about $200 billion, the last numbers that I saw.

So these hundreds of billions of dollars start to add up. And the question is, what is going to be the impact on inflation? Can you give us a sense of that?

Dr. HOLTZ-EAKIN. Well, certainly what we have heard in the discussions about the structure, one strategy is to shorten the amount of time that the spending programs are in place. So you front-load all that spending, leave in place permanent tax increases, and essentially back-load the pay-fors, and that is a stimulus bill. The $1.9 trillion in March was poorly timed. The economy was growing at 6.5 percent. It was way too big for any macroeconomic problem we faced, and it was poorly designed.

This would be a repeat of exactly that exercise.

Senator PORTMAN. So, bad timing in terms of spending this kind of money—even if you believe that some of this was a good idea—because of its impact on inflation.

The other concern I have in here is the home and community-based services. I am a big fan of what it is called HCBS, which is again, home and community-based services. If you look at this proposal, it creates some problems. It does not give States the opportunity to use it as flexibly as we would like. Right now we have a long waiting list and a shortage of qualified providers, and shortages of affordable and accessible housing for these programs. And the funding here that is in this proposal would make it even more

difficult for some States to use this HCBS proposal in a flexible way.

Do you anticipate that all States will get a big advantage with this enhanced funding to bolster the HCBS programs, given the new requirements that they would put on home-based care?

Dr. HOLTZ-EAKIN. I think that is a real concern. My remarks were about creating a high-value system. To do that, you have to allow the flexibility to innovate and find cheaper ways to reach quality outcomes. Getting the money with a whole bunch of restrictions is at odds with that approach.

Senator PORTMAN. Well, I think my time is ended, or close to being ended, but I do think there are a bunch of bipartisan proposals we should look at—including our Senior Care Act that Bob Casey and I have, including the Ticket to Work program—that are bipartisan and do make sense in this area. And my hope is that we do not put too many restrictions on the home care and community-based health care system, because that, to me, is a way to save costs and improve care.

Thank you.

Senator STABENOW [presiding]. Thank you very much. We will next hear from Senator Brown, and then Senator Toomey.

Senator Brown?

Senator BROWN. Thank you, Madam Chair.

One of the witnesses just said that the Recovery Act passed in March, signed by the President, was, I believe his words were, "a bad idea" and, quote, "poorly timed." I think the 100,000 retirees in Ohio who had their pensions restored, who had earned them by negotiating at the bargaining table, and the 2.2 million children in Ohio and hundreds of thousands of families who have benefited 4 months in a row—July, August, September, October—from the Child Tax Credit of $250 or $300 and the poverty rate dropping by 40 percent, would disagree, if I can say that.

Dr. Blumberg, I have a little bit of an unusual request. Would you please reread the second paragraph of your written testimony, the part beginning with "Research has demonstrated that the Affordable Care Act"—would you read that again?

Dr. BLUMBERG. Research has demonstrated that the Affordable Care Act has increased health insurance coverage in the U.S. among the nonelderly by more than 20 million people. The enhancements of premium tax credits provided by the American Rescue Plan Act have increased coverage further, albeit temporarily, given that limited duration of the enhanced credit period. These reforms also have increased the affordability of insurance coverage and increased access to care for millions of Americans.

Senator BROWN. Thank you. Shout that from the highest rooftops. For 20 million Americans, coverage was made more affordable by the American Rescue Plan, which one witness was just very critical of, which Democrats wrote and President Biden signed into law earlier this year. We know that.

Dr. Blumberg, another quick question. If Congress extended the enhanced subsidies from the American Rescue Plan and expanded them to lower-income Americans in nonexpansion States, how many Americans stand to benefit?

Dr. BLUMBERG. An estimate of my colleagues at the Urban Institute is an additional 7 million people would have health insurance coverage from that.

Senator BROWN. An additional 7 million. Okay, thank you for those numbers.

Mr. Isasi, thanks for being here and for all the work Families USA has done over the years to ensure Americans have high-quality, affordable health care. A few "yes" or "no" questions, if I could do that in the last 3 minutes or so. If you would, bear with me and answer "yes" or "no."

Would permanently extending funding for CHIP, the Children's Health Insurance Program, help ensure coverage for the children of working families for years to come?

Mr. ISASI. Absolutely.

Senator BROWN. Would providing continuous eligibility—"absolutely" counts as a "yes" or "no," so you can keep doing that. Would providing continuous eligibility for kids and post-partum individuals in Medicaid and CHIP help new moms and their kids stay healthier and reduce disparities and improve the continuity of their coverage?

Mr. ISASI. Yes, and you have been a tremendous champion on this issue.

Senator BROWN. Thank you.

Could adding a public option to the ACA, or allowing older Americans to buy in voluntarily to Medicare before 65, help to reduce disparities and give Americans more health coverage options that they can afford?

Mr. ISASI. Absolutely. And the policies provide real security, and also allow the government to finally start addressing the pricing abuses that we are dealing with.

Senator BROWN. Thank you for that.

Would extending ACA provisions allowing children to remain on their parent's health insurance policies till age 26 to CHAMPVA enrollees help to ensure that children of disabled veterans have stronger coverage options?

Mr. ISASI. Absolutely.

Senator BROWN. Would fixing the so-called family glitch in the ACA help give working families more affordable coverage options?

Mr. ISASI. Absolutely it would ensure that families are not being unfairly penalized and held to an individual standard instead of their family income standard. Really important.

Senator BROWN. Thank you for that insight and illumination.

Last question. Would extending guarantee issue protections to Medigap policies help provide seniors and individuals with disabilities with more coverage options and greater out-of-pocket protections for those individuals affected?

Mr. ISASI. One hundred percent. And it would ensure that in Medigap, you could not be denied coverage for preexisting conditions—that should be the law of the land in this country.

Senator BROWN. Thank you very much.

Madam Chair, these ideas would help bring down health insurance costs. As was illustrated, they would give families more options. We ought to share those goals. Yet, my Republican colleagues continue to oppose all of these policies. It should be past time for

them to end their decade-plus long attacks on the Affordable Care Act.

We remember them year by year by year. Finally, work with us on ways to give our constituents more coverage options, what Democrats have been focused on from the Affordable Care Act a decade ago to the American Rescue Plan. Today's hearing is an opportunity to discuss ways to build on those efforts—not subtract from them—like permanently funding CHIP, ensuring continuous eligibility of children and post-partum individuals, and extending the Enhanced Rescue Plan subsidy as a part of the Build Back Better plan.

These are important steps forward that we could take, Madam Chair, right now. I yield back my time.

Senator STABENOW. Well, thank you very much, Senator Brown. That is a wonderful list of things that we should be focused on.

We now will turn to Senator Toomey, and then go to Senator Thune, who I understand had been bypassed at an earlier point. So we will go to Senator Thune, and then Senator Casey.

So, Senator Toomey?

Senator TOOMEY. Thank you, Senator Stabenow. Can you hear me okay?

Senator STABENOW. Yes.

Senator TOOMEY. Okay. Terrific. Thank you.

First, I want to register my continuing disappointment that our Democratic colleagues are still trying to ram through this reckless $3.5-trillion tax and spend bill, despite significant reservations even from their own caucus. And, given the really unprecedented scope and scale of this legislation, the Republican request to hold hearings and a markup, I think at a minimum, should be considered an obligation.

I am not aware of any plans to do that, and I suspect that is related to the fact that this bill is going to do a lot of damage. It is going to make millions of middle-class Americans dependent upon government. It is going to raise taxes on employers. It is going to diminish investment by increasing capital gains taxes. It is going to give the IRS, despite its history of abuses, access to financial information of ordinary Americans. It is going to put U.S.-based multinationals and their workers at a competitive disadvantage.

These are the kinds of things that ought to be scrutinized in public and subject to debate and amendment. But apparently that is not the path that we are on. So let me drill down on one specific aspect of our Democratic colleagues' plan, and that is, the expansion of Medicare that they are contemplating.

So, first of all, let us be clear. The Medicare trust fund is on track to be bankrupt in 5 years. That is not even the full story. CBO projects the program to have a $78-trillion shortfall over the next 30 years—not billions, $78-trillion shortfall—more than a $6-trillion shortfall just over these next 10 years alone.

And now what we understand is our Democratic colleagues want to expand benefits for a program that we know cannot keep its current promises. And by the way, they want to include coverages, including dental, vision, and hearing, for people who, to a large degree, already have these benefits. So 42 percent of all Medicare beneficiaries are currently enrolled in a Medicare Advantage plan,

and the Medicare Advantage plans have individual participants. Ninety-nine percent of them get a vision benefit. Ninety-seven percent get a hearing benefit. Ninety-four percent get dental benefits. So that is the 42 percent of people in Medicare Advantage.

By the way, about 99 percent of Medicare beneficiaries either are in Medicare Advantage or could choose to be in Medicare Advantage. So it is available to everyone already. So what is the problem that our Democratic colleagues are trying to solve?

It is certainly not to make the program sustainable. They have not identified a problem in terms of lack of coverage or availability of coverage. What it seems to be mostly about is making taxpayers pay for coverages that are already in place or available alternatively.

Dr. Holtz-Eakin, let me ask you this. I am trying to get a handle on how we should think about the actual cost of this Medicare benefit expansion. Democratic colleagues are saying the cost is $350 billion over 10 years. But CBO thinks it will be $80 billion per year, once all three benefits are implemented. But we know there is this phase-in. So could you tell us, what should we think about? What is the true cost of this expansion of Medicare?

Dr. HOLTZ-EAKIN. So I think the expectation is that this benefit will be available indefinitely. And so the $80 billion number over 10 years is the correct estimate of the cost—$800 billion.

Senator TOOMEY. And why do you suppose it is being phased in gradually?

Dr. HOLTZ-EAKIN. It is a way to make it appear cheaper, and to make it fit into some sort of budgetary restriction.

Senator TOOMEY. So my understanding is there is another proposal that is under consideration, which is to make permanent the changes to the premium tax credits that occurred on an entirely partisan basis under the American Rescue Plan. And our Democratic colleagues expanded Obamacare to provide more money to insurance companies, to those already in Obamacare, and to make individuals eligible for the premium tax credit regardless of income during 2021 and 2022.

And now just yesterday, CBO estimated the extent to which these benefits will go to people who do not need the benefit. Sixty-five percent of those set to receive more subsidies have incomes over 400 percent of the Federal poverty line. And $26 billion will go to cover individuals who make over 700 percent of the Federal poverty line.

So tell me—this is what CBO has told us, Dr. Holtz-Eakin. Is it your view that these benefits are going to go to people with substantial income and alternative ways of obtaining insurance?

Dr. HOLTZ-EAKIN. This is an unsurprising finding. The proposal to get rid of the cap at 400 percent of the Federal poverty level means it is targeted on people who are relatively affluent. And this is what CBO is saying.

Senator TOOMEY. Does it strike you that a program that is on a highway towards insolvency, running massive deficits, should be expanded to include people whose income is many multiples of the poverty line? Does that sound like a good idea to you?

Dr. HOLTZ-EAKIN. I think targeting all of these proposals much more carefully at the low-income and needy would be a good step in the right direction.

Senator TOOMEY. Thanks very much. I see I have consumed my time.

Thanks, Madam Chairman.

Senator STABENOW. Thank you very much.

Senator Thune?

Senator THUNE. Thank you, Madam Chair.

And I would like to associate myself with the comments from Senator Toomey with respect to the process. I think this looks like maybe the only hearing where we are likely to have an opportunity where this committee can engage in a public forum to discuss what are the sweeping policy changes and massive expansion of government that Democrats have embarked upon. And I think it should be noted that, even for bills that resulted in a partisan outcome, this committee has always followed regular order, debated and voted on amendments. And I think it is a shame that, after promises of bipartisanship and cooperation, even here today, we are facing policies that are fundamentally changing the tax code, affecting the economy and the way consumers access health-care coverage, on a completely partisan basis. The American public ought to be included in that conversation, and that to me suggests we ought to be having a process that includes regular order, hearings, and a markup.

Based on that recent CBO letter that Senator Toomey referred to about the House version of the Democrats' tax and spending spree, we now know that the proposed coverage provisions would cost more than half a trillion dollars to cover about 4 million people over 10 years. The CBO also predicts this means that 2.8 million Americans are going to lose their job-based coverage, which sounds like another "if you like your health-care plan, you can keep it" falsehood.

Dr. Holtz-Eakin, could you talk about what drives this shift away from private coverage into plans heavily subsidized by the Federal Government? And what does it mean for the long term?

Dr. HOLTZ-EAKIN. This has been a concern since ACA was passed. If you ran the numbers, the subsidies were already so rich that for anyone up to about 300 percent of the Federal poverty line, the employer could stop offering coverage, put the individual into the exchange, give them a raise, and make more money.

So the bottom line is, there was so much money on the table in the exchanges that it was really an incentive for employers to stop offering coverage. This is an increase in those premium tax credits, and we are just seeing the same behavior in the CBO estimates. You know, they have been watching this carefully, and there are clear incentives for employers to stop offering insurance—and in the process, to pay their workers more and make more money simultaneously.

Senator THUNE. Does the Democrat proposal to make the expanded ACA tax subsidies permanent include anything to prevent exchange premiums increasing? In other words, if insurers increase premiums, do the taxpayer-funded subsidies keep increasing too? And what does that mean, long-term?

Dr. HOLTZ-EAKIN. The answer is "yes." I mean, that is how these subsidies are calculated. And this is the concern I have about the discussion exclusively about access and coverage. In the end, insurance is a financial part to shift the medical bill around. The real problem is the national medical bill is too big and delivers too low-quality care. So getting control of the bill allows you to keep insurance premiums down directly and does not require as much taxpayer subsidy.

So I think the sustainability issue that was raised by Senator Cassidy, this is right where it hits.

Senator THUNE. And just as a quick follow-up, is it correct that these expanded taxpayer-funded subsidies could form plans to cover elective abortions?

Dr. HOLTZ-EAKIN. Yes.

Senator THUNE. And that is, again, a violation of a policy that has been in place literally for 50 years, since the early 1980s.

This year the administration allowed special enrollment periods on the exchanges that lasted more than 6 months. The Democrats are now proposing to create a continuous enrollment period for individuals at certain income thresholds through 2024.

For years we have heard about issues of adverse selection in the insurance markets. So what has changed?

Dr. HOLTZ-EAKIN. Nothing. Our analysis indicates the special enrollment periods would raise premiums because of the adverse selection issue, and that would make this program more expensive, on top of everything else.

Senator THUNE. Let me shift gears for just a minute. And again, I think Senator Toomey covered well what the Medicare trustees have told us about the insolvency being faced by the program in 2026, and the question of dramatically expanding some of these fee-for-service program benefits and what that is going to mean long-term in terms of the financial viability of Medicare more generally.

But I want to ask you about your past experience as CBO Director and just ask if you could perhaps provide some context to the CBO report recently about Federal revenues for the first time hitting $4 trillion, and increasing individual income taxes 27.5 percent, 80 percent of that coming from the top 10 percent of earners, corporate-rate income taxes rising 75 percent to $370 billion.

With revenues coming in at historically high levels, what would be the fiscal or economic impacts of raising taxes on American workers and businesses?

Dr. HOLTZ-EAKIN. The impact on the economy is decidedly negative. We are recovering well from the near-term losses due to the pandemic. We still have a long-term growth problem. The proposals that are on the table would inhibit the accumulation of intellectual property, capital, and other productivity-enhancing investments, and that would be negative over the long term for productivity, real wages, and the standard of living.

Senator THUNE. Thank you.

Senator STABENOW. Thank you very much——

Senator THUNE. Madam Chair, I have this—I want to include this CBO letter in the record, if I might.

Senator STABENOW. Without objection.

[The letter appears in the appendix beginning on p. 164.]

Senator STABENOW. Senator Casey?

Senator CASEY. Thank you, Senator Stabenow. I appreciate our witnesses being here. Thank you for your testimony.

I wanted to start with, I guess, more of a comment on the testimony of Mr. Isasi. On page 5 of your testimony—I am going to read it into the record, because it is, I think, very important for the American people to know this. You said on page 5, "An impressive research base now confirms that Medicaid expansion"—and I am enumerating here, it is not in your text, but—number one, saves lives; number two, protects people from cancer and other serious diseases; number three, helps combat the scourge of addiction; number four, prevents bankruptcy; number five, saves money for State budgets; number six, boosts employment; and number seven, keeps the doors open in rural—I will say that again—rural hospitals, all benefits of Medicaid expansion, a program much maligned by Republicans in the Senate and the House, maligning it over and over again, and they all voted against it, by the way, despite all the benefits.

You also were talking about the Affordable Care Act and the impact on people's lives in a very direct way. One expansion that we are trying to undertake in this Build Back Better budget is to make it more available at a State level, home and community-based services for seniors and people with disabilities.

That is never going to happen when the Republicans have a majority because they are hostile, not just to making the expansion, but they are hostile to the Medicaid program itself. That is not an opinion. You just need to look no further than their budgets. Budget after budget, especially during the Trump presidency, cutting Medicaid, proposed cuts to Medicaid of $500 billion and up. In fact, there is a House budget proposal to cut it by a trillion dollars over 10 years—Medicaid.

So if we are going to have home and community-based services expanded, it is not going to happen with Republicans because they are hostile to Medicaid itself, and Medicaid itself makes that possible. So that is my comment for today.

But I wanted to turn to Dr. Collins. Dr. Collins, you had extensive testimony about the considerable burdens that families face when it comes to both the impact of premiums and the impact of deductibles. How have Medicaid expansion and marketplace policies both lowered costs to help families save money when it comes to those burdens?

Dr. COLLINS. Thank you, Senator. There is a considerable body of research, as Mr. Isasi's testimony indicates, that you just quoted, showing that the expansions led to huge increases in people's ability to access care. So lowering the financial barriers to health care, lowering out-of-pocket costs across the population—we know that has also occurred. And Medicaid expansion in particular improves the financial protection for low-income families, with an average decline of more than 4 percentage points of the share of people who are spending more than 10 percent of their income out of pocket for health care.

This improved health-care access for people eligible for Medicaid and improved their overall financial well-being. Low-income fami-

lies saw reductions in the number of unpaid bills and the amount of debt sent to collection agencies, reduced their use of payday loans, and resulted in declines in housing evictions as a result. So these had dramatic spillover effects into other areas of people's lives.

Senator CASEY. Thanks for that. And I was going to turn back to Mr. Isasi on the reference I made earlier to home and community-based services. We all have had the real blessing and the privilege of meeting folks along the way who tell their story and inspire us to work on these issues. I think that is true in both parties.

One of the people I met throughout the course of this debate on these services was Kelly Barrett from Erie, PA. She has cerebral palsy and she lives—fortunately, lives independently in her own apartment for the last 4½ years. She says the difference between having these services and not having these services is, quote, "the difference between life and death."

So I would ask you, what are the current barriers to coverage for home and community-based services? And how would investments in these services help Americans like Kelly Barrett?

Mr. ISASI. Thank you very much for the question, Senator Casey, and also for your championing these issues and health for families and children. You are an amazing ally in this work.

So home and community services, as you point out, these are the key services that allow people who are aging, who are disabled, with chronic conditions, to be able to stay in the community and not end up in an institutional setting like a nursing home. They allow people to continue to be independent and to work, or to be close to their family. That is critically important, but right now in this country we have such a shortage. In fact, 800,000 people at least, almost a million people, are on waiting lists all over this country to get access to these services. It is a huge, huge need.

And as a result, we have people who are languishing and people who are in institutions. This is critically important. There is a deep investment we should make. The House bill makes well over $100 billion of investment in these services. And by doing this, we can really ensure that our elderly or disabled and those with a chronic illness have a shot at living in the community, being closer to families, having jobs, and things like that.

Senator CASEY. Thanks very much.

Thank you, Senator Stabenow.

Senator STABENOW. Thank you very much.

Senator Whitehouse?

Senator WHITEHOUSE. Thank you, Madam Chair.

This first question is going to be about the public option idea. Years ago, Senator Brown and I drafted the original public option that we tried very hard to get into the Affordable Care Act. And when we did so, there was a landscape of Americans who had no health insurance.

The ACA has been a huge success. It has rolled out effectively in almost all places, and it has changed the landscape of who cannot get affordable health insurance.

What is the population, Mr. Isasi—and then Dr. Blumberg—what is the population that you think, as we are designing a public

option here in the Finance Committee, we should make sure we are attending to?

Mr. ISASI. So, from my perspective, I think that the first, of course, are folks who are, for example, self-employed, owning their own small businesses, who simply cannot get access to high-quality global health insurance.

Senator WHITEHOUSE. Even through the exchanges?

Mr. ISASI. Well, in some cases, depending on where they live, they may or may not have access to high-quality insurance. And let me just point out—and you know, given your role of Insurance Commissioner in Rhode Island—one of the most important things about a public option is, it finally allows the government to get in there and demand a fair price and address the pricing crisis that we are in.

Senator WHITEHOUSE. Ben Franklin in his Almanac years ago said, "the best way to show that one stick is crooked is to lay a straight stick next to it."

Mr. ISASI. Beautiful.

Senator WHITEHOUSE. And we rather hope that the public option would be the straight stick.

Mr. ISASI. That is right. That is right.

Senator WHITEHOUSE. And where should it be offered? Should it be offered through Medicare? Should it be offered through exchanges? How would you think it should be administered?

Mr. ISASI. Well, the answer to that question is, how can we get it through the Senate and through the Congress? That is the most important thing. But the bottom line is, it has to have several dimensions.

The first is, is it available to everyone? The second is, does it actually provide affordable high-quality insurance that provides financial security? And that has to do with prices. As you said, the stick right now in America is incredibly crooked, right? And then the third piece is, the coverage has to be available in all kinds of communities—rural communities, urban communities. Things that have highly consolidated markets need to have more competition.

Senator WHITEHOUSE. Dr. Blumberg, anything to add to that?

Dr. BLUMBERG. Sure. Our analysis, Senator, about places where the public option would have the greatest impact are those areas that have either few insurers offering coverage in the area and/or have very highly consolidated providers, so that the prices for obtaining care are higher and, as a consequence, premiums are higher.

So those areas are often areas that are not big population centers, but not always. So, looking at where the prices are highest, and where the competition in the insurer and provider markets is below expectations and below where it would be in other areas, are really the prime areas where the public option would have the greatest impact.

You could——

Senator WHITEHOUSE. Let me ask Dr. Collins this. In Rhode Island, we have had two experiences. One was a Health Insurance Commissioner who required insurers to focus on primary care first. And that drove the market towards primary care being a center

point for service, as opposed to people hopping from specialist to specialist.

And the second has been the Accountable Care Organizations that have really done stunningly well in Rhode Island. They have been national champs. One is Coastal Medical, a primary care practice in Rhode Island, and the other is gathered together as the Integra program, it is called, with Rhode Island primary care physicians. And both of them have proven that significant savings in cost per patient can be achieved by improvements in care that lead to better health outcomes for those same patients. And that has always been the sweet spot that we have tried to hit. The Obamacare so-called "triple aim" was focused in that space.

What should we be looking at now to try to maximize these proven cost-reducing, quality-improving, better outcomes for Americans strategies?

Dr. COLLINS. Thank you, Senator. I think what you highlight is the innovation that is happening on this issue in States across the country. Rhode Island is a standout. The other thing that Rhode Island has done too is, they empowered their Insurance Commissioner—your Insurance Commissioner—to review rates, premium rates, and also review hospital rates.

So taking an active stance on the pricing problem that I highlight in my testimony and that has come up repeatedly in the hearing today—but we are also seeing lots of activity in a lot of States. So I think it is an indication of what we can learn from what States are experimenting with, watching the States on the public option experiments. Montana is looking at changes to their State employee benefit program on hospital pricing. I think Rhode Island is a leader, and a lot of other States are innovating in this space in very creative ways.

Senator WHITEHOUSE. Thanks.

I will just close with a comment, if I may, Madam Chair, which is that, once you free up doctors from having to march to the fee-for-service treadmill and give them the ability to adapt the way they treat patients to a patient-first way of dealing with the patients, you then open up this arena in which all three of those things happen at once. Patients are happier and healthier, costs go down, and everybody wins.

So we need to continue to work on that. And I would note that, in the quarrels about the Affordable Care Act, there were no quarrels about these provisions. Nobody is against Accountable Care Organizations. They are across the States. They are doing really well, and we can make a lot of progress. So thank you.

Senator STABENOW. Thank you so much, Senator Whitehouse. We have seen the same results in Michigan; so, thank you so much.

Senator Hassan?

Senator HASSAN. Well, thank you, Madam Chair. And I want to thank the chairman and the ranking member for having this hearing. And I want to thank the witnesses for being here today.

I want to start with a question to Dr. Collins. Dr. Collins, as my colleagues have mentioned throughout this hearing, the COVID–19 pandemic led to a drop in health insurance coverage, as many working-age adults lost their jobs and, with it, their insurance. Fortunately, though, many who lost their insurance had an oppor-

tunity to find new coverage, thanks to the special enrollment period, increased subsidies, and additional cost-sharing assistance for Affordable Care Act marketplace plans that were included in the American Rescue Plan last spring.

During the special enrollment period created by the American Rescue Plan, almost 6,700 Granite Staters enrolled in a new health plan, roughly double that of the same period in 2019 and 2020. Dr. Collins, we have talked about the numbers of people who gained access to coverage through these provisions, but can you speak a little bit about the impact that these expansions have had? You talked in a previous answer about the impact on working families' finances, but what has it meant for families to be able to access needed health-care services during the pandemic? What kind of services have they accessed?

Dr. COLLINS. Thank you, Senator; that is a great question. First of all, we know that the majority of people who are unvaccinated do not have insurance coverage. It is not because the vaccines are required to be covered by insurance, it is because people do not have a relationship with the health system that insurance coverage affords them, so they are not getting the information they need about vaccines.

It has been very important in terms of access to health care, particularly for people who did get sick with COVID, having the ability to get the care they need; having that relationship with a physician. So it has been important not only for COVID, but also across the spectrum of care that people get, in ensuring access to that care.

Senator HASSAN. Thank you.

Let me ask you a little bit more of a specific question. As I think you probably know, New Hampshire, like some other States, has been ravaged by the substance use disorder crisis. And we have seen firsthand how Medicaid-covered behavioral health care has improved access to treatment.

As Governor of New Hampshire, I worked to expand Medicaid to ensure that Granite Staters would have access to the care that they need, which includes treatment for substance use disorder. Since that time, this access to coverage has been a critical part of our State's response to the substance use disorder crisis.

Dr. Collins, can you speak specifically to the important role that Medicaid coverage has played in expanding access to treatment for substance use disorder and improving health outcomes?

Dr. COLLINS. Yes. Medicaid has been so important for substance abuse issues—also, just mental health generally across the population. States that have not expanded Medicaid have denied this access to their residents, which has been a critical part of our ability to address this crisis that we are seeing in substance abuse and drug overdose deaths. The marketplaces have also required insurance plans to cover mental health and substance abuse services, which has also been a critical part of this fight.

Senator HASSAN. Well, thank you for that. I will just note too the number of people I have talked to who have recovered from their substance use disorder and then become employed, and then gotten private insurance through their employment. So it can be a win/win in a lot of different ways.

To Linda Blumberg: post-partum depression and other perinatal health challenges can obviously exacerbate substance use disorders. Expanded Medicaid and ACA plans have helped ensure that mothers with substance use disorders have access to the specialized care that they need. In New Hampshire, Dartmouth Hitchcock's Moms in Recovery program provides access to mental health professionals, child care, women's health care, and medication-assisted treatment, among other supports.

So, Dr. Blumberg, can you speak to how expanded health coverage has helped pregnant women and new parents impacted by substance use disorders, as well as their children, through innovative programs such as Moms in Recovery and other avenues?

Dr. BLUMBERG. Sure. Having health insurance coverage through either Medicaid or private health insurance for mothers has a very positive impact not only on their own health, but on the health of their children. So, if the mothers are getting mental health care and treatment, then that has positive outcomes for the children. And there is a great deal of research that supports that.

So it is also the reason why a lot of folks are interested in looking at longer-term care for women post-partum, not just for birth-related care, but also for general health care, because of those outcomes.

Senator HASSAN. Thank you very much, and thank you, Madam Chair.

Senator STABENOW. Thank you so much.

Next we will hear from Senator Daines, and then Senator Cantwell.

Senator DAINES. Thank you, Senator Stabenow. Thanks to our witnesses today.

President Biden and the Democrats sadly are pushing forward a purely partisan, multi-trillion-dollar great big push towards big government, a reckless tax and spending spree that I think is going to reshape the foundation of this country. It is going to create new entitlement programs. It is going to increase Americans' dependence on government-subsidized, government-controlled insurance coverage. It is also going to increase Washington's control over the American people's lives. As they have seen what has happened here in this city over the course of the last year, they do not like it, especially when it comes to medical decisions. And it is the last thing that Montanans want to see happen.

The Democrats want to spend trillions on new and expanded government programs, when we are already in desperate need to fix the essential existing programs like Social Security and Medicare. There are unsustainable promises of benefits that we simply cannot afford. What the Democrats are trying to do and pass here is the definition, I would say, of fiscal insanity.

I am deeply concerned that this bill would violate the principles of the Hyde Amendment, despite a 45-year precedence, and mandate taxpayer funding for abortion and new Federal Medicaid-like entitlements through Obamacare.

Dr. Holtz-Eakin, for 45 years the Hyde Amendment has prevented Medicaid and other Federal health programs funded in the Labor/HHS appropriations bill from funding elective abortions, and it has saved nearly 2½ million lives.

The Democrats' tax and spend bill would create a new Federal health entitlement that mimics Medicaid. But rather than being funded through Labor/HHS where the Hyde Amendment would apply, it would receive an automatic, unlimited, and permanent appropriation in the bill itself.

Dr. Holtz-Eakin, is it accurate to say that the Hyde Amendment would not apply to this new Federal health entitlement and therefore that abortions would be covered and paid for by the Federal taxpayers under this program?

Dr. HOLTZ-EAKIN. Yes.

Senator DAINES. Interestingly enough, it was recently suggested that the Democrats' $3.5-trillion tax and spending plan would cost nothing, that there would be a zero price tag. Now, I do not know where those folks went and studied math, but I am a chemical engineer. I studied a lot of math. I am not sure I would define that as being nothing.

Dr. Holtz-Eakin, can you help us make some sense of that claim? And would the Democrats' tax and spending plan increase Federal spending and grow the Federal Government's role in the lives of everyday Americans, everyday Montanans?

Dr. HOLTZ-EAKIN. I think the simplest presentation of the budgetary impacts is to have each of the proposed programs be made permanent so we can look at them over 10 years. That is clearly the intent, in the end. And that is about $5.5 or $6 trillion worth of new spending.

The taxes that came out of Ways and Means are about $2 trillion, a bit above. So that is a huge structural deficit that is being added to the existing structural deficit, largely driven by Social Security and Medicare. So the scale is enormous, but the scope is also enormous.

This is a climate bill, an education bill, a health bill, a social safety net bill, a tax bill, education, housing—it is a big intrusion into these parts of the economy.

Senator DAINES. I think to try to simplify something that can be a bit confusing right now, because it is a very fluid situation, this is the largest spending bill in the history of the United States of America. It is the largest tax increase we have seen in 50 years. And of course we will see what the final product is, but you brought up a very important point, and that is, the underlying consequences here. If you want to see what will happen in the United States, look at what is going on in Europe at the moment, with natural gas prices up 500 percent, coal up 200 percent, oil up 80 percent. That is the movie trailer to what is coming to the United States of America if they get these Green New Deal policies passed.

Dr. HOLTZ-EAKIN. I am concerned about the inflation outlook. We discussed that earlier. And certainly there is a concerted effort to reshape the energy portfolio of the United States, and the strategy that is embedded in this bill, and more broadly, is to essentially run the electricity sector solely on renewables, run everything in the way of factories, homes, and vehicles on electricity, and somehow develop a national grid we have never had to connect them. It is not a low-risk bet, that is for sure.

Senator DAINES. There can be severe consequences to not getting this right, and we are seeing that, of course, right now in Europe.

They moved away from nuclear and coal, and they are in a world of trouble.

The last question: the recent CBO analysis found that healthcare policy in the Democrats' tax and spend bill will cause at least 2.8 million Americans to lose their job-based coverage. Dr. Holtz-Eakin, could you elaborate on this analysis and how it might impact taxpayers?

Dr. HOLTZ-EAKIN. Well, as I mentioned earlier, the basic phenomenon is that there is too much money on the table in the exchanges, so much money that it is possible for employers to stop offering health insurance and use those savings to give their workers a raise, and send them off to get their insurance in the individual markets, and actually make more money as a firm.

That is strictly the result of the subsidies, being played large. That was true of the original ACA for everyone up to about 300 percent of the Federal poverty level. These are richer subsidies, and so the same phenomenon is taking place.

Senator DAINES. Thanks, Dr. Holtz-Eakin.

Thank you, Senator Stabenow.

Senator STABENOW. Well, thank you very much. I do need to make one editorial comment at this point, and just indicate that I do not consider asking billionaires to pay more than zero a tax increase.

So, Senator Cantwell?

Senator CANTWELL. Thank you.

I would like to ask Dr. Blumberg about a couple of things, and this discussion is about a lot of aspects of the Affordable Care Act. One that I authored was the basic health plan. The basic health plan's final rules and regulations were written and implemented in, I think it was 2015 or 2016, finally. The basic health plan in New York covers approximately 800,000 people. In the essential plan, it costs less than $500 annually for a family of four buying separate coverage.

If you compare that to, on the exchange somewhere, the silver plan—basically these families are saving $1,000 in premiums. So I know you mentioned some innovation. Obviously the State of Washington is involved in a lot of innovation.

What can we do to get more people to look at the basic health plan as a way to deal with the working-class population above the Medicaid rate? And anybody else who wants to answer that question may as well.

Dr. BLUMBERG. I am happy to talk about that, Senator. So, from the perspective of experience, the basic health plan has had a very targeted interest in the State of New York, and in Minnesota, in terms of lowering the costs for private health insurance plans for the very low-income people below 200 percent of the Federal poverty level, above the Medicaid threshold. This has led to much higher participation, more enrollment, more coverage in those States, clearly, from the lower premiums. So extending the ARPA subsidies and making them permanent moves toward that direction nationwide without States having to make that jump into the basic health plan.

The basic health plan has a lot of positives for consumers. Unfortunately, it also pulls people out of the risk pool, the insurance

pool, the marketplace, and separates them. And doing so can have impacts on the premiums and the attractiveness of the core marketplaces for insurers. So there are clearly a lot of positives that have come in the States that have been able to do it, but——

Senator CANTWELL. What——

Dr. BLUMBERG [continuing]. It does have some down sides as well. There are tradeoffs, to be sure.

Senator CANTWELL. What proof points do you have on that?

Dr. BLUMBERG. Well, our analysis looks at the risks, the health-care risks, and expected expenditures of individuals who are eligible and enrolled in the marketplaces, and how that would change on average when moving individuals who are up to 200 percent of the Federal poverty level out into a separate program.

Not all of those under 200 percent of poverty are very high-cost. They have medical care needs like others do, but oftentimes they are healthier on average. So in some States, moving them out of that insurance pool would both decrease the size of the marketplace enrollment appreciably, and could also increase the average health-care risk of people in the marketplace.

By contrast, if you provide those more generous subsidies for those low-income people as the ARPA extensions do, and would if made permanent, with those that remain in the marketplace up to 200 percent of poverty, then those people stay in the pool and those pools have more strength.

Senator CANTWELL. Yes. I am not clear what you are suggesting on the pool, but I would say this: I disagree. The notion that we are—the market never bundled up these people. The market never served these people. The reason why we got this passed is because people realized that for these people, the market could not figure out a way to serve them. And so the fact that New York and Minnesota took the chance and did it, and now deliver more affordable health care for a population that was hard to serve—and guess what, you found a price point. And the answer was "yes" because of the price point.

So now, to continue this fallacy, this hooey, is what I call it, just plain hooey that somehow we should continue to subsidize very expensive silver plans when you could make a market for people at a price point and deliver savings and deliver more affordable health care, is just a big mistake.

And so people can keep talking all they want, but show me on the exchange where you have an affordable plan. You look at the basic health plan, you have an affordable plan.

I see one of the witnesses there—do you want to respond to that?

Mr. ISASI. I just wanted to say that I think that the concerns that my colleague is raising are real and important, which is what is the interplay between exchange coverage and the basic health plan options. However, what we have seen and experienced, as you are pointing out, Senator, is that those in New York and Minnesota, they only saw a 2-percent change in costs as that was offered.

And to your point, what you are doing is, you are allowing the State to negotiate on behalf of a very large group of people and get really high-value coverage at lower costs. That is a home run.

So I think the concern is real, but there has to be a way that we can allow that to happen. And what we saw in New York and Minnesota, the change was only 2 percent.

Senator CANTWELL. Exactly. So my point is—this is why I am saying it is hooey—if you look at the amount of money that we are going to continue to be asked for, as we were in the last COVID package—you know, hundreds of millions, billions of dollars to subsidize expensive health insurance when you do not have to. Why? Because you offered up a plan for a market that was not very interesting to insurers. You made it interesting, and you gave the States the right to negotiate on price. You got a price, and the answer was "yes."

So 800,000 people in the State of New York have more affordable insurance, and in Minnesota. So I would say that you can contrast that to this experiment where people are trying to say, "Oh, here is what I am going to do; I am going to offer you something on the exchange." It is not working to drive down the costs. It is not.

So at least for this population—now I get it, if you start talking about maybe 300 percent, or maybe 250, I can see where people start saying that that impacts the marketplace. But when you think about who these individuals are, they were people who did not have insurance, worked for somebody who did not carry insurance. You were trying to make them interesting in the marketplace, and this, I would have to say, was a home run. And the cost to all of us on subsidizing more expensive insurance just is not—you know, we could take those same savings and do what my colleagues down the dais were just talking about in other reforms in health care, and get more traction.

Mr. ISASI. And I think our position is that those policies are critically important. Not every State is going to be that forward and really take that on and make that kind of investment in building that basic health plan option. And it is really important that, at the end of the day, every family has access to high-quality insurance.

So we think both policies are really important. But underneath all of this, I think, Senator, what you are pointing out and being such a champion on is that we have to get much more aggressive with our health insurers, to demand that they negotiate good prices. And that is part of what the basic health plan does. It gives volume, and gives real weight to that negotiation so they can get in there and stop the pricing abuse.

Senator CANTWELL. Well, I will not disagree with you there. I mean, that is what we liked about it. We liked the fact that they could negotiate again in helping to create a market that people were happy to bid in. I call it "the Costco model." If you are going to buy in bulk, people are happy to give you a discount. And so this is a model that has successfully worked.

Okay, do I—am I over my time? I am over my time, I am sure, thank you. I am going to submit a telehealth question for the record. Look, I do not know that anybody has asked about that. I really think it is very important that we also get very granular about that.

Look, this is the information age. We should be taking information about health care, getting very granular about it, and coming

up with better results. I think that is what we strive to do all the time on this side of the aisle, on the innovation side, and you have heard it from all of my colleagues here, whether it is the ACOs, or patient-centered health care, or the innovative work that the chair has been doing on integrating mental health and behavioral health. Look, these are all numbers.

On telehealth, we just do not—I think we do not have the reimbursement rate that is truly incentivizing telehealth, and we are going to be in an information age where we have to have both the broadband and the reimbursement rate that allows physicians to move to this area where it is cost-effective. But I will submit a question for the record.

Thank you.

Senator STABENOW. Well, thank you very much, Senator Cantwell, and I could not agree more on the basic health plan and your leadership. Since we worked on the ACA together, it has been incredible. So, thank you very, very much.

We now have virtually Senator Cortez Masto, Senator Lankford, and I believe Senator Young.

So, Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you, Madam Chair. Thanks for holding this hearing. Thanks to the witnesses for being here. I have listened most of the morning to the testimony this morning.

Let me just say this. The last 2 years of the COVID–19 pandemic have been an unbelievable test on our health system's ability to respond to the dramatic changes in the economy. And as many of you know on this panel, insurance rates in 2020 remained generally stable, which tells us that there was much less disruption than we had anticipated.

But here is an important caveat: Congress played a key role in shoring up so many of the various plans and programs where individuals can get coverage. Our work to prevent families from going uninsured during this period of time was critical. I know. I come from the State of Nevada. We had the highest unemployment rate at one point in time, 30 percent during this pandemic. And we really needed to strive to make sure we were bringing health-care relief during the middle of the health-care pandemic to individuals, however we could. That is why I so appreciate that we are getting into the details here about health care in this country.

So, Mr. Isasi, let me start with you on the ACA tax credits. Prior to the pandemic, small businesses employed just under half the workforce in Nevada. These entrepreneurs are a critical part of our State's economy, but many of them are too small to offer health-care coverage.

The American Rescue Plan included a handful of temporary subsidies to support the purchase of health insurance, including an expansion of the ACA tax credit. Can you talk about how these tax premiums, or these tax credits in the Rescue Plan, might benefit small business owners and their employees who are still in recovery from the disruption of the pandemic?

And let me just add to this, Nevada is one of the States still in progress. We are not running at full capacity here. The hospitality industry is still stressed. The business travelers are not back. The

international travelers are not back. We are still in the recovery mode.

So if you could address that, I would appreciate it. And if you would also talk about gig workers, and the retail and hospitality workers who move from job to job as well, and how those tax credits, the tax credits we put in the Rescue Plan, might be essential to help them?

Mr. ISASI. Thank you so much for the question. It is a terrific and important one.

First and foremost, as you have heard, there are two main provisions within both the American Rescue Plan and now what is being considered in Build Back Better. The first, of course, is to provide support for small businesses to provide health insurance. Now in that regard, what we have to remember is, it is the most volatile source of employer-sponsored coverage; that is the hardest place. Small businesses oftentimes have the hardest time offering coverage.

So we know, for example, if the American Rescue Plan provisions were extended, that businesses and employers would receive at least $5.1 billion in additional support for making health insurance affordable. But that second prong is really important to talk about. Not all small businesses will be able to offer their employees coverage. And those employees I just described—employees who are between jobs, or employees who want to start new businesses—the second piece of this is making sure that coverage in the exchanges is affordable.

And what we have heard is, this question has been asked and answered. The subsidies have cut premium costs in half for families—in half—and that allows for a lot more mobility, a lot more economic development, as employees change jobs, lose jobs, et cetera. So these are really important provisions within both the American Rescue Plan and Build Back Better that protect employees and employers.

Senator CORTEZ MASTO. I appreciate that. Thank you.

And then, Dr. Blumberg, today there are more than 845,000 people enrolled in Nevada Medicaid. That is nearly one in three Nevadans. Over the course of the pandemic, the State took on more than 200,000 additional lives of Nevada's families who lost their income and their job-based health insurance, and really rely on the support that we were providing them.

This would not have been possible without bipartisan work—and let me stress that—bipartisan work that we did to provide States with an enhanced FMAP to keep folks on the rolls during the public health emergency.

Dr. Blumberg, let me ask you this. Can you describe—this may be difficult, but I am curious—can you describe how different the rates of uninsurance and underinsurance might have been had Congress not stepped in to support the Medicaid programs?

Dr. BLUMBERG. Yes, it is a difficult question to answer. Clearly, by our estimates, millions more people would have been uninsured. We have done estimates of what the implications are in making these changes, the changes to the subsidies that were provided. If they were permanent, that would extend coverage by about 4 million people. So I think between the presence of the Medicaid expan-

sion and the enhanced subsidies, we are talking about, Nationwide another 4 million people uninsured during the course of the pandemic, and maybe a little bit more than that in the short term.

Senator CORTEZ MASTO. Thank you. And I know my time is up, but let me just stress this abour my State. Again, many of our employees were furloughed. The COVID subsidies that we did, 100 percent were needed. The American Rescue Plan in my State was supported in a bipartisan way, because of the nature of the devastation from the health-care pandemic.

So it is important for us to work together to really address the health-care needs of so many families and businesses and entrepreneurs and individuals across the country. We should be working together. But I will tell you what, if we cannot get there in a bipartisan way, that is not going to affect our efforts in looking at how we address the needs of people in my State that will have a positive impact in other States as well. So thank you.

Senator STABENOW. Thank you so much, Senator Cortez Masto, for your incredible leadership on these issues.

We will now hear from Senator Young, remotely.

Senator YOUNG. Thank you so much.

Dr. Holtz-Eakin, welcome to the committee. As my colleagues on the other side of the aisle move forward with a very large spending bill, $3.5 trillion—the largest tax and spending bill in American history—I think it is really important that we examine what I regard as the dangerous consequences this legislation will have on hardworking Americans across the country.

Repeatedly, throughout the 2020 election, and since taking office, the Biden-Harris administration has pledged not to raise one single penny in taxes on anyone making less than $400,000 a year. That was a pledge, a promise. So I introduced an amendment during our August vote-a-rama to ensure my colleagues on the other side of the aisle had an opportunity to go on record in support of the Biden tax promise. My amendment received 49 votes from my friends on the other side of the aisle, and it successfully passed the Senate 99 to 1. It now binds this partisan budget package. Unfortunately, my Democrat colleagues seem poised to violate the Biden tax promise by proposing tax hikes on folks making less than $400,000.

According to the nonpartisan Joint Committee on Taxation, over 15 percent of taxpayers earning between $75,000 and $100,000 a year will experience a tax hike in 2023. By 2027, that number will jump to more than 50 percent of taxpayers.

So with that said, Dr. Holtz-Eakin, can you please speak for a moment on how the House Democrat package will raise taxes on people earning less than $400,000 per year?

Dr. HOLTZ-EAKIN. Well, certainly. There are really two mechanisms in play. One is simply the direct impact of some of the tax proposals, most notably taxes on cigarettes, e-cigarettes, where the buyers will have incomes under $400,000. So they get a direct tax increase.

The second mechanism is the result of the fact that some taxes will be shifted onto workers, and those workers will be in the sub-$400,000 range. So for example, if you raise the corporation income tax, a large body of research shows that that tax cannot be borne entirely by shareholders or they will get an inadequate rate of re-

turn that cannot be borne entirely by customers, because that is a big price increase. That prices the firm out of the market, so it gets shifted back to workers in the form of lower wages.

The Joint Committee has recognized this in their scoring of tax proposals for a long time. And so, the large increase in the corporation tax rate, the larger minimum taxes on global earnings, all of that will have impacts on people making less than $400,000.

Senator YOUNG. Well, thank you for explaining that. It gives some academic and economic respectability to the sentiment I hear on the ground in Indiana from regular people, who seem to understand that their taxes are going to go up should some variant of that House Democrat package pass the United States Senate and be signed into law.

Dr. Holtz-Eakin, I really am grateful for your perspective on how the Medicare program's coverage gaps for cutting-edge innovations and medical technology impact access for patients today and also impact innovation in the future.

I was disappointed with CMS's recent proposal to repeal the Medicare Coverage Innovative Technology rule 3 months prior to implementation. CMS developed MCIT in part due to concerns that delays and uncertainty in Medicare coverage limited seniors' access to important new and innovative technologies.

How could the delay in CMS's coverage and reimbursement process impact innovation of lifesaving diagnostic tools, preventive technologies, and treatment, Doctor?

Dr. HOLTZ-EAKIN. So the rule is intended to provide automatic CMS reimbursement for those therapies that got a breakthrough designation by the FDA. And in doing so, you would accelerate the movement of that product into earning some revenue. That has clear incentives on innovation. If you have an innovation that never generates any revenue, you are not going to pursue that. If the revenue's impact is years and years into the future, you might not be able to survive, so you will not undertake that innovation. So, if you can accelerate, essentially the marketability of an innovative technology, or a pharmaceutical, or a device, that is going to help innovation.

Senator YOUNG. Do you have—very briefly—do you have any recommendations on how CMS could revive the proposed rule, rather than kill it outright?

Dr. HOLTZ-EAKIN. I think the concern that arises is that every therapy that gets a breakthrough designation automatically gets reimbursement. It is not obvious what the appropriate reimbursement is. So I think that what CMS should have the ability to do is to—essentially, the default is in, but if they can make the case that it will be too costly, or they do not know how to reimburse it, they could opt some therapies out.

Senator YOUNG. Thanks so much.

[Pause.]

Senator YOUNG. Mr. Chairman?

The CHAIRMAN. Yes, I think——

Senator YOUNG. My time has expired. My apologies.

The CHAIRMAN. I thank my colleague. And I appreciate particularly Senator Stabenow filling in for so much of this, and Senator Crapo's courtesy.

I believe our last questioner will be Senator Lankford. Senator Lankford, are you out there in cyberspace?

Senator LANKFORD. I am, Mr. Chairman.

The CHAIRMAN. Wonderful. Have at it.

Senator LANKFORD. Thank you. And last means final for everyone who is on the panel as well. Thank you for being on the panel, for answering questions from us remotely, and physically. We appreciate your engagement on this. There is a lot of conversation that needs to happen on the health-care front.

I have worked across the aisle on health-care solutions, trying to work to find innovative market-based solutions. Senator Brown and I have worked on issues with DIR fees, which are very significant in the drug pricing issue and keeping our independent pharmacies open. I have worked with Senator Menendez on the issue of tiering for drugs, also Senator Cardin on that issue of tiering for drugs, making sure that new drugs, when they come out, actually end up on the right tier to have the right pricing to be able to help the consumer. There are lots of market-based things that need to be done in this.

Dr. Holtz-Eakin, I have a question for you—you have raised several of these issues. What do you see as the key market-based solutions that are not going to be a government-controlled health-care system that could actually bring lower prices and more innovation?

Dr. HOLTZ-EAKIN. I think the central set of attributes is to have it be highly decentralized, so the competition takes place on the ground with recognition of the population health-care districts.

It should involve essentially capitated payments to insurers and managed care organizations and give them strong incentives to manage their costs and not let them become large. But there has to be with that a set of quality metrics that are easy to implement, and which allow observation of whether we have high-quality outcomes. And then you are moving the system towards something that pays for value, does so in a way that is suitable for the population characteristics—it might even include things outside of the traditional range of health services. You will get better health, and you will have incentives to keep costs down.

Senator LANKFORD. Do you see a good example of that currently in our system?

Dr. HOLTZ-EAKIN. There have been attempts at this kind of thing all through the system. So we have seen bundles in traditional Medicare, where the idea is to look at a set of services and provide a bundled payment for that. Clearly, you have to ensure the quality of the outcome. Medicare Advantage is essentially one big bundle. And with the Medicare Advantage stars program, we have quality metrics. I think we could improve on that dramatically in the years going forward, and that would be a good place to start.

Because with Medicare being such an important payer in the system, it is an important determinant of practice patterns. And using Medicare Advantage to drive a high-value delivery system that differs across the country, I think is a very smart strategy.

Senator LANKFORD. Dr. Holtz-Eakin, none of us really know what this proposal is, this reconciliation proposal. It is sometimes $3.5 trillion, it is sometimes $2 trillion, it is sometimes $1.5 trillion. It has been a moving targets on things, so it has been difficult to be

able to articulate some of the issues that are in it. From what you have seen in the public arena, how do you think that some of the proposals would affect R&D for the future in the United States for new drugs, new treatments, new therapies, new procedures?

Dr. HOLTZ-EAKIN. Well, certainly the tax proposals would hit, directly, a lot of the firms, and that would be a drain on their ability to pursue R&D. Some of the individual proposals on capital gains top rates are likely to affect the venture financing that is such an important part of the biopharmaceutical ecosystem and provides the financing for the startups that have been leaders in the innovative new oncology drugs, in particular recently.

So I would worry about the impact of these proposals—which are sort of viewed as just benign ways to raise money—what they will do to the culture for investments, innovation, and the accumulation of intellectual property in the United States.

Senator LANKFORD. So again, none of us have seen text on this. We are all just reading bits and pieces of it back and forth on the reconciliation proposal. We have had an agreement for decades across the government that we do not use Federal dollars, Federal taxpayers' dollars, to pay for the taking of life—that is, an abortion. We use health-care dollars to provide for protecting life, not actually taking life.

So we have had what we call the Hyde Amendment—which you know extremely well—since the 1970s that has said we do not use Federal tax dollars to take the life of children. This seems to be a method to try to get around that and to actually now take Federal tax dollars for the first time and use them for abortion funding. Is that your best understanding, that the new mechanisms being put in place in this reconciliation proposal will allow for Federal tax dollars to be used for the taking of life in abortion?

Dr. HOLTZ-EAKIN. Yes.

Senator LANKFORD. How far do you think that expansion could go, based on what you have seen?

Dr. HOLTZ-EAKIN. I hate to speculate. As near as I can tell, at the moment it is centered in the proposal to have a Federal Medicaid-like program in the States that did not expand Medicaid, and that program begins with 3 years of participation in the individual market for those targeted beneficiaries. It is certainly at least that.

And as you say, until we see the final legislative text, we cannot know exactly where the boundaries might lie.

Senator LANKFORD. Well, that will definitely be an incentive to—obviously I am very supportive of health care, and have been very, very engaged on community health centers and Federally Qualified Health Centers, and for all kinds of health-care innovation. We need a lot of innovation. We need a lot of marketplace ideas. But I have been strongly opposed to using health-care dollars to actually take the life of individuals, of children.

I would like to be able to see our health-care dollars invested towards actually protecting life in the future.

So, Mr. Chairman, thank you for allowing me to be the last questioner and to be able to jump into the conversation today. Thanks again to all the witnesses.

The CHAIRMAN. We are doing—and let me thank our witnesses for being so extraordinarily patient. We are waiting for Senator Warren. I am supposed to be in another place, and Senator Warren will finish it up and will liberate you all.

[Pause.]

The CHAIRMAN. Okay, we are continuing to await Senator Warren.

Apropos of this question of costs and the critiques of them, clearly expanding health coverage to the uninsured is important. And we also have to help families that have coverage who are getting crushed by health-care costs that drain their pocketbooks. And I am so pleased that Senator Warren is here. I am going to finish my question.

And, Senator Warren, with your leave, when I finish this question, we will allow you to ask your questions and close the hearing. Is that acceptable to you?

Senator WARREN. Very acceptable. Yes.

The CHAIRMAN. Okay. Here is the question. Apropos of you, Dr. Collins, these health plans with sky-high deductibles, and monthly premiums that are also in the stratosphere, can threaten people's access to care and are not worth the paper they are written on. If you want to reduce these out-of-pocket costs for families and make sure coverage is meaningful, we need to address the underlying costs here, which are the high prices we pay in this country for health care. We have been talking about that for upwards of 3 hours.

And I just want to have Dr. Collins answer this question, and then I am going to turn it over to Senator Warren.

What does it mean to these low- and middle-income families when we see the deductibles and out-of-pocket costs account for a larger and larger share of their income? Dr. Collins?

Dr. COLLINS. Thank you, Senator Wyden.

First of all, spending more on your premiums already burdens households that are struggling with the housing prices, food prices, child care prices. So that just adds to their burden at the front end.

But then having high deductibles also impacts people's ability to access needed health care. And we know from years and years of surveys that high deductibles lead people to make decisions that go against their best health-care interests.

The other dynamic that is happening is—and this has also been consistent—high deductibles lead people to be unable to pay their bills and to accumulate debt over time. And that has long-running financial implications for people, including having their credit scores ruined; accumulating credit card debt; depleting their savings; not being able to pay for food, heat, or their rent.

So this is really an affordability crisis for lower-income people that we do need to address, first by protecting people, but then also addressing the underlying problem, which is high prices in the commercial insurance markets.

The CHAIRMAN. Very important, Doctor. And the last point I am going to make is, Donald Trump's effort to repeal the Affordable Care Act would have more than doubled the deductibles under the proposal as written. And you got a sense from Dr. Collins about the pain that people are already going through when they are pur-

chasing deductibles. Another good reason why it made sense to resist that Trump effort.

Senator Warren, we have been 3 hours into it. It is very fitting that you wrap it up. And, after you have completed your questions, I appreciate your adjourning the Finance Committee.

Senator WARREN. I will do that. Thank you. Thank you very much, Mr. Chairman.

As many people have talked about today, health-care coverage continues to be out of reach for millions of Americans. And right now Congress has this historic opportunity to take a big step in the right direction by passing the Build Back Better agenda to close the Medicaid coverage gap; to expand Medicare coverage for dental, vision, and hearing; to tackle affordability; and more.

So let me start with you, Dr. Blumberg. You have written about many of these proposals. Now, if all of the remaining States expanded their Medicaid programs, how many of the uninsured people who would become eligible for health-care coverage have incomes below the poverty line?

Dr. BLUMBERG. My colleagues estimate about 3 million of the newly eligible uninsured in those 12 States would currently have incomes below poverty.

Senator WARREN. Okay. And unless a person in this coverage gap gets a job that offers them health insurance, or unless they move to another State that has already expanded Medicaid, do these people have any other coverage opportunity?

Dr. BLUMBERG. They do not have adequate and affordable other opportunities, no.

Senator WARREN. Okay. All right, so 3.2 million people below the poverty line—they do not have any other coverage options. The people caught in the Medicaid coverage gap are not boxed out of care because they are too wealthy, or because they have some other option available to them. Instead, these individuals, 60 percent of whom are people of color, have no health-care coverage because they are poor. That should not happen in America.

So, Dr. Blumberg, if the 12 States that have not taken up the Medicaid expansion decided to do so tomorrow, how much new Federal money would the Federal Government be expected to find to finance these expansions?

Dr. BLUMBERG. It would cause no increase and no need for revenue because it was already covered by the Affordable Care Act of 2010.

Senator WARREN. So this has already been budgeted for?

Dr. BLUMBERG. Correct. There is a lot of money left on the table that has not been used by those States since 2014.

Senator WARREN. Okay. Money left on the table. If Congress passed a bill to close the coverage gap and found new money to cover the costs, would Congress be paying twice to cover this same population?

Dr. BLUMBERG. Essentially, yes, that is the truth, since it was already funded—the same people and the same benefits.

Senator WARREN. All right; thank you.

You know, this is an important point to focus on, especially in light of the CBO estimates that were released yesterday. To anyone saying that it is too expensive to cover the Medicaid coverage gap,

or that we can only afford to cover this gap for a few years, I have some good news for you. Congress has already paid to insure this population. And it is time for the Federal Government to deliver these individuals the coverage that they have long been promised. And there is no reason to pay for it a second time.

Now, Mr. Isasi, last year 9.5 million Medicare beneficiaries said that they could not access dental, vision, or hearing services that they needed. Can you just give us a little bit of a description about who those people were?

Mr. ISASI. Absolutely. Thank you for the question.

So we are talking about—it is really important to say this—three times as many folks are having trouble who have incomes below $10,000, than the people who have higher incomes. These are—in large, large part we are talking about the most vulnerable Medicare recipients. Also, it is many, many people of color compared to White Medicare beneficiaries; twice as many Black beneficiaries who cannot see a dentist and one-third as many Hispanics. Twice as many Black adults have lost all their teeth, as compared to the national average. And three times as many Mexican-American older adults have untreated tooth decay.

So this is very much an issue for some of our most poor, vulnerable, and beneficiaries of color.

Senator WARREN. And they are the ones who would benefit most if Medicare were expanded to cover vision, dental, and hearing?

Mr. ISASI. Without a question. Without a question.

Senator WARREN. Thank you very much for this. Low-income Americans, and people of color, will disproportionately benefit from Medicare dental, vision, and hearing coverage. Of the millions of Medicare beneficiaries who do not have access to these services, about 70 percent have said it is just because they cannot afford it.

The best approach to getting universal coverage is through a single-payer system, but we should not overlook how powerfully important the provisions in the Build Back Better agenda are.

We have a historic opportunity to make a real difference in people's lives, and we should do that.

Mr. ISASI. I could not agree more.

Senator WARREN. Thank you very much.

Senator Scott wishes to ask questions? Is that right? Oh, he wants to enter—sorry, I did not read the note—wants to enter documents into the record. Without objection, so ordered.

[The documents appear in the appendix beginning on p. 157.]

Senator WARREN. And with that, I close this hearing. We will keep it open for questions for the record, and comments. Thank you very much.

[Whereupon, at 1:08 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. MICHAEL F. BENNET, A U.S. SENATOR FROM COLORADO

Mr. Chairman, I want to thank you for holding this hearing. I am glad we are here to talk about the importance of health coverage and the need to achieve universal coverage, which should be a priority for every single one of us on this committee.

It has been over 4 years, September 12, 2017 to be exact, since we've had a dedicated hearing on coverage. Unfortunately, at that moment we were in the middle of combating an unsuccessful threat to the Affordable Care Act (ACA), and millions of Coloradans who would have been affected are deeply grateful it failed. One Urban Institute study found that under just partial repeal of the ACA, similar to legislation vetoed by President Obama in January 2016, 588,000 Coloradans would have tragically lost their insurance.[1]

This hearing is essential to remind the American people of how the ACA led to increased health insurance coverage for millions of Americans while reducing the cost and improving the quality of plans available on the individual market. The American Rescue Plan Act (ARPA), signed into law earlier this year, expanded the Advance Premium Tax Credits (APTCs) identical to provisions in my Medicare-X Choice Act, which reduced the cost of health insurance for individuals and families purchasing non-group health insurance. Although I believe there are still steps we should take to achieve universal health coverage, like establishing a public option to finish the work of the ACA, I want to make it abundantly clear that it has been Democrats who have taken major legislative steps to improve coverage for Americans.

Under the leadership of Senator Mitch McConnell and President Donald Trump, there were only efforts to reduce coverage, increase the availability of subpar health insurance, and remove patient protections like allowing insurance plans to deny coverage for preexisting conditions. In fact, Mitch McConnell has forced the Republican caucus to vote countless times to undermine the ACA and the needs of constituents across the country.

Notably, five times proposals were brought to the floor, and five times those bills failed to become law:

(1) In February 2011, Senator McConnell proposed an amendment to S. 223, the FAA Air Transportation Modernization and Safety Improvement Act. This amendment would have prevented the ACA from being implemented in its entirety. It failed by a vote of 47 to 51.[2]

(2) In December 2015, Senator McConnell led the effort to pass the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015. This legislation would have repealed premium support, Medicaid expansion, and the individual and employer

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[1] *http://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliatio_0.pdf.*

[2] *https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=112&session=1&vote=000.*

mandate penalties, among other provisions. The bill passed by a vote of 52 to 47.[3] President Barack Obama rightfully vetoed this legislation.

(3) In July 2017, Senator McConnell, with the full support of President Donald Trump, brought to the floor a series of proposals to undermine the ACA. The first Senate proposal, the Better Care Reconciliation Act, repealed and replaced the ACA with a proposal that would increase the uninsured by 22 million.[4] The proposal failed by a vote of 43 to 57.[5]

(4) Just a day later, Senator McConnell and President Trump continued their efforts to repeal the ACA by putting forward a budget resolution amendment titled the Obamacare Repeal Reconciliation Act of 2017. This would have repealed Medicaid expansion and premium support in 2020, right as the Coronavirus Disease 2019 unexpectedly created a public health and economic crisis. This amendment failed by a vote of 45 to 55.[6]

(5) Finally, after a few days of further discussion on a wide range of careless proposals, Senator McConnell put forward his final proposal, the Health Care Freedom Act of 2017, a "skinny" repeal of the ACA, without a replacement, that would have reduced coverage for 15 million Americans.[7] This failed by a vote of 49 to 51.[8]

Over and over, Senator McConnell took actions that communicated that the party he leads will not work to increase coverage, often burdening the very individuals that they represent.

Time and time again, Democrats have worked to improve and increase coverage for all Americans, regardless of income, geography, race/ethnicity, or any other background.

I will continue work with my colleagues and fight to protect the ACA, the improvements made under the ARPA, and take further actions, like creating a public option, to achieve a shared goal of universal coverage.

This hearing is just the next step to accomplish this, and I thank my colleagues and the witnesses for their efforts in realizing this goal.

National Academy for State Health Policy

State-Based Marketplaces Report Savings and Growth for Older Adult and Moderate Income Populations

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The American Rescue Plan Act (ARPA) had a significant impact on the ability of Americans to access and afford health insurance through the federally facilitated marketplace and state-based exchanges across the country. ARPA's dual policies of enhancing existing tax credits used to purchase coverage and providing first time tax credits for moderate income households (those above 400% of the federal poverty level (FPL)) enabled millions to access [1] coverage through marketplace plans since the law's enactment in March of 2021.

The National Academy for State Health Policy (NASHP) recently analyzed how ARPA has impacted enrollees in state-based health insurance marketplaces (SBMs) across different age and income groups. Specifically, NASHP examined households with individuals over 55 years of age for whom health insurance is often cost- prohibitive because of higher charges associated with age (known as age rating) and individuals with income over 400% FPL who newly qualify forsubsidies.

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[3] *https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=114&session=1&vote=00329.*

[4] *https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2017_jul_ku_bcra_economic_effects_states.pdf.*

[5] *https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=115&session=1&vote=00168.*

[6] *https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=115&session=1&vote=00169.*

[7] *https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s.a.667.pdf.*

[8] *https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=115&session=1&vote=001.*

[1] *https://www.hhs.gov/about/news/2021/09/15/biden-harris-administration-announces-2-8-million-people-gained-affordable-health-coverage-during-2021-special-enrollment.html.*

To conduct this analysis, NASHP collected data from 13 SBMs operating in **CO, CT, DC, ID, MD, MA, MN, NV, NJ, NY, PA, VT,** and **WA.** This analysis was conducted as part of NASHP's work with the State Based Exchange Leadership Network—a consortium of state leaders and staff operating the SBMs. Data are current as of September 2021, except where otherwise indicated.

Increased Enrollment and Affordability for Pre-Retirees in SBM Plans

Over a half million (552,069) 55+ year-olds are currently enrolled in plans through the 13 SBMs reporting data, with the majority of SBMs **(CO, CT, ID, MD, MA, MN, VT, WA)** [2] reporting increased enrollment of this population when compared to this time last year. For example, Colorado reported an increase in enrollment of 11 percent and two States, **Idaho** and **Maryland,** reported a significant increase in enrollment of 63 and 55 percent, respectively.

Enrollment increases may be a result of lower out-of-pocket premium costs resulting from ARPA's premium tax credit enhancements. Eleven SBMs report lower average premiums paid by 55+ year-olds after the enactment of APRA. Average premiums for 55+ year-olds fell by over 20 percent in eight States **(CT, DC, MD, NV, NJ, PA, RI, WA),** with six of those States reporting decreases in premiums of over $100 per month (or $1,200 per year) **(CT, DC, NV, NJ, PA, WA)**.[3]

Increased affordability may also be driving this population to seek higher value coverage in the form of silver and gold level plans available through the marketplaces. Growth was especially notable in gold-level enrollments, as SBMs saw a 17% increase compared with last year.[4] Overall 63% of 55+ enrollees elected either a silver or gold plan across the 13 SBMs.

ARPA Yields Significant Savings for Some Pre-Retirees

Subsidy enhancements have enabled single digit coverage for the first time for older adults. For example, a 60-year-old in Connecticut making $19,000 a year can now access a silver-level plan through the SBM for as low as $3/month or $36 per year (a 95 percent savings from pre-ARPA rates).

Affordability and Enrollment Gains for Moderate-Income Enrollees in SBM Plans

ARPA imposed a first-time ever cap [5] on monthly premium expenses households must pay toward marketplace coverage, regardless of income. This meant that, for the first time, households earning at or above 400% FPL ($104,800 for a family of four in 2021), could qualify for premium tax credits available through the marketplaces. The availability of tax credits has led to significant savings, with eight States **(CO, DC, ID, MA, MD, NV, NY VT)** reporting that average out-of-pocket premiums has fallen by greater than $100 per month (or $12,000 per year) since ARPA's enactment. The **District of Columbia** and Idaho report that average premiums have fallen over $300 per month (or $3,600 per year), while **Colorado** reports savings of $497 per month (or $5,964 per year).[6]

The increased affordability of SBM plans for those with income at or above 400% FPL may have triggered more of these moderate income households to enroll in coverage through SBMs. Since the enactment of ARPA, the U.S. Department of Health and Human Services reports that an estimated 88,600 individuals from households with income above 400% FPL have enrolled in coverage through the SBMs.[7]

Looking ahead, SBMs are preparing for the next open enrollment season, launching on November 1, and working to ensure that customers, new and old, continue to leverage their resources to access the best value coverage. NASHP will continue to monitor emerging SBM trends. See addendum and infographic below for some additional details.

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[2] 2020 data not available for NJ and PA during which they operated on the federally facilitated marketplace. Data from NV unavailable at the time of reporting.

[3] Analysis is based on premium data reported as of April 1, 2021. Data not available for MA and NY which do not allow for age-based rating of premiums.

[4] 2020 data not available for NJ and PA during which they operated on the federally facilitated marketplace. Data from NV unavailableat the time of reporting.

[5] Under ARPA, the cap is set at 8.5% of household income.

[6] Based on households electing to receive financial assistance in the form of advanced premium tax credits. Data not available for CT, MN, NJ.

[7] U.S. Department of Health and Human Services, "2021 Final Marketplace Special Enrollment Period Report." Report, September 15, 2021. Accessed at: *https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.*

Customer Testimonials on ARPA and Marketplace Coverage

Since enactment of ARPA, customers of the **Washington Health Benefit Exchange** report greater ability to afford and use coverage through the marketplace. As shared by one 57-year old customer: "My bill [is] $242 less than I presently pay. . . . If this continues, I could afford to get better insurance or pay out of pocket for occupational therapy that my insurance and the third party employer tell me I can't have." Another consumer reported that the additional subsidies enabled them to move from bronze to silver-level coverage which, in-turn, enabled them to afford prescription medicines the individual had previously been unable to purchase.

Addendum

Additional Customer Testimonials as Reported by State-based Marketplaces

Massachusetts Health Connector

Responses reported from a customer survey of enrollees over 55 years of age:

"The American Rescue Plan helped me tremendously. I was struggling paying high rent, high insurance of $ 498.00 a month plus dental insurance, bills, food, and personal protective equipment. I know I would not be able to pay insurance without the help of The American Rescue Plan I can use the extra money for transportation back and forth to work." —Sheila (Boston, MA)

"My husband passed away in May 2020 from the coronavirus. We owned our own construction business and since we were self-employed, we had no help with health insurance. I had to sell my home and close our business, and I didn't know what I was going to do for health insurance as I was out of a job. Thank goodness the American Rescue Plan helped me continue to have health insurance coverage." —Debra (Peabody, MA)

"I have been a diabetic for 58 years and having no premium and very low cost on prescription has been huge. I have never made a lot of money and shelling out what I used to held me back from doing a lot of things. Diabetes is a rich man's disease. Prices on everything are going up and what I save in medical costs leaves me with more money for living." —Lisa (Brockton, MA)

Pennie/Pennsylvania

"I had an incident a year ago. I retired from the Harrisburg school district. I tore my Achilles heel and was in a cast for longer than 6 weeks. I needed to transfer to a 'boot'—[but could not get] one without insurance. I [paid] $2,000 per month for health insurance. This was too much, but we made it work. This year, Pennie has made things very, very affordable. I was diagnosed with Lupus and Prostatitis if I did not have this insurance there is no way in the world that I would be protected. I am getting the proper help now I pay $40 for therapy or $15 for an office visit—before it was $100 per visit. I used to have to cancel my appointments so that my wife could go to her appointment. This year, my wife has Crohn's disease—under Pennie, she's protected! My wife and I now have the help that we need." —Keith, Age >55

Since enactment of ARPA, Keith and his wife now pay only $99.84 a month for coverage, a savings of $22,802 per year.

American Rescue Plan Act Encourages Coverage Uptake for Older, Moderate Income Americans in State-Based Marketplaces

This graphic examines trends in state-based marketplace enrollments for pre-retirees (55+ year olds) and households with income ≥400% of the federal poverty level (FPL) that followed enactment of the American Rescue Plan Act (ARPA). The analysis used data collected from 13 state-based health insurance marketplaces (SBMs) CO, CT, DC, ID, MD, MA, MN, NV, NJ, NY, PA, VT, and WA. Data is current as of September 2021 except where otherwise noted.

Pre-retiree enrollment has grown across the majority of SBMs

ENROLLED
552,069
55+ YEAR-OLDS ENROLLED IN SBM PLANS

GROWTH
35%
GROWTH SINCE 2020

GROWTH
8
SBMS REPORT GROWTH OF THEIR 55+ ENROLLEES

GROWTH
50%
ENROLLMENT FOR THIS POPULATION GREW BY MORE THAN 50% IN ID AND MD

Households experienced significant savings since implementation of ARPA

FOR ENROLLEES 55+ YEARS OF AGE

LOWER PREMIUMS
ALL SBMS REPORT LOWER AVERAGE PREMIUMS FOR 55+ YEAR-OLDS.[1]

MEDIAN REDUCTION
$95/MONTH OR $1140/YEAR

DECREASE IN PREMIUMS
6
SBMS REPORT A DECREASE IN PREMIUMS OF >$100/MONTH OR $1200/YEAR
CT DC NV NJ PA WA

IN HOUSEHOLDS ≥400% FPL

LOWER PREMIUMS
ALL SBMS REPORT LOWER AVERAGE PREMIUMS FOR HOUSEHOLDS WITH INCOME ≥400% FPL[2]

3
SBMS REPORT A DECREASE OF >$100/MONTH OR $1200/YEAR
MD NV NY

2
SBMS REPORT A DECREASE OF >$200/MONTH OR $2400/YEAR
MA VT

3
SBMS REPORT A DECREASE OF >$300/MONTH OR $3600/YEAR
CO DC ID

55+ households are purchasing higher metal-level coverage

SILVER OR GOLD
63%
OF 55+ ENROLLEES PURCHASED EITHER A SILVER OR GOLD METAL PLAN

GOLD
17%
ENROLLMENT IN GOLD PLANS GREW BY 17% PERCENT IN 2021.[3]

SILVER OR GOLD
50%
OF ≥400% FPL ENROLLEES PURCHASED EITHER A SILVER OR GOLD METAL PLAN[4]

[1] Data reported as of April 2021. MA and NY prohibit age-rated premiums and were excluded from these data.
[2] Based on households electing to receive financial assistance in the form of advanced premium tax credits. Data not available for CT, MN, NJ.
[3] Data not available for NV, NJ, PA
[4] Data not available for CT, MN, NV, NJ, PA

PREPARED STATEMENT OF LINDA J. BLUMBERG, PH.D.,*
INSTITUTE FELLOW, URBAN INSTITUTE

Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee, thank you for inviting me to address current issues related to health insurance in the U.S. While I am an employee of the Urban Institute, the views expressed in this testimony are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

Research has demonstrated that the Affordable Care Act has increased health insurance coverage in the U.S. among the nonelderly by more than 20 million people.[1] The enhancements of premium tax credits provided by the American Rescue Plan Act (ARPA) have increased coverage further, albeit temporarily, given the limited duration of the enhanced credit period. These reforms also have improved affordability of insurance coverage and increased access to care for millions of Americans.

As a result, the U.S. health insurance system provided a stronger safety net during the pandemic-induced economic downturn than in prior recessions. According to the Urban Institute's Health Reform Monitoring Survey, the number of nonelderly adults with employer-based insurance fell by approximately 5.5 million between March 2019 and April 2021.[2] Yet unlike prior recessions, the number with Medicaid increased even more. As a consequence, the number of uninsured held steady instead of increasing nationwide. However, while nationwide data is encouraging, the number of uninsured rose in nonexpansion States because smaller shares of people who lost employer coverage were eligible for Medicaid.

Still, nationwide, the private nongroup insurance Marketplaces are, by all indications, fundamentally stable. In 2021, the national average benchmark premium fell for the third year in a row, with average decreases in 43 States and only 1 State with an increase of more than 6 percent, following very large premium increases in 2018.[3] In addition, insurer participation in the Marketplaces has increased since 2017 in many population centers. However, in areas with lower insurer participation and/or consolidation among health providers, premiums and premium growth tend to be higher.

Even recognizing the successes, significant gaps remain in the health insurance system. First, more than 3 million people living below the poverty line and 1.2 million near-poor people are uninsured and ineligible for any financial assistance because they live in States that have not expanded Medicaid eligibility.[4] In addition, absent the temporarily increased ARPA Marketplace subsidies, my Urban Institute colleagues estimate that the number of uninsured nationally would reach 30 million in 2022.[5] Conversely, they estimate that making the ARPA subsidies permanent and extending them to lower-income people in nonexpansion States would decrease the uninsured by another 7 million people at a net Federal cost of $27.7 billion in 2022, or $333 billion over 10 years. In addition, these estimates indicate that such policies would increase Marketplace enrollment while decreasing Marketplace premiums by 18 percent, on average, because of the relatively better average health of the new enrollees.[6] Taking lower premiums and out-of-pocket costs into account, the average per enrollee health-care costs for those insured through the Marketplaces would be over $1,100 lower per year.[7]

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*The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

[1] Linda J. Blumberg, Michael Simpson, Matthew Buettgens, Jessica Banthin, and John Holahan, "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Washington, DC: Urban Institute, 2020).

[2] Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased: Trends in Health Insurance Coverage between March 2019 and April 2021" (Washington, DC: Urban Institute, 2021).

[3] John Holahan, Jessica Banthin, and Erik Wengle, "Marketplace Premiums and Participation in 2021" (Washington, DC: Urban Institute, 2021).

[4] Michael Simpson, Jessica Banthin, and Matthew Buettgens, "Most Uninsured People Gaining Medicaid Eligibility under Potential Expansion Would Have Incomes below the Federal Poverty Level" (Washington, DC: Urban Institute, 2021).

[5] Jessica Banthin, Michael Simpson, and Andrew Green, "The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress" (New York: Commonwealth Fund, 2021).

[6] Jessica Banthin, Matthew Buettgens, Michael Simpson, and Robin Wang, "What If the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022" (Washington, DC: Urban Institute, 2021).

[7] Banthin, Buettgens, Simpson, and Wang, "What If the American Rescue Plan's Marketplace Subsidies Were Made Permanent?"

While such opportunities exist to expand coverage, further action also must be considered, because the pending end of the national public health emergency (PHE) will also end the requirement that States keep people enrolled in Medicaid, and this transition poses future challenges for coverage. Urban Institute estimates indicate that Medicaid enrollment could decrease by as many as 15 million people during 2022 once the PHE-related maintenance-of-effort requirement ends, including 8.7 million adults and 5.9 million children. These numbers are partly offset by the projection that one-third of those adults would qualify for subsidized private health coverage in the Marketplaces. About two-thirds of the children would be eligible for assistance, much of it through CHIP. However, others have highlighted that the number losing Medicaid coverage at the end of the PHE could exceed 15 million people, given the difficulty of contacting still-eligible people to reverify and renew enrollment when they have not been in contact with State Medicaid systems for up to 2 years.[8]

Thus, the risk of a significant increase in the number of people uninsured following the end of the PHE is substantial, and such risk merits legislative and administrative consideration. As I have outlined, permanent, enhanced premium tax credits should encourage more people to move from Medicaid to the Marketplace once they lose Medicaid eligibility. Further, aggressive outreach and enrollment efforts at the State and Federal levels, in addition to streamlining Medicaid redetermination and enrollment processes, are among viable options available to address the potential for a near-term increase in the number of uninsured Americans.

Thank you for the opportunity to share information with you on these important issues. I'd be happy to answer any of your questions.

The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress

by Jessica S. Banthin, Michael Simpson, and Andrew Green

Errata

On October 5, 2021, we corrected errors in this brief resulting from a coding error that did not apply all cost-sharing reductions to household spending. In the "Changes in Household Spending" section and Appendix Table 3, the increase in households' out-of-pocket spending is $0.6 billion and households' overall savings is $8.2 billion in 2022. Previously, these estimates were $7.0 billion and $1.8 billion.

Highlights

- Making ARPA premium subsidies permanent and filling the Medicaid coverage gap would reduce the number of people without insurance by nearly one-quarter, or 7.0 million people, in 2022.
- All States would see a drop in their uninsured population, with the largest percentage declines in States that have not yet expanded Medicaid eligibility.
- Enrollment in subsidized marketplace plans would nearly double, while premiums would fall by 18 percent on average.
- Federal spending would increase by an estimated $442 billion over 10 years and, after accounting for increased revenues because of higher wages and some offsetting savings, this reform would increase the Federal deficit by an estimated $333 billion if no other changes in policy were made.

Introduction

As part of the budget process for fiscal year 2022, Congress is considering a package of two reforms to the Affordable Care Act (ACA). Under the package, the enhanced premium subsidies included in the American Rescue Plan Act (ARPA) would become permanent. Additionally, the so-called Medicaid coverage gap would be filled by extending eligibility for marketplace subsidies to people earning below 100 percent of the Federal poverty level (FPL) in 12 States that have not yet expanded Medicaid.

Following is a closer look at the two reforms.

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[8] Kinda Serafi, Cindy Mann, and Nina V. Punukollu, "The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID–19 Public Health Emergency Ends," To the Point (blog), Commonwealth Fund, September 23, 2021, *https://www.commonwealthfund.org/blog/2021/risk-coverage-loss-medicaid-beneficiaries-covid-19.*

Making the ARPA Premium Subsidies Permanent

Passed in the wake of economic disruption and job losses because of the COVID–19 pandemic, the ARPA temporarily enhances premium tax credits in the marketplace for 2021 and 2022. The law lowers the limits on premiums paid by families who were eligible for subsidies before ARPA and expands eligibility for subsidies to individuals and families who were previously ineligible because their incomes were greater than 400 percent of FPL (more than $106,000 for a family of four).

The new subsidy schedule substantially reduces households' premium payments (see Appendix Table 1). Making these changes permanent would have significant effects on coverage, as we've previously estimated.[1]

Extending Eligibility for Marketplace Subsidies in Nonexpansion States

Under current law, people with incomes below 100 percent of FPL are not eligible for marketplace subsidies. Because of the large gap between traditional Medicaid eligibility levels in some States and 100 percent of FPL, about 5.8 million uninsured adults living in the 12 nonexpansion States do not have access to affordable health insurance coverage. (For example, Texas covers parents below 17 percent of FPL while Alabama covers those below 21 percent of FPL; childless adults are generally not covered in nonexpansion States.)

Although health insurance coverage through the marketplace is not as comprehensive as Medicaid coverage, expanding eligibility for marketplace subsidies to this group results in large increases in coverage.[2]

For this analysis, we examined the coverage and cost impact of these two key reforms together, using the Urban Institute's Health Insurance Policy Simulation Model (see "How We Conducted This Study.") Our analysis incorporates the effect on enrollment of increased Federal spending on outreach.

Findings

Changes in Coverage

Implementing these two policies would increase insurance coverage, reducing the number of uninsured people by nearly one-quarter. The number of uninsured people would fall by 7.0 million, from 30.3 million to 23.3 million (Exhibit 1).

EXHIBIT 1

Coverage of the Nonelderly Population Under Pre-ARPA Law and Permanent ARPA Subsidies with Medicaid Gap Filled by the Marketplace, 2022

Thousands of people	Pre-ARPA	Reform	Change	Change (%)
Employer	149,214	148,543	−670	−0.4%
Subsidized nongroup	9,219	17,252	8,033	87.1%
Unsubsidized nongroup	5,636	5,301	−335	−5.9%
Medicaid/CHIP	71,896	72,242	346	0.5%
Other coverage *	11,213	10,832	−381	−3.4%
Uninsured	30,269	23,276	−6,993	−23.1%
Total	**277,446**	**277,446**	**0**	**0.0%**

Notes: Reform includes permanent ARPA subsidies and filling the Medicaid gap by expanding subsidies for marketplace plans below 100 percent of the Federal poverty level. ARPA = American Rescue Plan Act. CHIP = Children's Health Insurance Program.

*Other coverage includes Medicare and other public coverage and a small amount of Affordable Care Act noncompliant nongroup coverage.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021), *https://doi.org/10.26099/4gyx-ry85.*

The enhanced subsidies would motivate many people who were previously eligible for marketplace subsidies but uninsured to sign up for coverage. Enrollment in the

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

[2] John Holahan et al., *Filling the Gap in States That Have Not Expanded Medicaid Eligibility* (Commonwealth Fund, June 2021).

subsidized nongroup marketplace would jump by 8.0 million people, nearly doubling in size to 17.3 million people across the health-care.

We also estimate 670,000 fewer people would be covered by employer-sponsored insurance (ESI). Most of the people who would leave ESI are those whose employers still sponsor health insurance but whose offerings are not deemed affordable; only a very small number would likely leave ESI because their companies would stop offering health coverage. This number does not include the reduction in ESI because of an administrative change in the so-called family glitch, which is discussed later in this brief.

We project that Medicaid and Children's Health Insurance Program (CHIP) enrollment would increase slightly by 346,000 people. Higher enrollment in the marketplace would likely trigger eligibility determinations that prompt family members to enroll in Medicaid. (Additional details on coverage changes are available in Appendix Table 2.)

Changes in Marketplace Premiums

An important result of the large increase in marketplace enrollment is the effect on premiums. We estimate that lower health risk scores among new enrollees would reduce premiums by about 18 percent in 2022 if insurers were able to adjust premiums immediately. The main reason average health risk would fall under these policies is that those with greater health-care needs are more likely to have already obtained coverage before passage of the ARPA.

Changes in Coverage by Income

Exhibit 2 shows that reductions in uninsured people would be concentrated in the lowest income categories. About 3.3 million uninsured people with income below 138 percent of FPL would gain coverage, largely because more residents of the 12 nonexpansion States would be eligible for marketplace subsidies. Nearly 600,000 uninsured people with income between 138 percent and 200 percent of FPL would gain coverage, while 2.2 million uninsured people with income between 200 percent and 400 percent of FPL would become covered as well, mainly because of more generous premium subsidies. Among those with income above 400 percent of FPL, 830,000 uninsured people would obtain coverage because of lower premiums and expanded eligibility for premium subsidies under the ARPA.

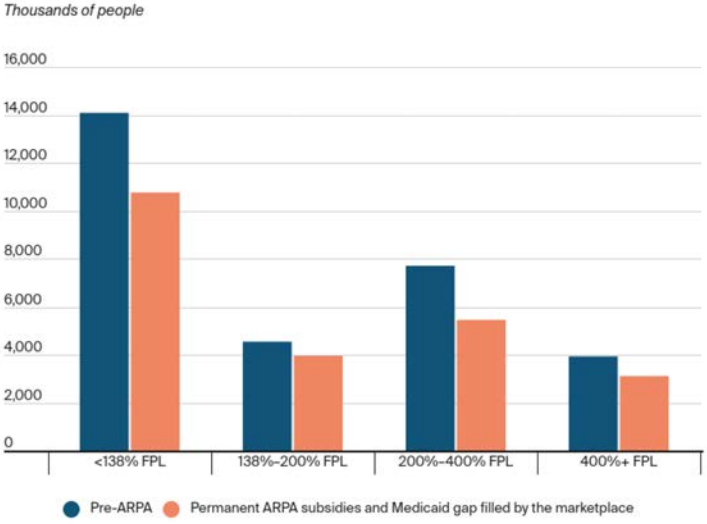
Changes in Coverage by Race and Ethnicity

As a result of the new policy, all racial and ethnic groups would experience large declines in the numbers of nonelderly people without insurance (Exhibit 3). According to our estimates, Black non-Latino/Hispanic and white non-Latino/Hispanic groups would see the largest percentage reductions—33.5 percent and 26.9 percent, respectively.

People of Latino/Hispanic ethnicity have the highest rate of uninsured people (20.9 percent, data not shown) compared to other groups, owing to the undocumented immigrant population. Under this policy, they would see the smallest percentage reductions in uninsured people, 15.7 percent, compared to other groups.

EXHIBIT 2

Number of Uninsured Nonelderly People, by Income Group, 2022



Notes: ARPA = American Rescue Plan Act. FPL = federal poverty level. Income groups are based on computations for Medicaid eligibility.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021). https://doi.org/10.26099/4gyx-ry85

EXHIBIT 3

Number of Uninsured Nonelderly People, by Race and Ethnicity, 2022

Thousands of people	**Pre-ARPA**	**Reform**	**Change**	**Change (%)**
American Indian and Alaska Native	596	455	−141	−23.6%
Asian and Pacific Islander	1,640	1,366	−274	−16.7%
Black, non-Latino/Hispanic	3,638	2,421	−1,217	−33.5%
Latino/Hispanic	10,539	8,883	−1,656	−15.7%
White, non-Latino/Hispanic	13,458	9,836	−3,622	−26.9%
Other	398	316	−83	−20.7%
All racial and ethnic groups	**30,269**	**23,276**	**−6,993**	**−23.1%**

Notes: Reform includes permanent ARPA subsidies and filling the Medicaid gap by expanding subsidies for marketplace plans below 100 percent of the Federal poverty level. ARPA = American Rescue Plan Act.
Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021), *https://doi.org/10.26099/4gyx-ry85.*

Changes in Spending and Effects on Deficits

By making the ARPA premium subsidies permanent and extending eligibility for marketplace subsidies, we estimate Federal spending on marketplace subsidies and Medicaid and CHIP would increase by $36.9 billion in 2022 (see Appendix Table 3). This increased spending would be offset partly by savings from reductions in the demand for uncompensated care. Although we include all of the estimated $7.5 billion reduction in uncompensated care in our calculation, only about half would be realized as savings directly through a reduction in Medicare Disproportionate Share Hospital (DSH) payments. The net effect on the deficit would amount to $27.7 billion in 2022 after accounting for higher Federal revenues because of reductions in ESI coverage, which is generally exempt from income and payroll taxes.

The increased cost of marketplace subsidies and Medicaid from 2022 to 2031 would add up to $442 billion (Exhibit 4). After accounting for increased revenues because of reductions in ESI and reductions in uncompensated care, we estimate that the net effect on the Federal deficit would be $333 billion over 10 years, from 2022 to 2031. The costs would likely be somewhat lower than presented here because consumers and insurers may take more time than we assumed to fully respond to the new options.

EXHIBIT 4

Federal Spending for the Nonelderly Population Under Pre-ARPA Law and Permanent ARPA Subsidies with Medicaid Gap Filled by the Marketplace, 2022–2031

Billions of dollars	**Pre-ARPA**	**Reform**	**Change**
Federal spending on acute health care	**5,655**	**6,007**	**353**
Medicaid	4,578	4,603	25
Marketplace tax credits	689	1,106	418
Marketplace cost-sharing reductions	0	0	0
Reinsurance	16	16	0
Uncompensated care *	372	282	-90
**Increase in Federal revenue ** **	**n/a**	**n/a**	**20**
Total net change in deficit	**n/a**	**n/a**	**333**

Notes: Reform includes permanent ARPA subsidies and filling the Medicaid gap by expanding subsidies for marketplace plans below 100 percent of the Federal poverty level. ARPA = American Rescue Plan Act. CHIP = Children's Health Insurance Program. n/a = not applicable; HIPSM computes only changes for revenues and deficits.

* Uncompensated care represents demand for care by the uninsured. At the Federal level, about half the change in demand resulting from a decrease in the number of uninsured people would automatically be realized as Federal savings to Medicare disproportionate share hospitals.

** Change in Federal revenue include the income and payroll tax effects of employer-sponsored insurance crowd-out.

Data: Urban Institute, Health Insurance Policy Simulation Model (HIPSM), 2021.

Source: Jessica Banthin, Michael Simpson, and Andrew Green, *The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress* (Commonwealth Fund, Sept. 2021, updated Oct. 5, 2021). *https://doi.org/10.26099/4gyx-ry85.*

Changes in Household Spending

We estimate that household spending on premiums would fall $8.8 billion in 2022 even as enrollment increases. However, household spending on out-of-pocket costs for health-care services (including deductibles and copayments) would increase by an estimated $0.6 billion in 2022 as access to and utilization of health-care increases. Overall, households would save $8.2 billion, according to our estimates. In previous work, we found the ARPA by itself would reduce average household spending per enrollee by 23.1 percent.[3]

Changes in Coverage by State

If passed, this proposal would reduce the number of uninsured people in every state. We find that the largest percentage declines would occur in States that have not

[3] Banthin et al., *What If the American Rescue Plan's Enhanced Marketplace Subidies Were Made Permanent?,* 2021.

yet expanded Medicaid (Appendix Table 4). Declines in the proportion of uninsured people range from nearly 44 percent in Alabama to less than 6 percent in Utah.

Impact of Additional Reforms Through Administrative Action

Our estimates incorporate the effect on enrollment of administrative changes designed to increase participation, including a longer open enrollment period starting with the 2022 plan year and additional Federal spending on navigators, advertising, and other types of outreach activity.

Under current law, families are generally ineligible for marketplace subsidies if a family member is offered "affordable," worker-only coverage through an employer. The cost of covering the entire family is not considered and may be unaffordable, resulting in the so-called "family glitch." If this policy were changed through administrative action to allow family members to become eligible for marketplace subsidies, we estimate that about 710,000 additional people would enroll in the subsidized nongroup market, most switching out of ESI. In addition, about 90,000 family members, mainly children, would newly enroll in Medicaid or CHIP as their parents seek marketplace coverage. There would be 190,000 fewer uninsured people as a result of this change. Families switching from ESI would save about $400 per person in premiums on average. These changes in coverage were estimated separately in a previous report and are not included in the numbers discussed here.[4]

We are not able to specifically model the provision of continuous open enrollment for people below 150 percent of FPL for this report. In our assessment, however, this provision would increase enrollment into the marketplaces by between 100,000 and 200,000 people.

Conclusion

We estimate that making the enhanced ARPA subsidies permanent and filling the Medicaid coverage gap by expanding marketplace eligibility to those earning below 100 percent of FPL would have significant changes on coverage. Together, these two policies would broadly expand eligibility for marketplace subsidies, reduce the number of uninsured people especially at lower income levels, and lessen household financial burdens for health care.

HOW WE CONDUCTED THIS STUDY

Our estimates use the Urban Institute's Health Insurance Policy Simulation Model's (HIPSM) baseline for 2022. HIPSM is a detailed microsimulation model of the health-care system designed to estimate the cost and coverage effects of proposed health-care policy options. HIPSM is based on 2 years of the American Community Survey, which provides a representative sample of families large enough for us to produce estimates for individual States and smaller regions, such as cities.[5]

For the pre-American Rescue Plan Act (ARPA) baseline of our analysis we chose 2022, a year when economic conditions should be more stable, following the COVID–19 pandemic and consequent recession in 2020. We assume, consistent with Congressional Budget Office projections, that the economy will have partly recovered from the pandemic recession by that time.

For this analysis, we also assume that Medicaid's enhanced Federal Medical Assistance Percentage (FMAP) and the maintenance of effort provisions in the Families First Coronavirus Response Act will have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the U.S. Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.[6] This means Medicaid's Maintenance of Eligibility (MOE) requirements, which prohibit States from disenrolling Medicaid enrollees unless they request it, are expected to last through January 2022. After that, the increased enrollment because of the MOE requirements will start to decline as States resume normal eligibility determinations.

Although recent guidance allows States up to 12 months to unwind the MOE provisions, it remains uncertain how fast this will happen. As a result, Medicaid enroll-

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[4] Matthew Buettgens and Jessica Banthin, *Changing the "Family Glitch" Would Make Health Coverage More Affordable for Many Families* (Urban Institute, May 2021).

[5] Matthew Buettgens and Jessica Banthin, *The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology* (Urban Institute, Dec. 2020).

[6] Norris W. Cochran IV, Acting Secretary, U.S. Department of Health and Human Services, letter to Governors regarding the public health emergency, Jan. 22, 2021.

ment may be higher in early 2022 than indicated in our estimates. Also, the enhanced FMAP is expected to be available through March 2022. The Federal Government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

The baseline and estimates presented here differ from earlier national HIPSM projections of coverage and costs in that we now treat Missouri and Oklahoma as Medicaid expansion States. Both States passed ballot measures in 2020 to expand Medicaid but had not actually begun coverage when we published earlier projections.

The ARPA includes an additional financial incentive for States that have not expanded Medicaid to do so; newly expanding States receive a boost of 5 percentage points to their FMAP for 2 years. Because neither Oklahoma nor Missouri had begun covering Medicaid expansion beneficiaries as of March 2021 when the ARPA became law, they are eligible for the incentive payment. We estimate that the incentive would shift $808 million of state costs to the Federal Government in 2022. As limited duration incentive payments, these costs are not included in our baseline or in the estimates presented in this paper.

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CITATION

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Urban Institute

Design of Public Option and Capped Provider Price Reforms

Important Interactions Between Provider and Other Program Features

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The 2020 presidential election brought discussions of introducing a public option into U.S. health insurance markets back to the forefront of health policy debates. A public option would consist of a government-designed and administered (directly or via contract) health insurance plan or set of insurance plans that would be introduced in one or more health insurance markets. The federal government would determine payments made to providers (*e.g.,* doctors, hospitals, pharmaceutical manufacturers) participating with a public option or negotiate prices with providers to attract them to participate; alternatively, state governments or a quasi-governmental or nonprofit entity could govern a public option. Conversations about public option plans have also prompted discussions about a related policy option, capping payments made to providers by commercial insurers. This strategy would require providers participating in particular insurance markets to accept prices from commercial insurers at or below a government-designated level. Thus, these capped prices would apply to providers participating in any private insurance plan offering coverage in the specified markets, whereas a public option would apply government-designated rates in new government-administered insurance plans alone.

These two health reform approaches are related in that both seek to provide insurance options to consumers that would pay providers based upon payments determined (in the case of the public option) or limited (in the case of capped provider prices) by the federal government or its chosen agent. As noted, the public option would do so via a new insurance plan or set of insurance plans administered by the government, and the capped prices would do so via private insurers participating in the markets chosen. Depending on where these rates or rate limits are set, either approach could reduce premiums relative to current levels. Either policy could be used alone or in tandem with the other.

Though people broadly support the idea of a public option and/or lowering the costs of health care (Politico 2020),[1] implementing such policies requires numerous design decisions, can have significant unintended consequences, and is politically challenging. Design decisions profoundly affect such policies' abilities to meet their stated objectives, disruptions to the U.S. health-care system, and health-care providers' finances. Many of these design decisions interact with one another, meaning they ought to be considered together. This is especially true of how the chosen schedule of provider prices interacts with other design choices. Here I delineate the major design choices that must be made for public option and/or capped provider price reforms and outline their trade-offs in government costs, household costs, impacts on providers, and access to care. I explicitly recognize that a public option and capped provider prices paid by commercial insurers can be implemented independently or simultaneously.

What follows is a summary and interpretation of an extended discussion in 2020 with a small group of health policy experts that included, in addition to me, Michael Chernew, Jack Ebeler, Matt Fiedler, Richard Frank, Sherry Glied, Tim Gronniger, John Holahan, Mark Miller, and Cori Uccello. No particular view presented below should be attributed to any particular participant or organization with which they are affiliated. The central conclusions of the discussion include the following:

- Advocates of public option and capped provider price reforms do not always agree on the reforms' intended objectives. Some see a public option primarily as a cost-containment mechanism, intended to lower public and private health-care spending and thereby increase insurance coverage and access to care. Others view a public option as most importantly an alternative to commercial insurance that could better serve the interests of consumers; these supporters may have little interest in designing a system to reduce the costs of care. Capped provider prices could reduce health-care spending, increase coverage, and improve access to care as well but would not provide an alternative to commercial insurance.
- Both reforms could reduce health-care spending, but the extent of savings depends on the prices the reforms rely on and the markets in which the reforms are introduced.
- In designing either reform, the interaction of the provider price schedule and the size of the markets included will have powerful implications for the magnitude of system-wide savings and effects on provider revenue. The lower the price schedule and the larger the markets to which they apply, the greater the potential for public and private savings. But greater, too, is the potential to disrupt health-care provider markets.
- In either reform, the provider price schedule will directly affect providers' voluntary participation in the insurance plan networks. Lower price schedules will tend to decrease voluntary provider participation and thus make it more difficult to establish broad provider networks. However, prohibiting providers refusing to participate with the public option or commercial insurers relying on capped prices from participating with other insurers in the same market could increase participation.
- A public option reform requires many additional design decisions beyond those required of a capped provider price reform. These include whether state variation in essential health benefit requirements would be permitted, the actuarial value tiers in which a public option would be introduced, risk adjustment participation, applicability of premium taxes, reserve fund requirements, and financing of start-up and administrative costs.
- Setting capped provider prices at a relatively high point in the provider price distribution (*e.g.,* the 75th or 80th percentile) would reduce the prices of the highest-priced insurance plans, and such a reform could be introduced into both employer group and nongroup markets with little anticipated health care delivery disruption. Introducing a public option in nongroup insurance markets would provide new competition in markets dominated by monopolistic providers and/or insurers and would constitute a new tool that could evolve into a valuable option for consumers dissatisfied with private insurance options.

[1] Gaby Galvin, "About 7 in 10 Voters Favor a Public Health Insurance Option. Medicare for All Remains Polarizing," Morning Consult, March 24, 2021, *https://morningconsult.com/2021/03/24/medicare-for-all-public-option-polling/*.

Objectives: Cost Containment versus Availability of Noncommercial Broad Network Plans

Central to the effective design of any public policy is clarity in the policy's intended objectives. Advocates of a public option are not unanimous in their objectives, and design choices will determine which objectives are most likely to be met by the program ultimately introduced.

Some see a public option as a cost-containment mechanism. In many areas of the country, lack of competition among insurers and/or health-care providers is associated with high premiums, generally because of high provider prices.[2] Regardless of the source of high medical prices, many support lowering them to improve access to care and free up public and private funds for other priorities. A public option run by the federal government could make payments to health-care providers that are lower than those paid by most commercial insurers. Doing so would mean public option plans could offer consumers actuarially fair premiums lower than many of those offered by commercial insurers. Lower premiums translate into household savings on out-of-pocket costs for people enrolled in the option, and lower premiums may put competitive pressure on private insurers in markets where the public option is introduced (Blumberg et al. 2019). A public option introduced in the employer market could provide a lower-premium insurance option for employers and their workers. Likewise, a public option offered in the private nongroup insurance market could offer a lower-premium option to nongroup enrollees, especially those with higher incomes that make them ineligible for federal financial assistance (Blumberg 2021). In addition, if a public option were to decrease the nongroup Marketplace benchmark premium (currently set at the second-lowest silver Marketplace premium in a person's area of residence), federal spending on premium tax credits would decrease as well, leading to government savings. Likewise, placing caps on provider prices for commercial insurers in all or some markets could generate both private and government savings.[3] Depending on how it is administered, a public option could also operate with lower administrative costs than those typical of private insurers, another possible source of savings that could lower premiums.

Lower health-care spending during the first year of the COVID–19 pandemic reduced the sense of urgency some felt in addressing rising health-care spending via a public option or provider price caps. However, the drivers of increased health-care spending in private markets that many were concerned about before the pandemic have not changed, meaning those concerns will return. Moreover, an ongoing focus has been placed on the extent to which Medicare and private insurers overspend on prescription drugs, and concerns remain about how Medicare Advantage plan pricing potentially increases health-care costs. In addition, the Biden administration has already issued an executive order instructing federal agencies to work on addressing broad issues related to the economic consequences of market consolidation, including in the health-care sector. This signals that health-care cost containment strategies remain an important policy interest.

Others see a public option as an alternative insurance vehicle that would be more responsive to the interests of consumers than profit-motivated insurers. Some people are concerned with the narrow provider networks offered in many nongroup insurance market plans in particular, and they see a public option as a way to offer consumers broad provider networks at an affordable premium, not unlike the traditional Medicare program. Some people value a single insurance plan being available

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[2] Though monopolistic (or otherwise strongly consolidated) insurers should have substantial leverage to reduce provider prices and thus reduce premiums, many areas with highly concentrated insurance markets also have highly concentrated provider markets. Even when that is not the case, dominant insurers do not face strong incentives to be tough negotiators with providers, and thus they seldom use that leverage to significantly reduce prices. For example, highly concentrated insurance markets are strongly correlated with high premiums in the nongroup market (Holahan, Banthin, and Wengle 2021).

[3] The greatest savings resulting from lower nongroup Marketplace premiums accrue to people with incomes sufficiently high that they pay for full premiums independently, without federal premium subsidies. However, lower premiums can also generate savings for people eligible for premium subsidies who choose insurance options that are more expensive than the second-lowest silver (benchmark) premium available, since these consumers are liable for the full difference between premiums for the benchmark and the more expensive plan. In addition to government savings resulting from lower nongroup Marketplace benchmark premiums, lower commercial insurance premiums in the employer market can also generate government savings. Economic theory and empirical research suggest lower employer spending on health insurance premiums tends to translate into higher wages. Because wages are taxable as income but health insurance contributions are not, lower premiums in the employer market tend to increase government tax revenue.

to everyone across the country, particularly one theoretically less likely to deny claims or limit important benefits. Some view a public option as a vehicle for providing subsidized coverage to populations currently without coverage options (*e.g.,* those in the Medicaid eligibility gap),[4] whereas others see it as a first step toward a Medicare for All program.

Capping provider prices for all commercial insurers could create public and private health-care savings, as noted above, regardless of whether capped prices are implemented alongside a public option. In fact, because most insurer premiums could be affected by the caps, depending on where they are set, the caps could lead to greater aggregate private savings than a public option alone. However, capping prices paid by commercial insurers cannot satisfy the desire for an alternative to insurers motivated by profit or other interests that benefit certain private entities (*e.g.,* private nonprofit insurers), as the public option could do. Consequently, the primary purpose of capped provider prices is to reduce health-care spending by reducing providers' and/or insurers' market power over prices while maintaining sufficient quality of and access to care. In addition, such an approach can improve equity in the markets by reducing the variation in prices paid across providers and markets.

These different objectives will often be in some tension with one another. Creating and maintaining broad provider networks, for example, generally requires paying providers higher prices to attract their participation. Higher provider prices, in turn, will generally translate into higher premiums and reduce the opportunities for private and public savings. Plans with lower rates of claims denials will also, however, tend to increase provider participation even at lower prices (Dunn et al. 2021), but they may lead to increased costs as well.[5] Therefore, I refer to these somewhat competing objectives while presenting the advantages and disadvantages of specific design choices.

Private and public savings resulting from lowering payments to providers under either a public option or capped provider prices can increase health insurance coverage. Combined with current medical loss ratio restrictions, lower payments to providers per service should translate into lower premiums. In turn, lower premiums facing consumers can increase the number of people purchasing coverage in the nongroup market. For employers, lower premiums can translate into greater enrollment by workers and some current premium spending being transformed into higher taxable wages. Government savings from lower premium tax credits in the nongroup market and/or greater tax revenue from increased wages in the employer market make more dollars available to enhance financial assistance in the nongroup market (*e.g.,* improved premium tax credits) or expand eligibility for public programs (*e.g.,* filling in the Medicaid coverage gap).

Though related, the public option and caps on private insurers' provider prices will likely affect different insurance markets differently. Capped provider prices constrain the range of prices of participating insurers but otherwise leave the markets structured as they are today. The public option introduces a new and potentially lower-priced insurer into the market, but it does not explicitly constrain commercial insurers' pricing. Depending on the characteristics of particular insurance and provider markets, the resulting competitive responses could differ.

The Foundation for Developing Provider Price Schedules

Both a public option and capped provider prices for private insurers require delineating provider price schedules. With a public option, a schedule would determine

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[4] Currently, 12 States continue to refuse to expand Medicaid eligibility to all lawfully present residents with incomes up to 138 percent of the federal poverty level (FPL). Because the Affordable Care Act was written assuming Medicaid expansion would be implemented in all States, its drafters only made people with incomes above the FPL eligible for premium tax credits through the Marketplaces. Consequently, many people with incomes below the FPL are ineligible for any financial assistance obtaining health insurance in 11 of those States, because those States' traditional Medicaid eligibility rules exclude nonparents and are generally very limited for parents. For example, in Alabama, only parents with incomes up to 18 percent of FPL are eligible for Medicaid and nonparents are ineligible regardless of income. In Texas, parents with incomes up to 17 percent of FPL are eligible and all nonparents are ineligible. The one notable exception is Wisconsin, which has not expanded Medicaid eligibility under the Affordable Care Act but extended its traditional Medicaid program to all adults with incomes up to the FPL. In addition to people with incomes below the FPL in these States, others with incomes between 100 and 138 percent of FPL are excluded from Marketplace assistance if someone in their family is eligible for worker-only employer-based insurance deemed affordable to them.

[5] Lower claims denial rates will generally mean higher total amounts of claims paid. Higher spending on claims payments translates into higher premiums.

the reimbursements for medical services provided to enrollees. With capped prices, a schedule would limit commercial insurers' provider payments to no more than specified levels. Schedules could be based on services for health care professional payments and per admission diagnostic related groups for hospital payments, for example, as is the case for the Medicare program. Under either approach, payment schedules or limits on prices should reflect the intensity of services provided. The main foundations considered for creating such payment schedules are the traditional Medicare schedule and commercial insurer fees. Both have distinct advantages and disadvantages for public option and capped provider price policies.

The Medicare Fee Schedule

This schedule is an existing set of prices that accounts for geographic variation in the costs of providing care. Consequently, the Medicare schedule could be applied to new programs or plans quickly. A small number of services, particularly those for pediatric care, may need to be added to the existing schedule, but it already accounts for the vast majority of care. The Medicare fee schedule has also been developed with the intent to reimburse providers at levels relative to each other based on variations in input costs and the relative value of different services provided. Thus, price differences across the schedule have a rational basis. Depending on how high policymakers want prices to be, multiples of Medicare prices could be used, for example, 110 or 160 percent of Medicare prices. Different multiples could be used for hospital versus professional care. This would account for current commercial rates for professionals already being closer to Medicare rates than are hospital rates. And, institutionally, provider participation issues for public insurance programs have been a greater concern for physicians than for hospitals. More complexity could be introduced by varying the percent adjustments more finely, for example, by treating different types of hospitals differently (*e.g.,* teaching hospitals, rural hospitals) or treating various physician specialties differently.

The Medicare fee schedule—based approach also has the advantage of containing a ready-made measure of provider volume. One risk of lowering provider prices is that some providers could respond to the ensuing reduction in revenue by increasing the volume of services they provide per patient on average. Medicare's relative value units and diagnostic related groups can be aggregated for each provider, as measures of each provider's volume. These can be used as a basis for further price adjustments should the average volume of services provided per patient increase significantly under reform.

The trade-off of using the Medicare payment schedule, however, is that it could complicate the general Medicare rate setting process and the process of establishing these rates (*e.g.,* the recommendations of the Relative Value Scale Update Committee). If a public option or commercial provider price limits were to rely on the Medicare schedule, then any discussion or debate over modifications to Medicare rates (*e.g.,* productivity adjustments, growth rates) would have implications for provider prices more generally. Lobbying around the Medicare schedule would become more complicated and fraught, and these pressures could push Medicare rates higher than they otherwise would be, because a larger share of provider revenues would be at stake, leading providers to lobby harder to keep prices up. However, the savings to government and consumers would be commensurately larger, potentially leading policymakers to pursue them more aggressively; consequently, the ultimate impact of a public option or capped provider prices on Medicare payment rates is uncertain.

Provider Prices Used by Commercial Insurers

These prices vary dramatically across insurers, providers, and even plans offered by the same insurers. A substantial part of the variation in commercial insurers' provider prices likely relates to geographic variation in provider and/or insurer competition. A schedule for a public option or capped prices could be developed using a specified percentile of the distribution of commercial provider prices, say the median, depending on the payment schedule desired. The advantages of relying on a payment schedule based in commercial rates are that the schedule (1) may be more politically palatable to health-care providers and (2) would not interfere with negotiations between providers and the federal government over Medicare rates. However, that political appeal may fall appreciably if provider prices are set well below the median of current rates (*e.g.,* at the 35th percentile).

If a schedule based on a low percentile of national commercial rates were chosen, the impact of consolidation and noncompetitive markets that have inflated prices in some areas would be less likely to affect the delineated schedule. For example, if the 20th percentile of the commercial rate distribution for each service were chosen

as a benchmark, those rates could be multiplied by a factor greater than 1 to increase payment levels without having the relative prices for different services affected by existing monopolistic behavior. Geographic cost adjustments could be applied after the fact. In addition, the commercial rate approach does not require providers or insurers to change the definition of services they use to be consistent with Medicare definitions; however, commercial insurers' definitions of services likely vary, so some disruptions and system modifications would be required to standardize these definitions regardless.

The first disadvantage of the commercial benchmark is that determining the distribution for every existing medical service would be a significant data-collection undertaking. This information does not currently exist, so collecting it will take considerable time and resources. In addition, market forces, not relative value, determine commercial providers' prices, an important difference from the Medicare schedule, which explicitly accounts for relative value. Consequently, the current variation in commercial prices across the country is tremendous. Any particular point in the pricing distribution may not appear to make sense based on rational criteria, because the pricing distribution is the product of market distortions. Plus, many commercial insurers pay hospitals based on days instead of admissions, which tends to increase spending by private payers. Further, coding across private insurers is seldom comparable, which creates considerable complexity in comparing current prices across these insurers.

Regardless of which benchmark is used, the final payment schedule and annual update approach chosen will determine a reform's effect on the provider market (*i.e.,* savings and access to care). Theoretically, using an upwardly adjusted Medicare schedule as a benchmark (*e.g.,* 120 percent of Medicare rates) could achieve similar savings as using the distribution of commercial prices as a benchmark, depending on which percentile is chosen and whether any additional adjustments are applied. The same is true regarding the annual adjustment chosen. The closer rates remain to current ones, the lower the risk of disruption to the health-care system, but the lower, too, are savings from the reform.

Managing a public option or capped prices, including the level and growth of prices, could be entrusted to an active administrator or possibly to a state department of insurance if national variation were permitted. In this way, the administrator could adjust prices (including for geographic variation) as a function of information collected on access to different types of care, provider participation, the quality of care provided, and aggregate spending. Such discretion would create some additional uncertainty about ultimate public and private savings, but the flexibility would provide the administrator with the nimbleness necessary to modify prices and correct for unintended consequences of over or underpricing particular services. Limits on the flexibility provided to such an administrator would likely be needed, however. Otherwise, providers with market strength could effectively negotiate prices with the public option and drive prices higher than appropriate or desirable. In addition, the capabilities of different departments of insurance vary considerably across States. Thus, if they were to administer a public option or capped prices, they could define important economic parameters differently, which could lead to some positive and some negative outcomes.

Interaction of the Provider Price Schedule and the Size of Markets Included in a Reform

As analysts have shown (Holahan and Simpson 2021), introducing a public option or capped provider prices into nongroup insurance markets alone is unlikely to generate large aggregate savings. This is purely because the number of people buying coverage in those markets is small, an estimated 15 million people in 2022 (Banthin et al. 2020). The employer group market is roughly 10 times as large, an estimated 150 million people in 2022. Consequently, implementing these types of reforms in the employer group market creates more potential for private and public savings and disruption of the health care delivery system. Commercial insurers' payments to providers in many nongroup insurance markets are also likely already significantly lower than those paid in employer-sponsored insurance markets, an additional reason why these types of reforms have greater savings potential in the employer market than the nongroup market (Blumberg et al. 2020). For example, according to Urban Institute estimates, introducing a public option paying providers rates modestly above Medicare's (Medicare plus 10 percent for professionals and Medicare plus 25 percent for hospitals) in nongroup insurance markets alone would reduce health system spending (public and private combined) by $15 billion in 2022 (Holahan and Simpson 2021). Introducing that same public option into both nongroup and employer markets would reduce health system spending by $156 bil-

lion in 2022, more than a 10-fold difference. Capping provider prices across both markets at the same rates would reduce health system spending by more than double that amount, $331 billion in 2022.

Lower prices applied to a smaller number of consumers will affect overall provider revenues less, and thus the risk of health care delivery system disruption is rather small. That means that reforms using provider prices well below commercial levels only for public option enrollees in the nongroup market would carry less risk of delivery system disruption than broad caps on provider prices for all insurers in both the employer group and nongroup insurance markets. But the former reform would also achieve smaller aggregate savings than would the latter.[6] In addition, lower provider prices could limit the number of providers willing to participate with these plans, especially if the enrollees constitute a small percentage of the providers' expected revenue.

A more limited public option or capped prices targeted solely to nongroup insurance consumers could also phase in lower prices more quickly without significantly disrupting health-care delivery (Skopec and Holahan 2021). Conversely, the larger the share of health-care consumers affected by lower prices, the longer it will likely take for health-care providers to respond with the organizational changes necessary to preserve supply and quality.

One policy option that has been discussed is creating a public option solely to provide coverage for adults with low incomes caught in the Medicaid eligibility gap. In the 12 States that continue to refuse to expand Medicaid eligibility under the Affordable Care Act, more than 3 million uninsured people living in poverty are ineligible for any financial assistance to enroll in insurance coverage, because their incomes are too low to qualify for Marketplace subsidies but too high to be eligible for their States' traditional Medicaid programs (Simpson, Banthin, and Buettgens 2021). Because the population in the eligibility gap in these States is largely uninsured today, providing them coverage through a federal public option, even one paying Medicare rates, would put additional revenue into the health care delivery system, not less. Consequently, such a narrow program should not risk significantly disrupting health-care delivery.

Interaction of Provider Price Schedule and Network Breadth

In recent years, many nongroup insurers have built narrow provider networks to be able to offer price-competitive plan options to consumers (Wengle et al. 2020). Including only health-care providers willing to take lower prices in a provider network translates into lower insurance premiums. Creating broader provider networks generally requires paying some providers at higher prices or having some other type of purchasing leverage that attracts more providers to participate.[7]

Consequently, ensuring voluntary participation of a broad network of providers is difficult if a public option pays providers substantially below typical commercial prices. Relying on voluntary provider participation will most likely lead to a tradeoff between network breadth and premium savings. Requiring providers participating with the Medicare program (or the Medicaid program) to also participate in the public option may increase provider participation, even at relatively low payment levels. However, this could also risk some providers leaving the Medicare or Medicaid programs instead. In addition, physician participation is difficult to enforce. Thus, one option is to require hospitals to participate, say, as a requirement of participation in the Medicare program, but not requiring the same of physicians. Because all hospitals participate with the Medicare and Medicaid programs and those programs constitute a large share of hospital revenues, hospitals are far less likely to stop participating in those programs, even if public option participation is tied to them. The most challenging network breadth issue is related to physicians

[6] If a public option or capped provider prices were available only in the nongroup market, these large price differences between the employer and nongroup markets could, at least theoretically, pressure more people to seek nongroup insurance coverage and decrease incentives for some employers to provide insurance. However, evidence shows the provider prices in nongroup insurance markets made competitive by Affordable Care Act reforms are considerably lower than prices in employer markets, yet employer-provided coverage has not decreased. The value of the tax subsidy provided for those with employer-based insurance, benefits tailored to worker preferences, frequently broader provider networks, and ease of enrollment seem to keep workers in their employer-provided policies.

[7] For example, the traditional Medicare program offers enrollees a very broad network of providers, even though it pays providers at rates below those of commercial insurers, because few providers can turn down the large volume of Medicare enrollees and their high average use of medical services.

in this context. Failing to enforce consequences for physicians declining to participate with the public option could lead to a significantly narrower provider network than envisioned, however.

Another option for increasing physician participation is prohibiting physicians who decline to participate with the public option from participating in other plans serving that same market.[8] For example, if a public option were introduced into the nongroup market in a given area, a physician refusing to participate in the public option would be prohibited from participating with the private nongroup insurers offering coverage in that area. If physicians' decisions not to participate with the public option depend on their desires to protect their pricing leverage with private insurers, this approach could significantly increase physician participation. In addition, it would not risk a decrease in Medicare or Medicaid participation. The same approach could be used for hospitals as well.

Capping provider prices for commercial insurers at low levels raises similar concerns about physician participation. However, if providers are reticent to participate with the public option over concerns that doing so could jeopardize their pricing negotiation leverage with private insurers, capping prices for all insurers in a given market minimizes participation concerns. In general, though, the larger the number of insured people in the markets where the caps are implemented, the harder it is for physicians to avoid accepting those prices. For example, capping commercial prices in the nongroup market alone would affect physician revenues less than would capping them in the nongroup and employer group markets, because the employer insurance markets are so much larger. But at the same time, physicians can more easily refuse to participate with nongroup insurers than they can refuse to take patients with employer-based insurance, because the number of enrollees in the former is so much smaller than the number in the latter.

Provider Payment Schedules and the Interaction of a Public Option with Capped Prices for Commercial Insurers

At least theoretically, the reach of a public option is smaller than that of capped provider prices for commercial insurers. The primary effect of a public option would be on the people who choose to enroll in it, though some evidence shows that a public option could alter the dynamics of provider-insurer negotiations and lead to somewhat lower private insurer prices as well, particularly in highly concentrated markets (Blumberg et al. 2019). Capping commercial insurer prices, depending on where the rates are set, could affect all commercial insurance enrollees to some degree, thereby affecting a larger group of people and potentially to a greater extent. Consequently, the prices used for a public option could be set below capped prices for all commercial insurers. Either of these policies could be implemented alone or together, using different price schedules for the two strategies. With such an approach, the public option can provide broadly available insurance options designed by the government and not motivated by profit, whereas the capped prices play the central cost-containment role and somewhat improve equity of payments among providers and markets.

Additional Design Considerations for a Public Option

Though capping provider prices used by commercial insurers has various benefits, as noted earlier, it is primarily designed to lower insurance premiums. This is achieved by either reducing the most extreme prices, by setting capped prices at a higher point in the price distribution, or by reducing prices more broadly, by setting the capped prices at a lower point in the price distribution. Capped provider payments do not, however, provide an insurance product that is not subject to profit motives or other private entities' interests. To address the latter, a government-designed and administered plan, the public option, is needed. Because it would create a new public source of insurance, a public option would require additional design considerations beyond the prices the plan pays to providers.

State Variation in Essential Health Benefit Requirements

Although the 10 categories of essential health benefits defined in the Affordable Care Act must be covered in each state's nongroup and small-group markets, the rules surrounding benefit definitions and the quantity limits on some of these benefits vary (dollar limits on benefits are prohibited, however). Benefits covered by a public option could be made uniform nationally or could vary modestly by state to be consistent with the other qualified health plans sold in each state.

[8] This approach is discussed in Fiedler (2020) and (2021).

Though a public option offering a uniform set of benefits ensures everyone in the country has access to at least one plan, offering a public option plan (or plans) that differs from the other plans offered in the markets where the public option is sold carries significant risks. Benefit variations can make it more difficult for consumers to compare their options, but more importantly, they can lead to adverse selection either into the public option or private plans. To the extent that either the public option's or private plans' benefits in a state are more or less attractive to higher-risk enrollees, the risk-adjustment system may be unable to completely compensate for the difference. Consequently, if uncorrected adverse selection escalates premiums in the plan(s) selected against, the public option or the private health plans may be unable to compete for consumers in the long term.

Actuarial Value Tier Participation

Likewise, if no private insurers offer a particular actuarial tier of coverage (current law only requires insurers to offer silver and gold levels), introducing a public option in that tier could create selection problems. For example, a significant number of Marketplace rating areas currently lack an insurer offering a platinum (90 percent actuarial value) option, largely because these high-value plans are felt to attract enrollees with higher medical needs. If a platinum public option were introduced in these areas, all else staying the same, it could attract enrollees with higher-than-average health-care costs. Given the imperfection of risk adjustment, this outcome could make it hard for the public option to compete with private insurers in the area.[9]

Level Playing Field Issues

The politics of the public option are also extremely challenging. Many consumer advocates' distaste for for-profit commercial insurance leaves them uninterested in designing a system that provides these insurers with the level playing field they feel they need to compete with a public option. In other words, some are happy to let an uneven playing field lead to a fully public system, like Medicare for All. Meanwhile, the private insurers with which a public option would compete are focused on any possible unfair advantages a government insurer would have over them in their markets. And, in truth, a large financial advantage that allows a public option to set its premiums well below those of private insurers could drive at least some current private options out of the markets—for better or for worse, depending on one's perspective. Beyond the core component of provider payments discussed above, at least four categories of expenses can affect the extent to which a public option competes with private insurers on a level playing field: risk adjustment, premium taxes, reserve funds, and start-up and management costs.

Risk adjustment. In nongroup insurance markets, risk adjustment reallocates a portion of insurers' premium revenues to compensate insurers that disproportionately enroll people with higher-than-average health-care costs in a year. The objective of this strategy is to allow all insurers to set premiums in a manner that reflects the average risk of the entire pool of people enrolled in nongroup insurance in the state, enabling insurers with higher-cost enrollees to remain attractive and affordable to potential enrollees with various medical needs. Risk adjustment also undermines the incentives for insurers to attempt to enroll healthier people and to dissuade people with greater medical needs from enrolling in their plans.

Consequently, creating a level playing field within an insurance market that includes a public option would require that the public option participate in the risk-adjustment system. It is unclear a priori whether a public option would attract disproportionately healthy or sick enrollees, or neither. Therefore, excluding the public option from the system could help or hurt private insurers and similarly increase or decrease actuarially fair premiums associated with the public option based on the risk profile of those enrolled. In turn, this could make it difficult, if not impossible, for either the public option or private insurers to remain viable.

Likewise, including the public option in risk adjustment could result in the government plan making payments to some private insurers or vice versa. The Affordable Care Act's risk adjustment payments are calculated as a function of the differential risk of enrollees and the average premium in a state. As such, if a public option were to lower the average premium in a state, it would also lower the size of risk-adjustment payments between insurers. This could disadvantage some

[9] If, however, the premium tax credit benchmark plan were changed to gold (instead of the current silver) under broader reforms, platinum plans could be much more attractive, leading more private insurers to offer them.

higher-priced private insurance plans should they be selected against, which would benefit plans enrolling healthier people.

Premium taxes. Almost every state and the District of Columbia imposes taxes on insurers' gross premium revenues. The most common tax rate is 2.5 percent, though such rates range as high as 4 percent (Grace, Sjoquist, and Wheeler 2007). Usually, these taxes take the place of corporate income taxes on insurers and are likely passed on to consumers purchasing insurance through higher premiums.[10] Consequently, private insurers would be at a direct pricing disadvantage if equivalent taxes were not imposed on a public option plan introduced in the state. Leveling the playing field to improve private insurers' abilities to compete would therefore require the public option to pay premium taxes as well.

Reserve funds. Typically, state laws require insurers to maintain reserve funds that ensure the company would be able to pay enrollee claims even if premium revenue for the year fell short of actual claims. States regulate the level of required surpluses, but they typically range from 15 to 25 percent of expected annual claims. Insurers cannot increase premiums in subsequent years to cover costs associated with underestimates in prior years; doing so could run afoul of medical loss ratio requirements, and insurers doing so would be placed at a competitive pricing disadvantage. Though the federal government could obviously use general revenues to cover any public option shortfalls in a given year, doing so would create, at minimum, a perception of an unfair competitive advantage from private insurers' perspectives. Including small premium add-ons to build up reserve funds for a public option may be unnecessary as a practical manner but could enhance private insurers' sense of competitive fairness.

Start-up and ongoing administrative costs. The administrative costs associated with starting a private insurance plan and supporting its ongoing operations are generally recouped by the administrative load added on to expected annual claims when computing premiums. These costs include such necessities as provider network development, data infrastructure development and maintenance, claims payment, and customer service. The instinct with a public option may be to build off the government's existing infrastructure for the Medicare and Medicaid programs in the Centers for Medicare and Medicaid Services, for example. Depending on one's perspective, using existing infrastructure could be considered good savings or an unfair advantage, however. Start-up costs could, for example, be amortized in the premium or absorbed via general revenues along with those for the other existing public insurance programs. Adding something small to the premiums to account for a reasonable level of such costs may be unnecessary but, again, could improve private insurers' perceptions of fairness.

Discussion

Public option advocates do not always share the same objectives for establishing such a program. However, the central design choices necessary to develop a public option are inextricably tied to the intended objectives. The level and growth of payments to providers are critical features of a public option, and these choices have tremendous implications for premium affordability and cost-savings potential, network breadth, and disruption to the health care delivery system. Sufficient political support for a public option will likely require greater agreement on such a program's objectives than is apparent today; some people currently focus on a public option's cost-savings potential, whereas others focus on the availability of a consumer-motivated, instead of profit-motivated, broad-network plan.

As research has indicated (Holahan and Simpson 2021), a public option alone has limited power to contain health care system costs broadly, particularly when only made available in the nongroup insurance market. It would, however, provide new competition in markets dominated by monopolistic providers and/or insurers. It would also be a new tool that could evolve into a valuable consumer-oriented, administratively efficient entity that serves as an alternative coverage option for those dissatisfied with their commercial insurance options.

Capping provider prices paid by commercial insurers is primarily a cost-containment tool that could be implemented with or without a public option. In the presence of a public option, capping commercial prices paid to providers may allow private insurers to lower their premiums and compete more effectively. Setting such caps at a relatively high point in the provider price distribution (*e.g.,* at approxi-

[10] The precise incidence of premium taxes depends on elasticities of demand and supply, which may differ by market and geography.

mately the 75th or 80th percentile) would primarily reduce the prices of outlier plans, whereas setting the caps at a lower percentile would reduce costs more broadly.

Regardless of the presence of a public option, caps on provider prices would have the greatest effect when applied broadly to insurers in the group and nongroup markets, as opposed to nongroup markets alone. Caps could be set high initially, thereby lowering provider prices and associated premiums only in the highest-priced markets to start. Caps could then be lowered over time in conjunction with a significant data collection and monitoring effort that could be used to prevent provider price adjustments from significantly disrupting the health care delivery system, a particularly important consideration if the caps are implemented across all commercial insurers.

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Urban Institute

The Uninsurance Rate Held Steady During the Pandemic as Public Coverage Increased

Trends in Health Insurance Coverage Between March 2019 and April 2021

Michael Karpman and Stephen Zuckerman

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Rapid job losses in the early months of the COVID–19 pandemic raised fears that millions of people would lose their health insurance coverage and become uninsured (Banthin et al. 2020; Garfield et al. 2020; Garrett and Gangopadhyaya 2020). In previous recessions, laid-off workers who lost employer-sponsored insurance (ESI) faced limited coverage options through Medicaid and the private nongroup insurance market and the number of people uninsured increased (Holahan and Chen 2011). The Affordable Care Act (ACA) significantly expanded access to those options in 2014, driving the uninsurance rate to record lows (ASPE 2021; Obama 2016). And as the pandemic posed the first test of the post-ACA health insurance safety net during an economic downturn, Congress further supported access to coverage by not allowing disenrollment from Medicaid through the March 2020 Families First Coronavirus Response Act (Brooks and Schneider 2020).[1]

In this brief, we examine changes in health insurance coverage among nonelderly adults ages 18 to 64 during the pandemic using data from the Urban Institute's Health Reform Monitoring Survey (HRMS). Since it was launched in 2013, the HRMS has provided timely information on coverage before data from federal surveys become available (Long et al. 2014). Our analysis focuses on changes in coverage across three rounds of the survey: March 2019; March/April 2020, just after the pandemic caused a steep decline in employment; and April 2021, more than 1 year after the secretary of health and human services declared a national public health emergency on January 31, 2020. We estimate regression-adjusted changes for the national nonelderly adult population overall, by state Medicaid expansion status,[2] and by annual family income as a percentage of the federal poverty level (FPL). We focus on adults with low incomes targeted by the ACA Medicaid expansion (with incomes at or below 138 percent of FPL) and adults with moderate incomes eligible for ACA Marketplace premium tax credits (with incomes between 139 and 399 percent of FPL).[3] We find the following:

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[1] The Families First Coronavirus Response Act has provided all States with a temporary increase in federal matching funds for Medicaid beneficiaries not in the ACA Medicaid expansion population. To receive the higher rate, States must follow several maintenance-of-effort requirements, including not disenrolling people from Medicaid unless they request termination of coverage or move to a different state. These provisions will remain in place at least until the end of the calendar quarter when the secretary of health and human services declares the end of the public health emergency.

[2] The States that did not expand Medicaid by April 2021 are Alabama, Georgia, Florida, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. Wisconsin has used state funding to expand eligibility to nonelderly adults with incomes up to the FPL. In other nonexpansion States, parents generally must have very low incomes to qualify for Medicaid, and nonpregnant, nondisabled adults who are not parents living with dependent children are ineligible. In 2020, voters in Missouri and Oklahoma approved ballot initiatives to expand Medicaid by July 1, 2021. Oklahoma's expansion took effect as scheduled. However, the Missouri legislature did not provide funding for the expansion in the state budget, and the governor withdrew the state plan amendment for the expansion. On July 22, 2021, the Missouri Supreme Court ruled that the state must implement the Medicaid expansion. For this analysis, we treat Missouri and Oklahoma as nonexpansion States because they did not implement their expansions by April 2021.

[3] Under the American Rescue Plan Act, many people with incomes above 400 percent of FPL are eligible for premium tax credits, but expanded eligibility is set to expire after 2022.

- Between March 2019 and April 2021, the share of nonelderly adults reporting ESI declined from 65.0 to 62.3 percent, a decrease of approximately 5.5 million adults. The share reporting public coverage increased from 13.6 to 17.5 percent, an increase of approximately 7.9 million adults. The national uninsurance rate held steady at approximately 11 percent.
- The share of adults reporting public coverage increased between 2019 and 2021 in both States that had and had not expanded Medicaid under the ACA (hereafter called expansion and nonexpansion States). Such coverage increased from 14.9 to 19.2 percent in expansion States and from 10.7 to 14.3 percent in nonexpansion States.
- In Medicaid expansion States, the uninsurance rate was near 8 percent across all three study years. In nonexpansion States, the uninsurance rate was higher in 2021 (18.2 percent) than in 2020 (16.5 percent) and 2019 (17.2 percent), though the difference between 2019 and 2021 was not statistically significant. Adults in nonexpansion States were more than twice as likely as adults in expansion States to be uninsured in 2021 (18.2 percent versus 7.7 percent).
- Declines in ESI and increases in public coverage between 2019 and 2021 were concentrated among adults with low and moderate incomes. Uninsurance rates among the national nonelderly adult population did not change significantly for any income group examined.
- The share of adults with low incomes reporting public coverage increased in both expansion States (from 54.6 to 62.9 percent) and nonexpansion States (from 30.4 to 37.3 percent) between 2019 and 2021. More than one in three adults with low incomes in nonexpansion States (37.7 percent) were uninsured in 2021, compared with about one in seven of such adults in expansion States (14.5 percent).

Between 2019 and 2021, the rise in public coverage helped offset a decline in ESI, and unlike in previous recessions, the uninsurance rate did not change. Medicaid and, to a lesser extent, private nongroup insurance sold through the Marketplaces have provided many adults with coverage options following unprecedented job and income losses. However, more than 1 in 10 adults were uninsured in April 2021, including nearly 1 in 5 adults in nonexpansion States.

Maintaining the current uninsurance rate will require protecting coverage for current and prospective Medicaid enrollees as the economy improves and the disenrollment freeze is lifted (which is unlikely to occur before early 2022). Adults eligible for Medicaid may be at risk of having their applications or renewals erroneously rejected if States resume normal operations for reviewing eligibility too rapidly (Rosenbaum, Handley, and Morris 2021). Other adults will no longer be eligible for Medicaid when their incomes recover and will need to seek private coverage to remain insured. For those without access to affordable ESI, outreach efforts can raise their awareness of the enhanced premium tax credits for Marketplace plans made available under the March 2021 American Rescue Plan Act (Haley and Wengle 2021). States will also need to assess eligibility for subsidized Marketplace coverage for people losing Medicaid eligibility after the public health emergency ends (Musumeci and Dolan 2021). Permanently extending the American Rescue Plan Act's enhanced tax credits could further reduce the number of uninsured people over the long term, and adults with moderate incomes would experience the largest decline in uninsurance (Banthin et al. 2021). Policymakers can also build on coverage gains under the ACA by addressing the persistently high uninsurance rates among adults with low incomes, particularly in nonexpansion States.

Results

Between March 2019 and April 2021, the share of nonelderly adults reporting ESI declined and the share reporting public coverage increased; the national uninsurance rate held steady.

Approximately 65 percent of nonelderly adults reported having ESI coverage in March 2019 and March/April 2020 (figure 1).[4] This share had declined to 62.3 percent by April 2021, when many adults remained out of work just over 1 year after

[4] Coverage estimates often vary across surveys because of differences in survey design (Au-Yeung and Hest 2019). In this brief, we discuss statistically significant changes in coverage over the study period. Previous analyses have found HRMS estimates of coverage changes to be consistent with estimates from other surveys (Karpman and Long 2015).

the pandemic recession began.[5] The 2.7 percentage-point decline in ESI between 2019 and 2021 represents a decrease of approximately 5.5 million adults (95 percent confidence interval: 2.5 million, 8.5 million).[6] During this period, the share of adults reporting public coverage—including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other state or government plans based on income or disability[7]—increased from 13.6 percent in 2019 to 17.5 percent in 2021, representing an increase of approximately 7.9 million adults (95 percent confidence interval: 5.4 million, 10.4 million).[8]

We did not observe a statistically significant change in private nongroup coverage, which approximately 8 percent of adults reported in each year and includes plans purchased through and outside the ACA Marketplaces.[9] But the share of adults with unspecified coverage (*i.e.,* reporting the name of a comprehensive health plan but not the type of coverage) declined by 1.1 percentage points between 2019 and 2021.[10] The share of adults with unspecified coverage was also slightly higher in 2019 than in March 2018, suggesting an anomalous result in 2019 (data not shown). Despite the significant loss of ESI, the uninsurance rate held steady nationally at approximately 11 percent in each study year.

Net changes in ESI, public coverage, and private nongroup coverage do not fully capture the transitions across coverage types that may have occurred during the pandemic. Income losses made some adults eligible for Medicaid and others eligible for subsidized Marketplace coverage, regardless of whether they were previously covered by ESI. The lack of net change in nongroup coverage could indicate that new Marketplace enrollment among people who became eligible for premium tax credits was not large enough to offset transitions from Marketplace or non-Marketplace nongroup coverage to Medicaid. In addition, the sample size of the HRMS may not be large enough to detect statistical significance for the relatively small changes in Marketplace enrollment found in administrative data.

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[5] U.S. Bureau of Labor Statistics, "The Employment Situation—May 2021," news release, June 4, 2021, *https://www.bls.gov/news.release/pdf/empsit.pdf.*

[6] We multiplied the estimated 2.7 percentage-point change in ESI between March 2019 and April 2021 by the projected number of adults ages 18 to 64 in 2021. We used national population predictions from the U.S. Census Bureau stratified by race, ethnicity, and sex for people of all ages from 2016 to 2060, based on estimated birth, death, and net migration rates over the period. Using the "main series" file, we summed the 2021 population projections for all nonelderly adults to arrive at 203,018,143 such adults that year. See "2017 National Population Projections Datasets," U.S. Census Bureau, February 20, 2020, *https://www.census.gov/data/datasets/2017/demo/popproj/2017-popproj.html.*

[7] In this brief, we combine Medicare, Medicaid, CHIP, and other government- or state-sponsored health plans into a single measure of public coverage because survey respondents may confuse the names of these coverage types (Pascale 2008). For a previous fact sheet based on data from the March/April 2020 HRMS and the Urban Institute's September 2020 Coronavirus Tracking Survey, we excluded Medicare from estimated changes in public coverage (Karpman and Zuckerman 2020). Estimates in this brief also differ slightly from estimates in that analysis because of differences in the survey weights and the regression adjustment, which we describe in the Data and Methods section.

[8] Administrative data show an increase of approximately 6 million adults enrolled in Medicaid between February 2020 and January 2021 in the 49 States and DC that report adult and child enrollment separately (Corallo and Rudowitz 2021). Differences between the HRMS estimates of changes in public coverage and administrative data for Medicaid enrollment may reflect several factors, including differences in the study period; inclusion of 18-year-olds as adults in the HRMS; inclusion of Medicare, CHIP, and state programs other than Medicaid in the definition of public coverage in the HRMS; survey sampling error; and measurement error in coverage type reported in the survey.

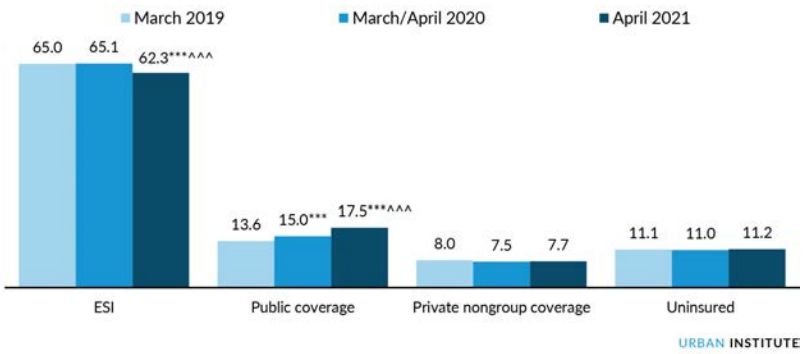
[9] The number of people selecting Marketplace plans increased from 11.4 million during the 2019 open enrollment period (November 1–December 15, 2018) to approximately 12 million during the 2021 open enrollment period (November 1–December 15, 2020). The Centers for Medicare and Medicaid Services reported an additional 940,000 people enrolled in Marketplace coverage during the special enrollment period between February 15 and April 30, 2021, compared with 266,000 and 391,000 people who signed up through special enrollment periods based on qualifying life events during the same periods in 2019 and 2020. Though the 2021 special enrollment period was extended to August 15, about half of new enrollment during the period's original time frame (February 15–April 30, 2021) occurred in April. Thus, some of these enrollments may have occurred after the HRMS was fielded. See "2021 Open Enrollment Report," Centers for Medicare and Medicaid Services, accessed June 30, 2021, *https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf;* and "2021 Marketplace Special Enrollment Report," Centers for Medicare and Medicaid Services, May 6, 2021, *https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-1.*

[10] The shares of adults with an unspecified coverage type were 2.3 percent in 2019, 1.4 percent in 2020, and 1.3 percent in 2021.

FIGURE 1

Health Insurance Coverage among Adults Ages 18 to 64, March 2019 to April 2021

Percent



Source: Health Reform Monitoring Survey, March 2019 through April 2021.

Notes: ESI is employer-sponsored insurance. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type (2.3 percent in 2019, 1.4 percent in 2020, and 1.3 percent in 2021).

*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

The share of adults reporting public coverage increased in both Medicaid expansion and nonexpansion States.

As shown in figure 2, ESI coverage declined between 2019 and 2021 in expansion States (from 67.0 to 64.6 percent) and nonexpansion States (from 61.3 to 57.9 percent). But public coverage increased during this period in both groups of States, from 14.9 to 19.2 percent in expansion States and from 10.7 to 14.3 percent in nonexpansion States. These patterns are consistent with Centers for Medicare and Medicaid Services data showing rapid Medicaid enrollment growth in both expansion and nonexpansion States during the pandemic (Corallo and Rudowitz 2021; Khorrami and Sommers 2021).[11]

The higher rates of public coverage in expansion States than in nonexpansion States in both 2019 and 2021 largely reflect the former's more generous eligibility for Medicaid; nearly all adults living in expansion States with incomes below 138 percent of FPL are eligible.[12] In nonexpansion States, nondisabled, nonpregnant parents typically must have very low incomes to qualify for Medicaid (*e.g.,* 17 percent and 18 percent of FPL in Texas and Alabama) and nonparents are ineligible.[13] The increase in reported public coverage in nonexpansion States over the study period was concentrated among the groups most likely to be eligible for Medicaid or CHIP.[14]

The uninsurance rate in Medicaid expansion States was approximately 8 percent between 2019 and 2021. In nonexpansion States, the uninsurance rate was higher in 2021 (18.2 percent) than in 2020 (16.5 percent) and 2019 (17.2 percent), though

[11] Joan Alker and Allie Corcoran, "What Is Happening with Medicaid Enrollment in Q1 of 2021?" Say Ahhh! (blog), Georgetown University Health Policy Institute, Center for Children and Families, May 21, 2021, *https://ccf.georgetown.edu/2021/05/21/what-is-happening-with-medicaid-enrollment-in-q1-of-2021/*.

[12] Noncitizens' eligibility for Medicaid depends on several factors, including whether they are lawfully present, considered qualified noncitizens based on their immigration status, and subject to the 5-year waiting period after receiving qualified status. *See* "Coverage for Lawfully Present Immigrants," Centers for Medicare and Medicaid Services, accessed June 30, 2021, *https://www.healthcare.gov/immigrants/lawfully-present-immigrants/*.

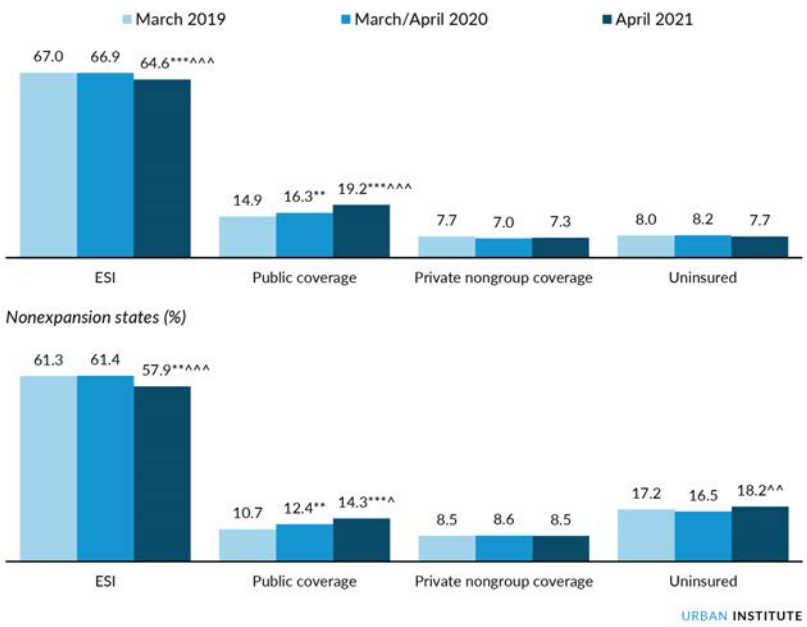
[13] "State Health Facts: Medicaid and CHIP," Kaiser Family Foundation, accessed June 30, 2021, *https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/*.

[14] The increase in public coverage between 2019 and 2021 in nonexpansion States was concentrated among the group of adults most likely to be eligible for Medicaid or CHIP: 18-year-olds (who qualify for Medicaid or CHIP based on eligibility thresholds for children), adults living with children under 18 in the household (who potentially qualify as parents or caregivers), and adults in Wisconsin, which has used state funds to provide coverage to adults with incomes up to the FPL (data not shown). The increase in public coverage for other adults was statistically significant but small in magnitude.

the difference between 2019 and 2021 was not statistically significant. As in prior years, adults in nonexpansion States were more than twice as likely as adults in expansion States to be uninsured in 2021 (18.2 versus 7.7 percent). However, differences in uninsurance are not entirely attributable to differences in Medicaid eligibility, because other factors (*e.g.,* access to ESI, funding for outreach and enrollment assistance) likely affect coverage status.

FIGURE 2

Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status, March 2019 to April 2021



Source: Health Reform Monitoring Survey, March 2019 through April 2021.

Notes: ESI is employer-sponsored insurance. Medicaid expansion states implemented expansions by April 2021. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type; these shares were 2.4 percent, 1.6 percent, and 1.3 percent in expansion states in 2019, 2020, and 2021 and 2.3 percent, 1.1 percent, and 1.2 percent in nonexpansion states in 2019, 2020, and 2021.

*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Declines in ESI and increases in public coverage between 2019 and 2021 were concentrated among adults with low and moderate incomes.

Adults with low and moderate incomes were hardest hit by the recession (Karpman, Zuckerman, and Kenney 2020)[15] and reported the largest declines in ESI over the study period. Among adults with past-year incomes at or below 138 percent of FPL, the share with ESI fell from 21.4 to 16.0 percent during this period (table 1). Among adults with incomes between 139 and 399 percent of FPL, the share with ESI fell from 64.5 to 60.0 percent. We did not find a statistically significant change in ESI among adults with incomes at or above 400 percent of FPL.

Increased public coverage among adults with low incomes, from 45.0 to 52.6 percent, and those with moderate incomes, from 9.7 to 14.3 percent, helped offset declines in ESI among these groups. Most adults must have incomes below 138 percent of FPL to qualify for Medicaid in expansion States, and eligibility in nonexpan-

[15] "Opportunity Insights Economic Tracker," Harvard University, accessed July 14, 2021, *https://www.tracktherecovery.org/*.

sion States is limited to parents with even lower incomes and generally nonexistent for nonparent adults. However, eligibility is based on current monthly income, meaning an adult whose annual family income in the past year was above the eligibility threshold may qualify if they experience a loss of income that places them below the threshold.

The uninsurance rate did not change significantly in any of the income groups examined. Nearly one in four adults with low incomes (23.7 percent) and about one in eight with moderate incomes (12.8 percent) were uninsured in April 2021.

TABLE 1. Health Insurance Coverage among Adults Ages 18 to 64, by Family Income, March 2019 to April 2021

Percent

Family income	March 2019	March/April 2020	April 2021
At or below 138% of FPL			
ESI	21.4	21.5	16.0***^^^
Public coverage	45.0	48.5**	52.6***^^
Private nongroup coverage	6.8	5.5	5.6
Uninsured	24.3	22.4	23.7
139–399% of FPL			
ESI	64.5	64.0	60.0***^^^
Public coverage	9.7	10.8	14.3***^^^
Private nongroup coverage	11.3	10.8	11.8
Uninsured	11.8	12.9	12.8
At or above 400% of FPL			
ESI	86.9	88.1	87.8
Public coverage	1.5	1.6	2.1**
Private nongroup coverage	6.1	5.8	5.3
Uninsured	3.6	3.5	3.7

Source: Health Reform Monitoring Survey, March 2019 through April 2021.
Notes: FPL is federal poverty level. ESI is employer-sponsored insurance. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type, which is between 1 and 3 percent across income groups and years.
*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.
^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

The share of adults with low incomes reporting public coverage increased in both Medicaid expansion and nonexpansion States between 2019 and 2021. More than one in three adults with low incomes in nonexpansion States were uninsured in 2021, compared with about one in seven of such adults in expansion States.

Among adults with incomes at or below 138 percent of FPL, the share reporting public coverage increased from 54.6 to 62.9 percent in Medicaid expansion States and from 30.4 to 37.3 percent in nonexpansion States between 2019 and 2021 (table 2). The uninsurance rate for adults with low incomes was statistically unchanged in both groups of States, but wide disparities by Medicaid expansion status persisted. In 2021, more than one in three adults with low incomes (37.7 percent) in nonexpansion States were uninsured, compared with about one in seven (14.5 percent) of such adults in expansion States. Adults with moderate incomes in nonexpansion States were nearly twice as likely as those in expansion States to be uninsured (17.8 versus 10.1 percent).

TABLE 2. Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status and Family Income, March 2019 to April 2021

Percent	Expansion States			Nonexpansion States		
Family income	March 2019	March/ April 2020	April 2021	March 2019	March/ April 2020	April 2021
At or below 138% of FPL						
ESI	20.7	21.2	15.7***^^^	22.7	22.2	16.2*^^^
Public coverage	54.6	57.3	62.9***^^^	30.4	34.3	37.3**
Private nongroup coverage	5.3	3.7**	4.4	8.8	8.3	7.6

TABLE 2. Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status and Family Income, March 2019 to April 2021—Continued

Percent	Expansion States			Nonexpansion States		
Family income	March 2019	March/ April 2020	April 2021	March 2019	March/ April 2020	April 2021
Uninsured	16.5	15.0	14.5	36.3	34.3	37.7
139–399% of FPL						
ESI	65.4	64.8	61.2**^^^	63.1	62.6	57.7***^^
Public coverage	11.4	12.2	16.6***^^^	6.2	8.0*	10.3***^^
Private nongroup coverage	11.5	10.7	11.3	10.9	10.8	12.9
Uninsured	9.3	10.8	10.1	16.8	16.8	17.8
At or above 400% of FPL						
ESI	87.9	88.3	88.4	84.6	87.3**	86.4
Public coverage	1.3	1.5	2.1***	2.2	1.8	2.5
Private nongroup coverage	5.9	5.7	5.5	6.5	6.1	4.9***
Uninsured	2.9	3.2	3.0	4.9	4.2	5.3

Source: Health Reform Monitoring Survey, March 2019 through April 2021.

Notes: FPL is federal poverty level. ESI is employer-sponsored insurance. Medicaid expansion States implemented expansions by April 2021. Estimates are regression adjusted. Estimates are not shown for the share of adults with an unspecified coverage type, which is between 0 and 3 percent across income levels, state groups, and years.

*/**/*** Estimate differs significantly from that for March 2019 at the 0.10/0.05/0.01 level, using two-tailed tests.

^/^^/^^^ Estimate differs significantly from that for March/April 2020 at the 0.10/0.05/0.01 level, using two-tailed tests.

Discussion

Despite losses of jobs, income, and ESI during the pandemic, the uninsurance rate did not change between March 2019 and April 2021. Increased public coverage helped counter ESI losses, protecting many adults from becoming uninsured both in Medicaid expansion and nonexpansion States. But in April 2021, the uninsurance rate in nonexpansion States was higher than it had been in March/April 2020 and was more than double the uninsurance rate in expansion States.

The growth in public coverage reflects several factors, including expanded Medicaid eligibility under the ACA that has strengthened the safety net in 37 States and the District of Columbia, the freeze on Medicaid disenrollment under the Families First Coronavirus Response Act, and the historic pattern of rising Medicaid enrollment during recessions (Corallo and Rudowitz 2021).[16] Assessing how each factor has affected coverage during the pandemic is beyond the scope of this brief. However, the study findings highlight several challenges and opportunities for protecting and expanding coverage in the near term.

Though the public health emergency and Medicaid disenrollment freeze will likely be extended at least until early 2022,[17] States will need to process a backlog of coverage renewals and redeterminations when the freeze is lifted (Musumeci and Dolan 2021). Resuming normal operations too quickly could lead to a surge in erroneously rejected applications and renewals, putting coverage at risk for people who are eligible for Medicaid (Rosenbaum, Handley, and Morris 2021). The Centers for Medicare and Medicaid Services recently issued updated guidance stating Medicaid eligibility and enrollment backlogs should be processed within 12 months of the end of the public health emergency.[18] The guidance also prohibits States from terminating Medicaid coverage for people deemed ineligible during the public health emergency until the state has completed an additional redetermination of eligibility after the

[16] Alker and Corcoran, "What Is Happening with Medicaid Enrollment in Q1 of 2021?" *Say Ahh!*.

[17] Norris Cochran (acting secretary, U.S. Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, *https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf*.

[18] Daniel Tsai (deputy administrator and director, Centers for Medicare and Medicaid Services), letter to state health officials regarding, "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID–19 Public Health Emergency," August 13, 2021, *https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf*.

emergency ends. Finally, under previous guidance from December 2020, the Centers for Medicare and Medicaid Services expected States to prioritize eligibility and enrollment actions for people most likely to no longer be eligible for coverage (Musumeci and Dolan 2021). The updated guidance requires States to consider how their approaches for processing these actions will ensure continuity of coverage for eligible people and limit delays for those who become newly eligible. State officials can begin preparing for the end of the public health emergency now and avoid terminating coverage based on outdated information for eligible enrollees, many of whom experienced disruptions to their employment and housing during the pandemic (Wagner 2020).

Medicaid enrollees whose incomes have risen above the eligibility threshold in their state will no longer qualify for coverage when the disenrollment freeze expires. If such adults lack access to affordable ESI, they will need to turn to the private nongroup market to remain insured. The temporarily expanded Marketplace premium tax credits under the American Rescue Plan Act will make Marketplace plans more affordable, but some adults may not be aware of the availability of zero-premium or low-cost plans. Outreach and enrollment assistance can help adults transition from Medicaid to Marketplace coverage and avoid disruptions in care (Haley and Wengle 2021). State agencies will also need to assess eligibility for subsidized Marketplace coverage and other insurance affordability programs for adults who lose Medicaid eligibility after the public health emergency ends (Musumeci and Dolan 2021).

The American Rescue Plan Act increased the subsidy amounts of Marketplace premium tax credits, reducing the percentage of income people have to pay toward premiums, and expanded eligibility for premium tax credits to adults with incomes above 400 percent of FPL. If Congress does not extend these changes, they will expire at the end of 2022. Making the enhanced subsidies permanent could reduce the number of people uninsured in the longer term, and most of the coverage gains would occur among adults with moderate incomes (Banthin et al. 2021).

Policymakers can further reduce uninsurance by addressing the high uninsurance rates among adults with low incomes, particularly in the remaining Medicaid nonexpansion States, where more than one-third of adults with incomes at or below 138 percent of FPL are uninsured. The American Rescue Plan Act provides these States with new incentives to expand Medicaid by increasing the federal matching rate for regular (*i.e.,* nonexpansion) Medicaid populations for 2 years (Musumeci 2021). If the nonexpansion States had adopted Medicaid expansion in 2020, 4.4 million fewer people would have been uninsured that year (Buettgens 2021). Federal policymakers are also considering approaches for closing the Medicaid coverage gap in States that have not expanded eligibility under the ACA.[19]

Additional health-care reforms, ranging from incremental improvements to the ACA to more comprehensive approaches, can advance the U.S. toward universal coverage, though they have different trade-offs in costs, provider payment rates, and disruptions to the existing health-care system (Blumberg et al. 2019).

Data and Methods

This brief draws on data from the Urban Institute's Health Reform Monitoring Survey, a nationally representative, Internet-based survey of adults ages 18 to 64. Launched in 2013, the HRMS provides timely information on health insurance coverage, health-care access and affordability, and other health topics before federal survey data become available. For each round of the HRMS, we draw a stratified, random sample of nonelderly adults from Ipsos's KnowledgePanel, the nation's largest probability-based online panel. Members of the panel are recruited from an address-based sampling frame covering approximately 97 percent of U.S. households, including those without Internet access. If needed, panel members are given Internet access and web-enabled devices to facilitate their participation.

For this analysis, we used data from the March 2019, March/April 2020, and April 2021 rounds of the HRMS. The 2019 round was fielded March 4 through 14; it had a sample size of 9,596 adults, and 91 percent completed the survey in the first week of fielding. The 2020 round was fielded March 25 through April 10; it had a sample size of 9,032 adults, and 75 percent completed the survey in the first week. And the

[19] Rachel Roubein and Alice Miranda Ollstein, "Plugging Obamacare's Biggest Hole Poses Dilemma for Democrats," Politico, July 10, 2021, *https://www.politico.com/news/2021/07/10/obamacare-medicaid-coverage-gap-democrats-499013.*

2021 round was fielded April 2 through 20; it had a sample size of 9,067 adults, and 82 percent completed the survey in the first week.

The 2019 round of the HRMS included an oversample of adults with incomes below 138 percent of FPL. In 2020, we changed the survey's design to include larger oversamples of adults in low- and moderate-income households, nonwhite and Hispanic/Latinx adults, and young adults. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population, based on benchmarks from the Current Population Survey and the American Community Survey. Participants can take the survey in English or Spanish, and the survey takes a median of 15 minutes to complete. The margin of sampling error, including the design effect, for the full sample of adults in the 2021 survey round is plus or minus 1.2 percentage points for a 50 percent statistic at the 95 percent confidence level.

Health Insurance Coverage Measures

In all rounds of the HRMS, respondents received a question, adapted from the American Community Survey, about their current health insurance coverage. Respondents could report more than one type of coverage, and those who did not report any coverage were asked to verify if they have health insurance. We used additional follow-up questions to determine whether respondents enrolled in their health plan through the Marketplace, whether they enrolled in a private plan through the Marketplace, whether they are covered under certain state programs, and the name of the health plan for their main source of coverage.

Because respondents could report more than one coverage type, we established a hierarchy of responses to assign coverage types so that coverage estimates sum to 100 percent: ESI/military coverage; public coverage, including Medicare, Medicaid, and CHIP; private nongroup coverage purchased through or outside the Marketplaces; and other unspecified coverage. To address the challenges associated with identifying health insurance coverage type in surveys (Call et al. 2013; Klerman et al. 2009; Pascale 2008; Pascale, Fertig, and Call 2019), we used a logical editing process to identify the most likely type of health insurance coverage held by respondents, based on the information they provided in the survey (Blavin, Karpman, and Zuckerman 2016). However, measurement error still occurs in survey estimates of coverage type, particularly in reports of private nongroup coverage (which can be purchased through government-run Marketplaces with public subsidies) and Medicaid coverage (which is often provided through private Medicaid managed-care plans).

Estimates from this brief are not directly comparable with estimates from HRMS analyses from before 2020 because of a change in the coverage editing process for respondents who reported having insurance but did not report a specific coverage type and who did not enroll in a health plan through the Marketplace. Under the previous approach, these respondents were identified as insured with an unspecified coverage type if they reported having a deductible. The updated approach only assigns unspecified coverage to these respondents if they report the name of a health plan that provides a valid form of comprehensive health insurance coverage. Based on this update, respondents reporting plans that do not offer comprehensive health insurance (*e.g.,* health care sharing ministries) are considered uninsured, yielding slightly higher estimates of uninsurance in this brief than in previous analyses of the HRMS. Under this updated coverage editing approach, estimates of the share of uninsured nonelderly adults in previous rounds of the HRMS would be 1 to 2 percentage points higher than under the previous approach. We applied the updated coverage editing process consistently for all years of data in this brief.

Analysis

Estimated changes in coverage are regression adjusted to control for any changes in the demographic and socioeconomic characteristics of respondents in each survey round not fully captured in the survey weights. This allows us to remove variation in coverage caused by changes in the observable characteristics of people responding to the survey over time. We control for measures used in poststratification of both the KnowledgePanel and the HRMS, including gender, age, race and ethnicity, primary language, educational attainment, marital status, presence of children in the household, household income, family income, homeownership status, Internet access, urban/rural residence, and region. We also control for citizenship status and participation in the previous round of the survey. In presenting the regression-adjusted estimates, we use the predicted rate of each coverage measure in each year for the same nationally representative population. For this analysis, we base the nationally representative sample on respondents for the 2020 and 2021 rounds of the survey.

We emphasize changes in coverage that are statistically different from 0 at the 5 percent level or lower and provide a 95 percent confidence interval for key estimates of changes in the number of adults with selected coverage types.

Limitations

This analysis has several limitations. First, studies have found significant measurement error in reported health insurance coverage type across surveys (Call et al. 2013; Klerman et al. 2009; Pascale 2008; Pascale, Fertig, and Call 2019). We attempt to mitigate this error using a logical editing process for coverage type that relies on multiple data elements (Blavin, Karpman, and Zuckerman 2016). Second, the probability-based internet panel underlying the HRMS does not cover some adult populations, including those who are homeless, are institutionalized, or do not speak English or Spanish. Third, the HRMS has a low cumulative response rate, and nonresponse bias is likely only partially mitigated by the survey weights. However, previous studies assessing recruitment for the panel from which HRMS samples are drawn have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008). Further, HRMS estimates of changes in coverage have been consistent with estimates from federal surveys with larger samples sizes, higher response rates, and stronger designs (Karpman and Long 2015). Finally, though nonresponse in federal surveys increased significantly during the pandemic (Dahlhamer et al. 2021; Rothbaum and Bee 2021), we find little change in nonresponse in the HRMS. Probability-based internet panels could potentially have more stable response patterns because panel members have previously agreed to participate in surveys. However, the impact of the pandemic on these types of surveys is not yet fully understood.

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Extending the American Rescue Plan Act's Enhanced Marketplace Affordability Provisions Could Benefit Nearly 1 Million Uninsured Children and Parents

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Signed into law in March 2021, the American Rescue Plan Act (ARPA) contained numerous provisions aimed at supporting recovery from the COVID–19 pandemic and associated recession.[1] Among these provisions are changes to the subsidy schedule governing access to financial assistance to purchase health insurance coverage in the Affordable Care Act (ACA) Marketplaces. These changes give Americans access to greater financial assistance purchasing coverage through 2022 and have the potential to reduce uninsurance and make coverage more affordable for those already purchasing nongroup coverage. Making these provisions permanent is a topline priority in Senate Democrats' fiscal year 2022 budget resolution.[2]

Though children were not the primary target of the ACA coverage expansions or subsequent efforts to strengthen the ACA, recent increases in children's uninsurance rates and the critical need to address unmet health needs and catch up on forgone care during the pandemic suggest that removing barriers to health care for children could be particularly important in the coming years (Alker and Corcoran 2020; McMorrow et al. 2020; Gonzalez, Karpman, and Haley 2021). These risks for children are also exacerbated by parents' rising uninsurance rates and pandemic-related unmet health needs (Gonzalez et al. 2020; Haley, Kenney, Wang Pan, et al. 2021).

Children may benefit from extending the ARPA's enhanced subsidies if they gain coverage or their parents gain coverage or experience premium or OOP cost savings (Wright Burak 2019). In this brief, we consider the impacts of extending the enhanced subsidies on all children and their parents and children under age 6 and their parents. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we find the following:

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[1] American Rescue Plan Act, Pub. L. No. 117–2 (2021).

[2] "FY2022 Budget Resolution Toplines," U.S. Senate Democratic Leadership, August 9, 2021, *https://www.democrats.senate.gov/imo/media/doc/Topline%20Summary%20of%20FY2022%20Budget%20Resolution.pdf.*

- Nearly 1 million uninsured children and parents, including approximately 300,000 uninsured children, would gain insurance coverage if ARPA subsidy enhancements were made permanent.
- About 67,000 uninsured children who would gain coverage through these provisions would be under age 6, and approximately 267,000 uninsured parents who would gain coverage would have a child under age 6. This suggests even more young children could benefit when their parents gain coverage.
- Nearly two-thirds of the coverage gains for families would be concentrated among children and parents with incomes between 200 and 400 percent of the federal poverty level (FPL).
- If ARPA subsidy enhancements were made permanent, we project that about 3.3 million children and 6.3 million parents would remain uninsured in 2022, unless additional policy changes are introduced. Most remaining uninsured children would be eligible for Medicaid or the Children's Health Insurance Program, or CHIP (57.2 percent), or tax credits (13.6 percent). But about 41.2 percent of parents would be ineligible for subsidized coverage because of their immigration status or residence in a state that has not expanded Medicaid under the ACA; this represents approximately 2.6 million parents, including 636,000 uninsured parents who would become eligible for Medicaid if their state were to expand Medicaid under the ACA.
- Approximately 4.5 million children and parents who had nongroup coverage before the ARPA would experience household premium reductions of 28 percent per person, on average; those with incomes below 200 percent of FPL would save even more, 41 percent per person. Total household spending on premiums and OOP costs would fall by averages of 18 percent per person overall and 25 percent per person in families with income below 200 percent of FPL.

Background

The ACA expanded coverage options for millions of Americans, and though such options focused largely on childless adults, children's and parents' uninsurance also declined (Karpman et al. 2016). From 2013 to 2016, uninsurance fell from 7.0 to 4.3 percent among children and from 17.6 to 11.0 percent among parents (Haley, Kenney, Wang Pan, et al. 2021). In recent years, however, declines in children's and parents' uninsurance have stalled (Haley et al. 2019, 2020), and uninsurance increased for both groups in 2019 (Haley, Kenney, Wang Pan, et al. 2021). From 2018 to 2019, uninsurance increased from 4.8 to 5.2 percent among children and from 11.2 to 11.7 percent among parents.

Thus, many families with children faced precarious health-care access and affordability as the COVID–19 pandemic and resulting recession took hold in 2020, and numerous families experienced additional economic and health challenges in the ensuing months. Many families with children lost jobs and incomes during the recession, but parents who kept working through the pandemic also faced challenges related to child care safety and availability (Karpman, Gonzalez, and Kenney 2020). Both children and parents have reportedly faced significant mental health challenges during the pandemic (Hamel et al. 2020; Panchal et al. 2021), as well as forgone and delayed care (Gonzalez et al. 2020, 2021). As of now, no definitive estimates of the number of children and parents who lost health insurance coverage during the pandemic exist,[3] but several protections have likely prevented catastrophic coverage losses. Under the Families First Coronavirus Response Act, for example, States became eligible for an increase in federal Medicaid funding throughout the public health emergency, so long as they maintain eligibility for those enrolled on or after March 18, 2020. As the recovery continues and some of these protections expire, it will be critical for families to be able to access affordable coverage and care, especially given the urgent need for children and parents to catch up on care they missed during the pandemic. Moreover, both physical and mental health-care needs for children and families may have increased because of the pandemic and the associated stressors of remote learning and social isolation.

The ARPA included numerous provisions with the potential to benefit families and children, including a child tax credit and efforts to make insurance coverage more widely available and affordable (Acs and Werner 2021; Wheaton, Giannarelli,

[3] Joan Alker, "Q: How Many Children Were Uninsured in 2020?" Say Ahhh! (blog), Georgetown University Health Policy Institute, Center for Children and Families, August 10, 2021, *https://ccf.georgetown.edu/2021/08/10/how-many-children-were-uninsured-in-2020/*.

and Dehry 2021). The changes to the Marketplace subsidy schedule were particularly important for children and parents, especially those whose families may have lost jobs and access to employer-sponsored insurance during the pandemic. Specifically, premium contributions for those with incomes below 150 percent of FPL were reduced to zero; required premium contributions were significantly reduced for those with incomes between 150 and 400 percent of FPL; and premium contributions were capped at 8.5 percent of income for people with incomes above 400 percent of FPL, who were previously ineligible for any subsidies (table 1). As under current law, people not meeting immigration requirements and those with access to an employer-sponsored plan deemed affordable under the ACA (*i.e.,* with employee premiums at or below 9.8 percent of household income) would remain ineligible for subsidies under extended ARPA subsidies.

TABLE 1. Subsidy Schedules under Current Law and the American Rescue Plan Act, 2022

Premium contribution percentage-of-income limits for benchmark coverage

Income (% of FPL)	Before ARPA	Under ARPA
< 138	2.07	0.0–0.0
138–150	3.10–4.14	0.0–0.0
150–200	4.14–6.52	0.0–2.0
200–250	6.52–8.33	2.0–4.0
250–300	8.33–9.83	4.0–6.0
300–400	9.83	6.0–8.5
400–500	n/a	8.5–8.5
500–600	n/a	8.5–8.5
600+	n/a	8.5–8.5

Sources: Internal Revenue Service, Health and Human Services Department, and American Rescue Plan Act of 2021, Pub. L. No. 117-2.
Notes: FPL is federal poverty level. ARPA is American Rescue Plan Act. n/a is not applicable; people with incomes above 400 percent of FPL are ineligible for subsidies under current law. Percentage-of-income caps applied in 2022; current-law caps are for 2021 and indexed each year. Annual adjustments to caps have been modest and are not made until close to the end-of-year open enrollment period.

Children and their parents may benefit from these enhanced affordability provisions in at least three ways. First, uninsured children may gain coverage if subsidy enhancements allow families to newly purchase coverage for children. Second, uninsured parents may gain coverage with newly affordable options, and their already insured children may benefit from the associated health and financial improvements for their family (Wright Burak 2017). Finally, household spending on premiums would decline for families who already had nongroup coverage before the subsidy enhancements, which frees up resources for other needs. Understanding these effects will provide policymakers with insights for strengthening the health and financial well-being of children and families and identify remaining gaps in coverage affordability and accessibility.

Methods

We used the Urban Institute's Health Insurance Policy Simulation Model to produce the estimates in this brief. HIPSM is a detailed microsimulation model of the health-care system designed to estimate the cost and coverage effects of proposed health care policy options. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. Results from HIPSM simulations have been shown to be consistent with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

An earlier report modeled the effects of the ARPA's enhanced subsidies on coverage for the entire nonelderly population in 2022 (Banthin et al. 2021). That simulation assumed the ARPA's changes to the subsidy schedule were permanent and the changes were fully phased in by 2022. In other words, consumers, employers, and insurers in the model had fully adapted their decision making to the new schedule. Additional details on the 2022 HIPSM baseline estimates, including assumptions about the pandemic's economic effects, can be found in the earlier report.

In this brief, we present estimates from the same simulation for children and parents overall and young children and their parents. We describe changes in the coverage distribution for children and parents under the enhanced subsidy schedule, and we consider changes in premiums and OOP spending for families who had

nongroup coverage before the ARPA. Children are those ages 18 and younger and parents are nonelderly adults (ages 19 to 64) with a child in their tax unit. We produce estimates for young children ages 5 and younger and their parents because of the importance of early childhood to future health and well-being.

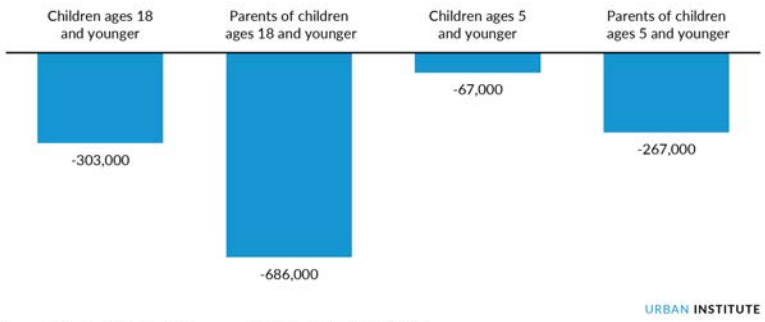
This analysis has some limitations. First, assumptions about population, income, and health cost growth are always somewhat uncertain, but the additional uncertainty associated with the current economic recovery and frequently changing pandemic-related policies exacerbate the issue. For example, the current projections assume the Medicaid maintenance-of-effort provisions will expire in early 2022, and States have up to 12 months to complete the redetermination process.[4] It is impossible to predict how quickly individual States will work through verifications, redeterminations, and renewals, however, so Medicaid enrollment may be higher in 2022 than these estimates indicate. In addition, our definition of parents excludes noncustodial parents and some unmarried parents living together with their children but assigned to different tax units.

Results

If the ARPA's enhanced subsidies were made permanent, we find that the number of uninsured children would fall by approximately 303,000, and the number of uninsured parents would fall by about 686,000 (figure 1). The number of uninsured young children would fall by about 67,000, and about 267,000 parents of young children would gain coverage.

FIGURE 1

Change in the Numbers of Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: ARPA is American Rescue Plan Act.

Uninsurance rates would drop from 4.6 to 4.2 percent for children and from 10.8 to 9.8 percent for parents (table 2). The increases in private nongroup coverage, of 0.5 and 1.2 percentage points for children and parents, are the key drivers of the projected decline in uninsurance. Young children have somewhat lower uninsurance rates than children overall, whereas their parents have somewhat higher uninsurance rates than parents overall both before and under the permanent ARPA subsidy schedule. But, the projected effects of the subsidies on young children and their parents are similar to those for parents and children overall; for both groups, reductions in uninsurance under the ARPA would be largely offset by gains in private nongroup coverage.

[4] Daniel Tsai (Deputy Administrator and Director, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services), letter to state health officials, regarding "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID–19 Public Health Emergency," August 13, 2021, *https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.*

TABLE 2. Coverage Distribution of Children and Parents before and under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

	Children ages 18 and younger			Parents of children ages 18 and younger		
	Before ARPA (%)	Under ARPA (%)	Percentage-point change	Before ARPA (%)	Under ARPA (%)	Percentage-point change
Employer	46.0	45.9	−0.1	60.2	60.0	−0.2
Private nongroup	1.7	2.2	0.5	4.8	6.0	1.2
Medicaid/CHIP	45.1	45.1	0.1	21.4	21.5	0.1
Other public	1.8	1.8	0.0	2.2	2.2	0.0
Noncompliant nongroup	0.8	0.7	−0.1	0.6	0.5	−0.1
Uninsured	4.6	4.2	−0.4	10.8	9.8	−1.1

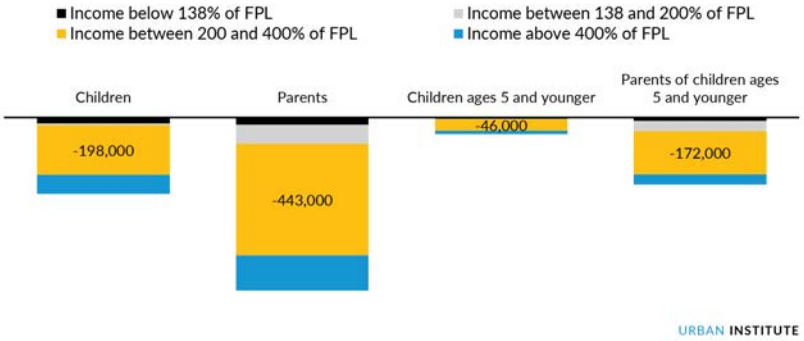
	Children ages 5 and younger			Parents of children ages 5 and younger		
	Before ARPA (%)	Under ARPA (%)	Percentage-point change	Before ARPA (%)	Under ARPA (%)	Percentage-point change
Employer	42.1	42.1	0.0	55.9	55.7	−0.2
Private nongroup	1.3	1.7	0.4	4.1	5.2	1.1
Medicaid/CHIP	50.3	50.3	0.0	25.3	25.4	0.1
Other public	2.1	2.1	0.0	2.1	2.1	0.0
Noncompliant nongroup	0.7	0.7	−0.1	0.6	0.5	−0.1
Uninsured	3.4	3.1	−0.3	12.0	11.0	−0.9

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA is American Rescue Plan Act. CHIP is Children's Health Insurance Program. Estimates may not add to 100 percent because of rounding.

If the ARPA subsidies were made permanent, the declines in uninsurance would be concentrated among children and families with incomes between 200 and 400 percent of FPL (figure 2). Of the approximately 303,000 children who would gain coverage, about 198,000 would live in families with moderate incomes. About 443,000 of the 686,000 parents expected to gain coverage would have incomes in this range. An additional 75,000 children and 139,000 parents expected to gain coverage would have incomes above 400 percent of FPL. These patterns are similar for young children and their parents. However, compared with all parents, a slightly larger share of parents of young children gaining coverage would have incomes between 138 and 200 percent of FPL.

FIGURE 2

Change in the Numbers of Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022

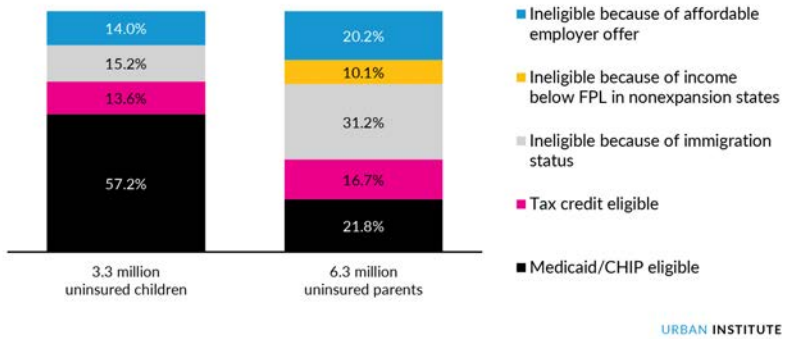


Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: FPL is federal poverty level. ARPA is American Rescue Plan Act. Income groups are based on calculations for Medicaid eligibility.

If the ARPA subsidy schedule were made permanent and no other coverage changes were enacted, we project 3.3 million children and 6.3 million parents would remain uninsured in 2022 (figure 3). Among the remaining uninsured children, we estimate about 57.2 percent would be eligible for Medicaid or CHIP coverage and another 13.6 percent would be eligible for Marketplace subsidies. About 29.2 percent of uninsured children would be ineligible for publicly subsidized coverage, including 15.2 percent ineligible because of their immigration status and 14.0 percent ineligible because they have access to an affordable employer offer of coverage.

FIGURE 3

Eligibility for Publicly Subsidized Coverage among Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA is American Rescue Plan Act. FPL is federal poverty level. CHIP is Children's Health Insurance Program. Income groups are based on calculations for Medicaid eligibility.

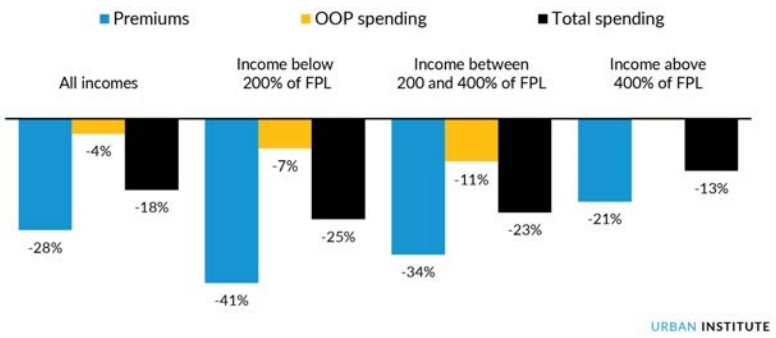
This distribution differs markedly for uninsured parents. Compared with more than 70 percent of uninsured children, only 38.5 percent of uninsured parents would be eligible for Medicaid/CHIP (21.8 percent) or Marketplace subsidies (16.7 percent). Nearly one-third of uninsured parents would be ineligible for publicly subsidized coverage because of their immigration status, and another 10.1 percent (or about 636,000 parents) would be ineligible for having income below the FPL in a state that did not expand Medicaid under the ACA. Finally, 20.2 percent of uninsured parents would be ineligible because they have access to an affordable employer offer. These patterns are quite similar to those for young children and their parents, ex-

cept young children are far less likely to be ineligible because of their immigration status (data not shown).

Approximately 4.5 million children and parents who had nongroup coverage before the ARPA could also benefit from the enhanced subsidies through reductions in household premiums and OOP spending. Across all income groups, these families would experience an average reduction in premium spending of about 28 percent per person and an average reduction in OOP spending of 4 percent per person; the overall reduction in household spending would be 18 percent per person (figure 4). These cost savings would be larger for families with incomes below 400 percent of FPL. On average, families with incomes below 200 percent of FPL would experience a 41 percent reduction in premiums per person and a 7 percent reduction in OOP spending per person. Those with incomes between 200 and 400 percent of FPL would experience an average premium reduction of about 34 percent per person and an average OOP spending reduction of about 11 percent per person. Total household spending on premiums and OOP costs would decline by an average of 25 percent per person for those with incomes below 200 percent of FPL and by 23 percent per person for those with incomes between 200 and 400 percent of FPL.

FIGURE 4

Change in Households' per Person Health Care Spending under a Permanent ARPA Marketplace Premium Subsidy Schedule among Families Who Had Nongroup Coverage before the ARPA, by Income Group, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA is American Rescue Plan Act. OOP is out-of-pocket. FPL is federal poverty level. Sample includes families in which at least one parent or child had nongroup coverage before the ARPA. Income groups are based on calculations for Medicaid eligibility. There is a small (0.3 percent) increase in OOP spending for families with incomes above 400 percent of FPL.

Discussion

This analysis finds that almost 1 million children and parents could gain coverage under extension of the ARPA Marketplace subsidy enhancements. These coverage gains would be concentrated among families with incomes between 200 and 400 percent of FPL and would likely improve access to needed care for children and parents in lower- and moderate-income families. In addition to those directly gaining coverage through the enhanced subsidies, many already insured children will likely benefit if their uninsured parents gain coverage. Evidence strongly suggests that parents having health insurance coverage has both health and economic benefits for children and families (Wright Burak 2017). Further, more than 4 million children and parents who had nongroup coverage before the ARPA could experience significant household premium and OOP cost savings, especially those with incomes below 400 percent of FPL.

Both children's and parents' uninsurance rates were increasing leading up to the pandemic (Haley, Kenney, Wang Pan, et al. 2021), and many families with children were struggling to meet health care and other basic needs (Karpman et al. 2018; Karpman, Kenney, and Gonzalez 2018). Since early 2020, pandemic-related job losses, fears of coronavirus exposure, and associated concerns have contributed to continued problems accessing needed health care and affording food, housing, and other basic needs (Gonzalez et al. 2020, 2021; Gonzalez, Karpman, and Haley 2021; Karpman et al. 2020; Karpman, Gonzalez, and Kenney 2020). Though some of these

concerns may ease as the pandemic recedes and the economy recovers, new complications will likely arise as pandemic protections run out and prepandemic inequities remain unchanged. Thus, making the enhanced ARPA subsidies permanent will provide much needed relief for many families struggling to afford health insurance and health care, and the additional cost savings may free up resources for other family needs.

Still, we project that more than 3 million children and 6 million parents would remain uninsured in 2022 even if the ARPA subsides were made permanent. Congress and the Biden administration are tackling several of the remaining barriers to coverage identified in this analysis. First, a federal program targeting people in the Medicaid coverage gap has been identified as a priority in Senate Democrats' fiscal year 2022 budget resolution.[5] Urban Institute estimates indicate that in combination with the extension of the ARPA subsidies, filling the Medicaid coverage gap would reduce the number of nonelderly uninsured people by 7.0 million, or about 2.8 million more than extending the ARPA subsidies alone (Banthin, Simpson, and Green 2021). Our analysis suggests an estimated 636,000 uninsured parents with incomes below the FPL in the 12 States that have not yet expanded Medicaid under the ACA would become eligible for subsidized coverage under the Democrats' proposed reforms.

Second, the Biden administration is committed to improving outreach and enrollment efforts to ensure people are aware of their eligibility for assistance and have the support needed to enroll.[6] In addition to the 2021 COVID–19 special enrollment period, which has resulted in at least 2.5 million new Marketplace enrollees,[7] the administration intends to expand the 2022 open enrollment period by 30 days and to invest $80 million in the navigator program. The latter will provide outreach and enrollment assistance targeted to people of color; rural communities; immigrant communities; people facing language, transportation, or internet access barriers; and other underserved populations. The administration has also proposed creating a special enrollment period for certain consumers with low incomes who may be eligible for the most generous Marketplace subsidies.[8] Taken together, these outreach and enrollment efforts could have meaningful impacts for the 70 percent of uninsured children and nearly 40 percent of uninsured parents who are already eligible for Medicaid or Marketplace tax credits.

Changing the employer affordability provision, which restricts otherwise eligible people from accessing Marketplace subsidies if they have access to an employer plan that costs the employee less than 9.8 percent of their household income, could affect about 20 percent of uninsured parents. One modest policy change would be eliminating the "family glitch," which restricts eligibility for subsidized coverage for the whole family even when the only affordable employer offer is for a single employee plan. Analyses of such a proposal have not found large effects on uninsurance, but they have found potential for household cost savings (Buettgens and Banthin 2021). To further reduce uninsurance for people affected by the employer affordability provision, however, lowering or eliminating the affordability threshold may be necessary.

Addressing immigration restrictions on receiving Medicaid and Marketplace subsidies will also be critical to closing coverage gaps, because almost one-third of uninsured parents are ineligible for publicly subsidized coverage because of their immigration status. Though the Biden administration reversed the Trump administration's changes to the public charge rule that made many immigrant families afraid to use public benefits for which they were eligible (Haley, Kenney, Bernstein, et al. 2021), further efforts to expand eligibility for affordable coverage to undocumented or otherwise ineligible immigrants will be needed to achieve universal coverage. Finally, children and families need far more than health insurance to thrive, so ongoing attention to paid leave, child care, and educational and income supports will also be critical to ensure all children and their families have the opportunity for healthy, stable futures.

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[5] "FY2022 Budget Resolution Toplines," Senate Democratic Leadership.

[6] Katie Keith, "ACA Round-Up: Navigator Grantees, GAO Investigation, Contraceptive Mandate, and More," Health Affairs Blog, September 1, 2021, *https://www.healthaffairs.org/do/10.1377/hblog20210901.961047/full.*

[7] Katie Keith, "Marketplace Special Enrollment Reaches 2.5 Million; Administration Announces Health Care Reconciliation Priorities," Health Affairs Blog, August 10, 2021, *https://www.healthaffairs.org/do/10.1377/hblog20210810.821428/full.*

[8] Centers for Medicare and Medicaid Services, "CMS Proposed Rule to Increase Americans' Access to Health Coverage for 2022," news release, June 28, 2021, *https://www.cms.gov/newsroom/press-releases/cms-proposed-rule-increase-americans-access-health-coverage-2022.*

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QUESTIONS SUBMITTED FOR THE RECORD TO LINDA J. BLUMBERG, PH.D.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The enhanced premium tax credits (PTCs) from the American Rescue Plan (ARP) are already providing vital assistance to American families to help them afford health insurance coverage on the Affordable Care Act's (ACA's) Health Insurance Marketplaces. During the Special Enrollment period for marketplace coverage this year, 2.8 million new customers signed up for coverage. The Centers for Medicare and Medicaid Services (CMS) estimates that consumers who returned to the marketplace to update their coverage during the Special Enrollment Period saw a 40-percent reduction in net monthly premiums on average, after accounting for the ARP's enhanced PTCs. The Congressional Budget Office (CBO) estimates that if the enhanced PTCs were made permanent and Congress closed the coverage gap in States that have not expanded Medicaid, 3.9 million fewer people would be uninsured over the next decade, compared to current law. This includes 1.4 million people obtaining marketplace coverage who would otherwise be uninsured.

CBO also estimates that 1.6 million people with employer-based coverage would move to marketplace coverage. One of the reasons for that shift is that the Build Back Better legislation as marked up by the House would allow for people to qualify for PTCs if their employee share of job-based health insurance premiums exceeds 8.5 percent of their income. Under current law, individuals who have offers of job-based coverage are only eligible for PTCs if their employee share of the job-based health insurance premium exceeds 9.83 percent of their income.

Can you discuss the positive impact of allowing premium tax credit eligibility for workers who bear very high cost burdens in employer-sponsored coverage?

Answer. One remaining inequity in the current health insurance system is that low-income workers with offers of health insurance coverage through an employer or through the employer of a family member may be prohibited from accessing subsidized marketplace nongroup health insurance that may be of lower cost and higher actuarial value than the employer-based insurance offered to them. A low-income worker with the same income but who is not offered employer-based insurance may have access to marketplace coverage at a household paid premium that represents a substantially smaller share of their family income, and they may well qualify for

out-of-pocket subsidies that lower their deductibles and co-payments/co-insurance to levels below typical employer-based plans, depending upon their income. In addition, the current "firewall" threshold of 9.83 percent of income (mentioned in the question above) is even higher than the maximum percent of income premium contribution of 8.5 percent included in the ARP and BBB legislation; the 9.83 percent is consistent with the pre-ARP marketplace subsidy schedule, which was less generous.

Consequently, lowering the employer-based insurance premium "firewall" percent of income threshold would make it consistent with the new, more generous marketplace premium tax credit schedule, and would allow more modest income workers and their family members the choice to enroll in subsidized marketplace coverage that could lower their insurance premiums and out-of-pocket costs. The value of this change would accrue to lower-income working families, since these are the people for whom employer-sponsored insurance premium contributions are most likely to exceed 8.5 percent of family income.

For example, a family of four with income of 150 percent of the Federal poverty level ($39,750) enrolling in subsidized marketplace insurance coverage would pay 4.14 percent of their income or $1,646 ($137 per month) for benchmark (second lowest premium) silver coverage in 2022 under the ARP premium tax credit schedule and the schedule provided under the reconciliation proposal. In addition, due to that family's low income, by enrolling in silver level marketplace coverage, they would receive a plan with an actuarial value of 94 percent (*i.e.,* on average, 94 percent of covered medical costs would be reimbursed by the insurer, 6 percent by the enrollee), significantly lowering the out-of-pocket costs they would face when using medical care. In contrast, the average full premium for employer-based family coverage was $20,758 in 2020 (according to the Medical Expenditure Panel Survey), and employer-based coverage generally has an actuarial value in the neighborhood of 80 percent. Thus, a family at this income being asked to contribute $3,890 ($324 per month, under 20 percent of the total premium) for an employer-based family insurance policy is, under current law, prohibited from obtaining subsidized marketplace coverage. However, that family would have to pay 2.3 times as much (an additional $2,244 per year) in order to enroll in the employer plan compared to a subsidized marketplace plan if they were not barred by the 9.83 percent of income "firewall." In addition, without the marketplace's cost-sharing reduction available to low-income families, an employer plan would, in almost all circumstances, require the family to pay higher deductibles, co-payments, and co-insurance when using medical care.

In sum, lowering the Affordable Care Act's employer-based insurance "firewall" to 8.5 percent would significantly lower both premium contributions and out-of-pocket cost requirements for low-income working families currently faced with very high financial burdens in order to enroll in employer-based health insurance coverage. The lower the percent of income threshold for the firewall is set, the larger the number of families who could be provided a more affordable choice than their employer may offer.

Question. The committee is examining approaches to help eliminate barriers that health insurance companies have put in place that can make it more difficult for people to obtain mental and behavioral health services. As we consider our options, we also want to assess the impact that short-term, limited-duration insurance plans have on access to mental and behavioral health care. These plans are not required to cover essential health benefits, including mental health services. One analysis of short-term, limited duration insurance plans found that only 57 percent of these plans covered mental health services and only 38 percent covered substance use disorder services. CBO estimates that 1.5 million Americans are enrolled in these plans.

Can you comment on the current scope of short-term, limited-duration insurance plans in the market today and the risk they pose to people who need coverage for mental health?

Answer. My Urban Institute colleagues estimate that 2.3 million people below the age of 65 will be enrolled in short-term limited duration (STLD) plans in 2022, absent additional policy changes.[1] These plans are not subject to the requirements

[1] Jessica Banthin, Matthew Buettgens, Michael Simpson, Robin Wang. "What if the American Rescue Plan's Enhanced Marketplace Subsidies were Made Permanent?" The Urban Institute, April 2021, *https://www.urban.org/sites/default/files/publication/104072/what-if-the-amer-*

Continued

placed on nongroup insurance plans qualified under the Affordable Care Act and sold through the marketplaces and directly by many insurers. The STLD plans pose considerable risks for all people who have, have had, or may have health conditions in the future, and those with mental health needs are no exception.

Outside of the 5 States that prohibit underwritten STLD plans, these policies can deny coverage outright to applicants based on their current, past, or expected health status. This means that people who have experienced a mental health issue are unlikely to be able to obtain coverage of any kind through one of these plans, and for those who are offered coverage, the issuer is permitted to charge them very high premiums compared to others without such conditions. Given the enormous increase in people reporting depression and/or anxiety disorders during the course of the COVID–19 pandemic, mental health issues may be on course to be the most prevalent pre-existing condition in the country. According to the National Health Interview Survey, between 2019 and 2020, the share of adults reporting one of these mental health conditions increased from 11 percent to 40 percent.[2] This means that a substantially larger population could be excluded from purchasing STLDs entirely or being "up charged" in order to obtain it.

Senator Wyden cited work by the Kaiser Family Foundation that found that large percentages of STLD plans do not provide any coverage for mental health care, given that these policies are not subject to essential health benefit requirements under the ACA. In addition, we know that large shares of the remainder that do provide some mental health-care coverage place substantial limits on the number of visits, prescriptions, or other types of mental health care that enrollees can receive. Some offer no prescription drug coverage at all, for example. In addition, most STLDs have annual and/or lifetime benefit limits, furthering capping enrollees' benefits, regardless of the type of care required. Thus, enrollees who have preexisting mental health needs or develop them once enrolled are very unlikely to have coverage that meets their needs, thus limiting their access to necessary care.

Further, because STLDs are not subject to the ACA's requirements to provide clear standardized summaries of what is and is not covered and any benefit limits imposed, many people buy STLDs without understanding just how limited the covered benefits are. Consequently, consumers may well miss a chance to enroll in comprehensive coverage during the annual open enrollment period only to find out that they have no or very limited coverage for their needs once they try to obtain reimbursement under their STLD plan. As a result, a nonwealthy person experiencing a mental health crisis while enrolled in one of these plans may well be unable to obtain the treatment they need, leading to unnecessarily bad outcomes.

Yet STLDs can have harmful implications even for people not enrolled in them. Since STLD issuers can screen out people with significant health needs while simultaneously limiting the claims paid out on behalf of those they do enroll, they can generally be offered to very healthy people at premiums below the unsubsidized premiums offered in the ACA compliant nongroup markets. To the extent that more very healthy people opt for STLDs instead of the comprehensive, higher value compliant plans, the average health-care costs associated with the enrollees in compliant plans will be higher than they otherwise would be. Higher average health-care needs among ACA compliant plan enrollees lead to higher premiums, pre-subsidy. This potential adverse selection into ACA compliant coverage can make comprehensive insurance more expensive for families, particularly those ineligible for financial assistance (premium tax credits). The greater the enrollment in STLDs, the greater the potential adverse effect on the comprehensive insurance pools, and the greater the financial burden on those wanting and needing that high value coverage.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

Question. The pandemic has brought about more advancement in telemedicine in a couple short years than we have seen in decades. It has been shown to work well for both patients and providers. UW Medicine, in my home State of Washington, demonstrated that telemedicine has provided a reliable modality for care for pa-

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ican-rescue-plans-enhanced-marketplace-subsidies-were-made-permanent-estimates-for-2022_0_0.pdf.

[2] Cynthia Cox. "Mental Illnesses May Soon be the Most Common Pre-Existing Conditions." Kaiser Family Foundation, October 2020, *https://www.kff.org/policy-watch/mental-illness-may-soon-be-most-common-pre-existing-conditions/*.

tients without increasing overall health-care costs or utilization, as some have feared.

Over the past 5 years, the number of people seeking telehealth services at University of Washington Medicine has steadily grown to around 21,000 per year in 2019. After the pandemic started, that number ballooned to over 20,000 per month, accounting for approximately 20 percent of all ambulatory visits. I've also heard from many constituents that they wish for expanded telehealth services to continue even after the end of the public health emergency.

That being said, there are several issues that need to be addressed first before we can provide quality telemedicine services to those who are most in need.

Access to telehealth requires that patients have a reliable broadband connection and access to monitoring equipment or devices. However, many people in underserved communities do not have access to either, making it difficult, if not impossible, for them to utilize telehealth services. What specific steps can the Federal government take to ensure equitable access to telehealth services?

As telehealth services become more popular across the country, more and more providers are offering them to their patients. However, there are population groups such as seniors that are sometimes not aware that they have access to these services, or do no possess the technical literacy to get the most out of telemedicine. How do we ensure that our current telehealth infrastructure supports people who may require additional assistance in accessing telehealth services? How can we support our health-care providers to help them promote telehealth literacy for their patients?

One persistent challenge with telemedicine, even with the flexibilities afforded by the public health emergency, is the ability for physicians to see patients across State lines. This can be challenging when large metropolitan areas straddle State lines, such as the city of Vancouver, Washington that borders Oregon. In these instances, State licensing laws are acting as a barrier for patients to seek telemedicine services with providers that they know and trust. Is there anything Congress can do to help ensure broader coverage for patients in these situations?

Answer. Unfortunately, the telemedicine topics in these questions are outside my area of expertise; consequently, I do not feel comfortable responding to them.

QUESTION SUBMITTED BY HON. TIM SCOTT

Question. We are seeing tremendous progress with therapeutic and technological innovations that could soon cure diseases such as Sickle Cell Disease.

As the science outpaces policy, how can reimbursement arrangements and public programs evolve to ensure immediate patient access for one-time curative treatments?

Answer. The technology for treatment of Sickle Cell Disease (SCD) has clearly been advancing quickly in recent years. Yet, given the long history of inadequate access to appropriate care for SCD patients, improving quality and access to care for those afflicted with SCD will require both changes to the way care is delivered to this population and ensuring access to new treatments through insurance programs.

There is considerable evidence that large percentages of health-care providers do not feel comfortable with their understanding of how to treat patients with SCD. Given the complex nature of the condition and the fact that most providers have little or no experience treating the disease, it is inappropriate to expect primary care physicians to be the central coordinator of care for these patients. Still, the variety of physicians treating SCD include hematologists, oncologists, pediatricians, and family medicine providers. Even among hematologists, however, many see few SCD patients, and lack of background and experience often leads to under prescribing of hydroxyurea. There is a clear need for broader training of physicians of all disciplines in cultural competency and acute and chronic pain management related to SCD, as well as emerging treatments.

The development of a larger number of comprehensive sickle cell centers, including those with a focus on adults, not just children, is cited by many experts as an important next step in improving care for patients with SCD. Development of these types of delivery systems can be encouraged through payment incentives provided by Medicaid and Medicare, the insurance systems covering the largest number of

SCD patients; it is estimated that Medicaid covers about 50 percent of the SCD population and Medicare covers another 15 percent. These comprehensive centers can be reimbursed not only for providing direct patient care, but also for providing telementoring to physicians treating SCD patients in geographic areas beyond the centers' reach.

Incentivizing hospital emergency rooms to have a dedicated system for people with SCD could also significantly improve care. Opioids are known by specialists in the condition to be the best treatment for acute SCD crises; however, many emergency department physicians are not aware of this, leading to poor treatment and unnecessary patient suffering.

In addition, the CMS Center for Consumer Information and Insurance Oversight, the agency that oversees implementation of the Affordable Care Act, could consider requiring that SCD therapies shown to be effective be included in any Qualified Health Plan prescription drug formulary. Doing so would ensure that enrollees with SCD in marketplace plans would have insurance coverage for needed treatments. Since the number of enrollees with SCD in any particular marketplace plan can be expected to be small, the additional costs of such a requirement could be spread broadly across all enrollees, likely adding a small amount to the pre-subsidy premium. In addition, the risk adjustment system in the ACA compliant nongroup insurance markets leads to sharing of the treatment costs for high need patients across all plans offering coverage in those markets, regardless of how many of those patients are enrolled in a particular plan. Note, however, that such an approach would mean SCD treatments were covered more broadly than is the case for treatments for other serious conditions.

QUESTION SUBMITTED BY HON. JAMES LANKFORD

Question. The Affordable Care Act allows taxpayer funding for abortion on demand, but at the very least it acknowledged the right of States to prohibit abortion coverage on the exchanges and that abortion could not be required as an essential health benefit. Eleven of the 12 States that have chosen not expand Medicaid have also chosen to prohibit abortion coverage on the exchanges. As written, the Democrats' reconciliation proposal would override these State laws and mandate coverage of, and funding for, abortions on demand, and transportation services to acquire them, for those under 138 percent of poverty and without cost sharing in 2024. However, the bill refers to abortions in an underhanded way.

Do you agree that abortion coverage is mandated and funded by the proposed reconciliation bill's reference to family planning services "which are not otherwise provided under such plan as part of the essential health benefits package" (subsection (c) of section 137505)?

Answer. No, I do not agree. Based upon the most recent language I can identify, the reconciliation proposal States: "services described in subsection (a)(4)(C) of section 1905 of the such Act for which Federal payments would have been so available: which are not otherwise provided under such plan a part of the essential health benefits package as described in section 1302(a)."

Section (a)(4)(C) of section 1905 states—(C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

Given that only services where "Federal payments would have been so available" (in Medicaid)—abortion (outside of Hyde circumstances) is not one of the services included.

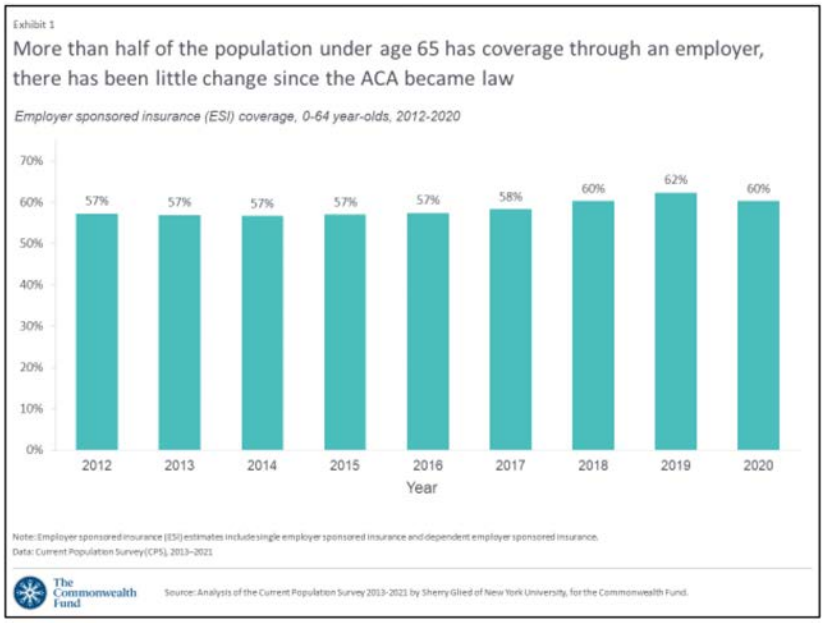
PREPARED STATEMENT OF SARA R. COLLINS, PH.D.,* VICE PRESIDENT, HEALTH CARE COVERAGE AND ACCESS, THE COMMONWEALTH FUND

THE CURRENT STATUS OF EMPLOYER HEALTH INSURANCE COVERAGE IN THE UNITED STATES

Thank you, Mr. Chairman, members of the committee, for this invitation to testify today on the current status of employer health insurance coverage in the United States. My comments will focus on trends in enrollment, the share of employers offering health insurance to workers, the costs of insurance and health care for people who are enrolled in the plans, and policy options to improve workers' coverage.

EMPLOYER HEALTH INSURANCE IS THE BACKBONE OF THE U.S. HEALTH INSURANCE SYSTEM

Employer health insurance continues to be the primary source of insurance coverage for the majority of the U.S. population. More than half the population under age 65—about 163 million people—get their health insurance through an employer, either their own or a family member's (Exhibit 1).[1]



Enrollment in employer health plans has changed little over the last decade even as the Federal Government expanded coverage options through the Affordable Care Act (ACA). Nearly all companies with 200 or more workers offer insurance to their employees (Exhibit 2).[2] Small firms, however, are less likely to offer coverage and there has been some decline in the share that offers over the last decade. Employers in some sectors of the economy, including food services and retail. are far less likely to offer coverage than some others, such as manufacturing, finance, and insurance (Exhibit 3).[3]

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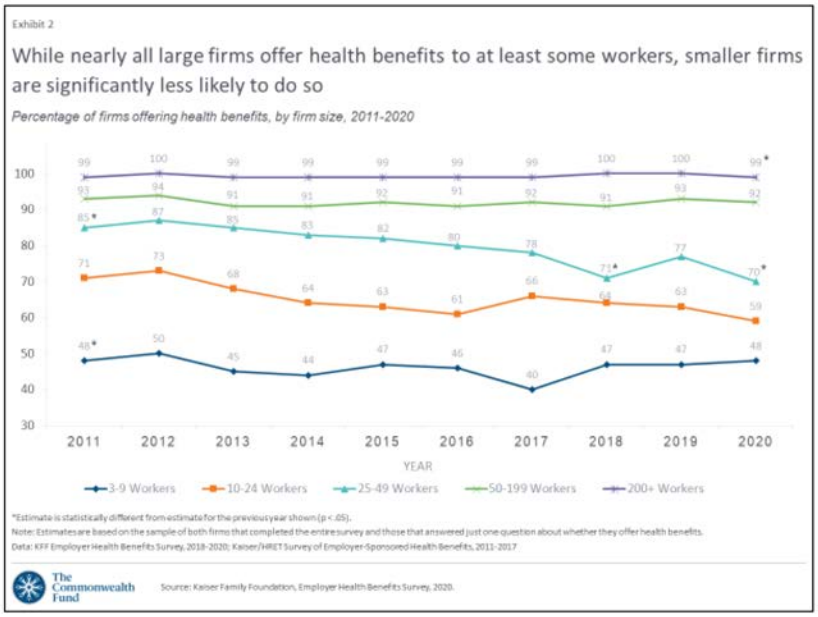
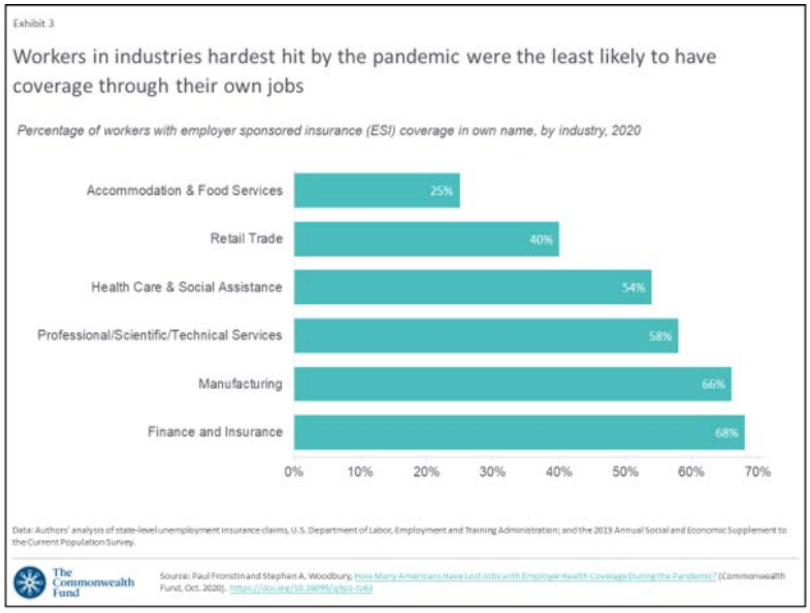
*The views presented here are those of the author and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

[1] Analysis of the 2021 Current Population Survey by Sherry Glied and Mikaela Springsteen of New York University for the Commonwealth Fund.

[2] Kaiser Family Foundation, Employer Health Benefits, 2020 Annual Survey.

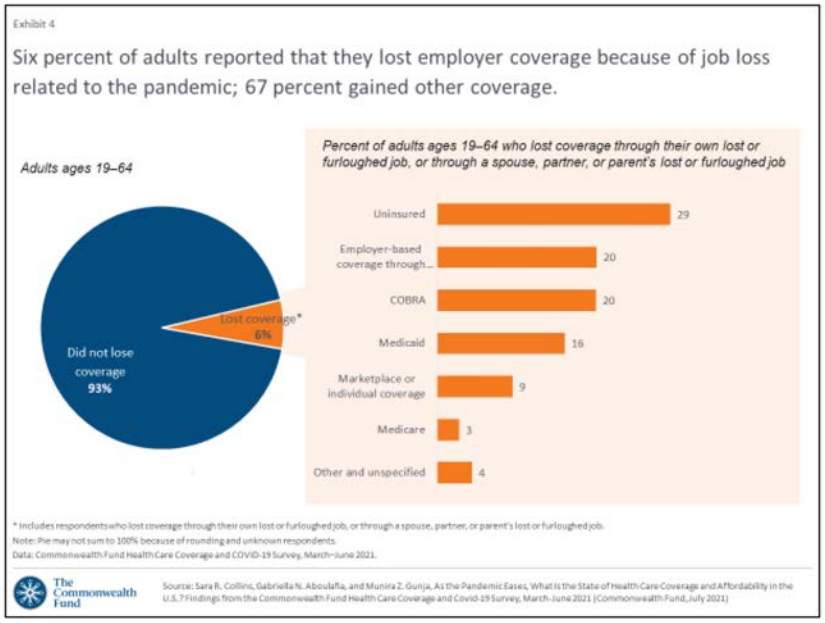
[3] Paul Fronstin and Stephen A. Woodbury, *How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?* (Commonwealth Fund, October 2020), *https://doi.org/10.26099/q9p1-tz63*.





Employer coverage proved to be resilient during the pandemic. Despite the deepest recession since the 2008 economic downturn, a recent Commonwealth Fund survey found that only 6 percent of working-age adults reported they lost employer cov-

erage during the pandemic (Exhibit 4).[4] Other research estimates about 3 million to 7 million people lost employer coverage.[5] This loss is limited compared to the large number of jobs lost in 2020 partly because industries hit hardest with pandemic-related job losses, such as hotel, food service, and retail, had among the lowest employer coverage rates before the pandemic. Other laid-off workers were more fortunate: about 42 percent of companies that dismissed workers during the pandemic continued to pay at least part of their insurance premiums.[6]

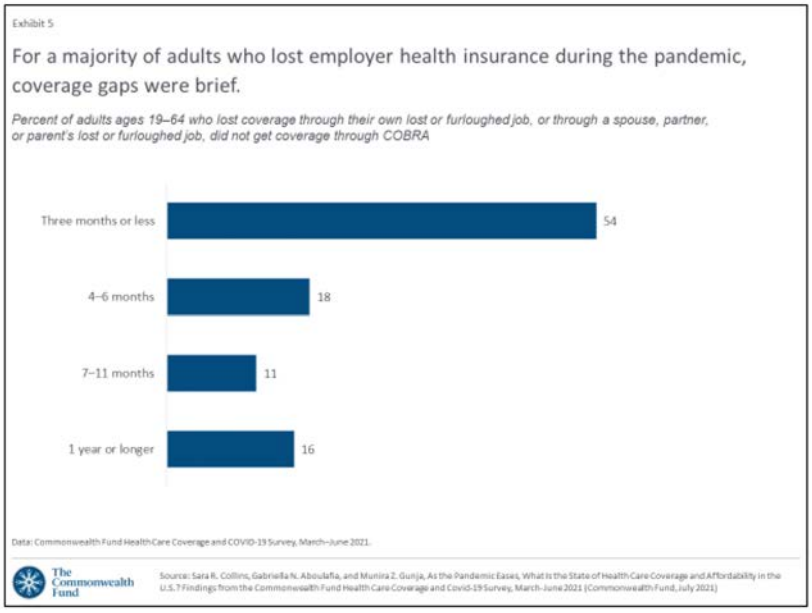


Unlike during prior recessions, the ACA's coverage expansions provided a safety-net for people who lost employer coverage. This safety-net was enhanced by Federal relief efforts to help people maintain their Medicaid coverage, a substantial increase in marketplace premium subsidies under the American Rescue Plan Act (ARPA), and extended special-enrollment periods in State-run marketplaces in 2020 and in the Federal marketplaces in 2021. Among workers who did lose employer coverage, 20 percent gained insurance through another employer, 20 percent elected COBRA, 16 percent gained coverage through Medicaid and 9 percent got covered through the marketplaces or individual market. Nearly 3 in 10—29 percent—became uninsured, reflecting ongoing holes in our coverage system and lack of awareness of options. But the availability of affordable coverage options kept gaps in coverage relatively short for a majority of people who lost employer coverage (Exhibit 5).

[4] Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, *As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID–19 Survey,* March–June 2021 (Commonwealth Fund, July 2021), *https://doi.org/10.26099/6w2d-7161.*

[5] Paul Fronstin and Stephen A. Woodbury, "Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?" To the Point (blog), Commonwealth Fund, January 11, 2021, *https://doi.org/10.26099/pg4k-k397.*

[6] Paul Fronstin and Stephen A. Woodbury, "Update: How Many Americans Have Lost Jobs with Employer Health Coverage During the Pandemic?" To the Point (blog), Commonwealth Fund, January 11, 2021, *https://doi.org/10.26099/pg4k-k397.*



THE U.S. HAS A HEALTH CARE SPENDING PROBLEM IN COMMERCIAL INSURANCE PLANS; CONSUMERS ARE PAYING THE PRICE

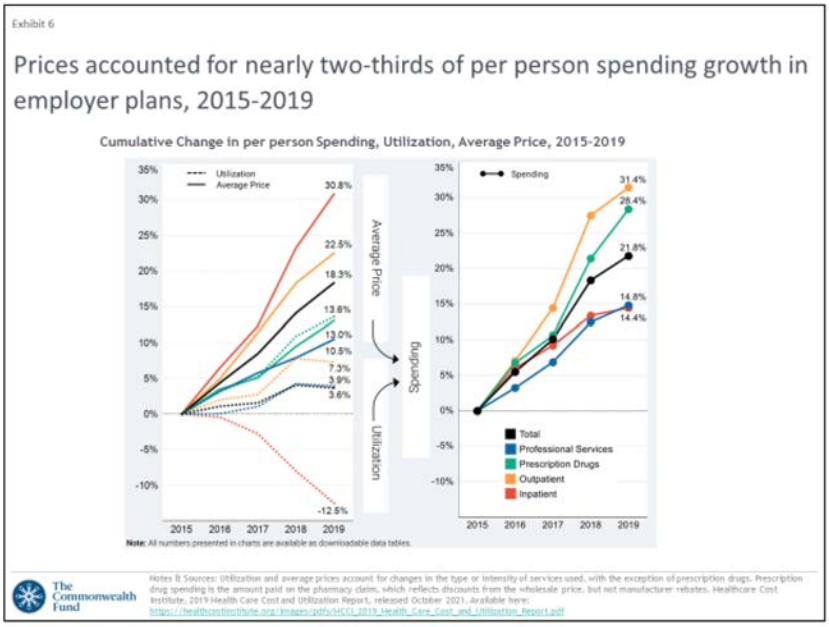
The ACA's coverage expansions, market rules against underwriting, and mandates for employers to offer coverage have enabled millions of previously people to get covered with comprehensive affordable coverage.[7] Research has shown that these provisions have led to an overall downward trend in out-of-pocket costs across the U.S. population.[8]

But the United States has a health-care spending problem in commercial insurance. This is demonstrated by the amount that the 180 million people with employer and individual market plans pay for their insurance and health care. New research from the Health Care Cost Institute show that among people with employer insurance, spending per person grew by 21.8 percent between 2015 and 2019, outpacing both inflation and GDP growth (Exhibit 6).[9] The data also show that average prices paid for health-care services and prescription drugs were the primary drivers, accounting for nearly two-thirds of overall growth.

[7] Sherry A. Glied, Sara R. Collins, and Saunders Lin, "Did the Affordable Care Act Lower Americans' Financial Barriers to Health Care?", *Health Affairs* 39, no. 3 (March 2020): 379–86, *https://doi.org/10.26099/79hw-ax66*.

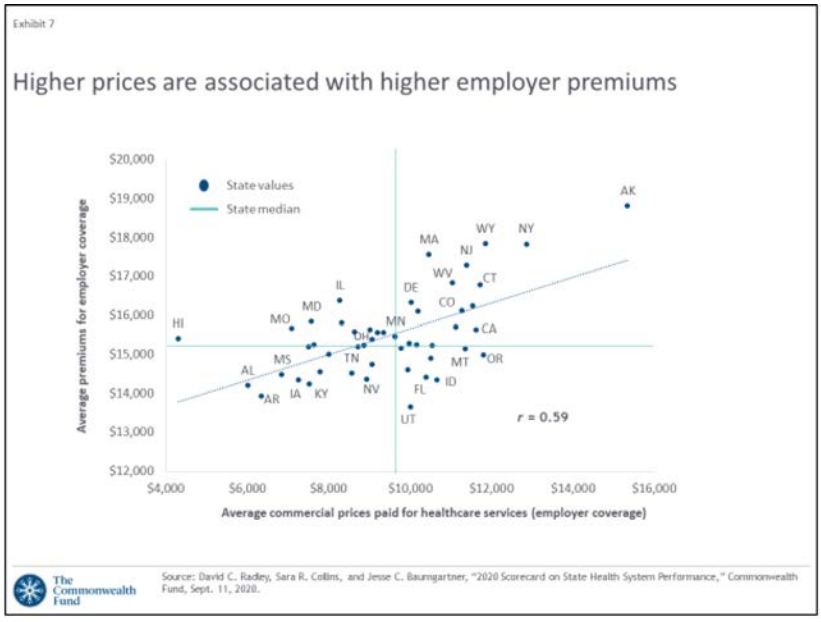
[8] Sherry A. Glied and Benjamin Zhu, *Catastrophic Out-of-Pocket Health Care Costs: A Problem Mainly for Middle-Income Americans with Employer Coverage* (Commonwealth Fund, April 2020), *https://doi.org/10.26099/x0cx-cp48*.

[9] Health Care Cost Institute, 2019 Health Care Cost and Utilization Report, October 2021.



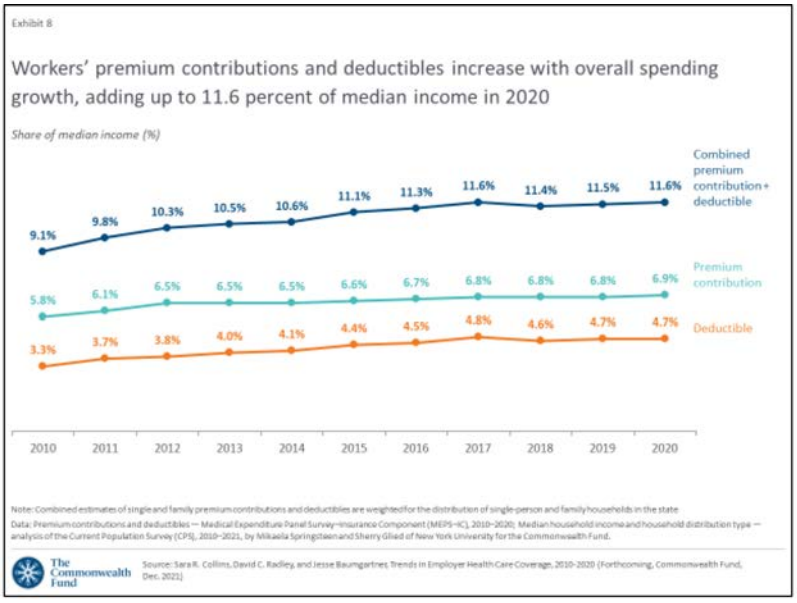
These high prices are associated with higher employer premiums (Exhibit 7).[10] Because employers share these costs with their workers in the form of premium contributions and deductibles, workers' costs are also rising. In most States, they are rising faster than median income.

[10] David C. Radley, Sara R. Collins, Jesse C. Baumgartner, *2020 Scorecard on State Health System Performance,* September 11, 2020, *https://www.commonwealthfund.org/publications/scorecard/2020/sep/2020-scorecard-state-health-system-performance.*

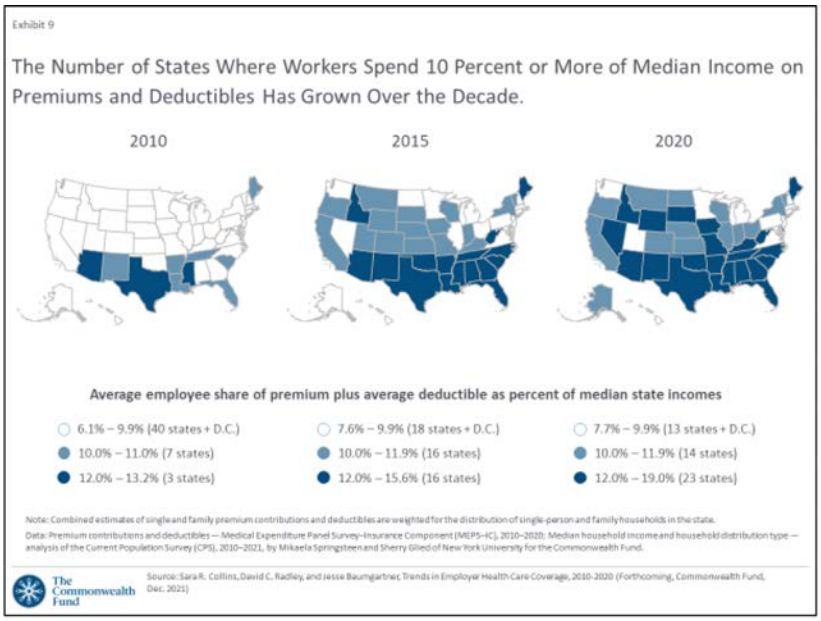


New data on employer plans released by the Federal Government this fall and analyzed by the Commonwealth Fund, show that worker premium contributions and deductibles in employer plans have taken up a growing share of worker's incomes over the past decade. These costs accounted for 11.6 percent of median household income in 2020, up from 9.1 percent a decade earlier (Exhibit 8).[11]

[11] Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Forthcoming Commonwealth Fund, December. 2021).



There is wide variation in what workers pay for employer coverage relative to their incomes across the country. Premium contributions and deductibles were 10 percent or more of median income in 37 States in 2020, up from 10 States in 2010 (Exhibit 9). In nine States (Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, South Carolina, and Texas) the average combined costs of premium contributions and deductibles amounted to 14 percent or more of median income in 2020. Middle-income workers in Mississippi and New Mexico faced the highest potential costs relative to income (19.0 percent and 18.1 percent, respectively).

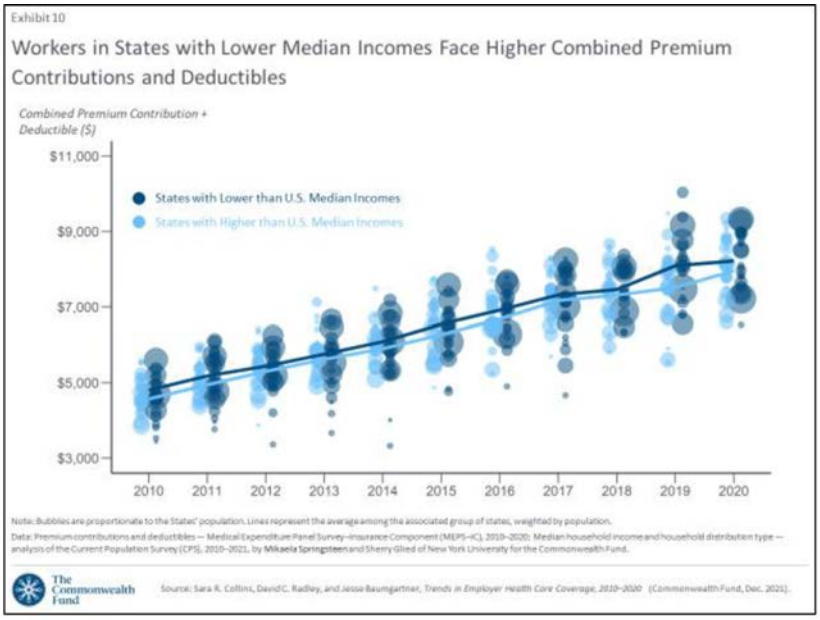


These costs add to already considerable burdens for families. For example, housing and food consumed 34 percent of average family income in 2020.[12] Among families with children under age 5 who pay for child care, average spending on child care took up 13 percent of family income in 2017.[13]

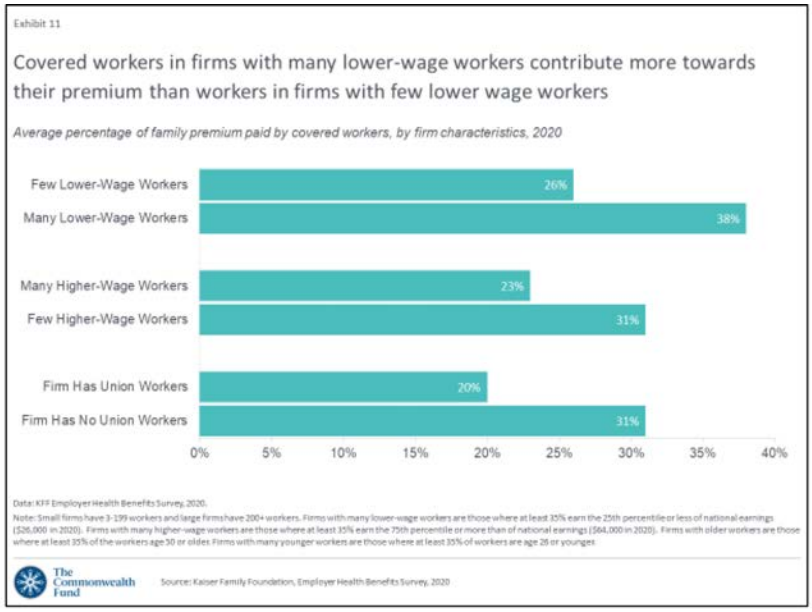
Workers across the income spectrum have experienced steady growth in their insurance costs. But people living in States with lower median incomes are doubly burdened. On average, workers in States with median incomes lower than the national median face higher absolute costs compared to people in States with higher median incomes (Exhibit 10).

[12] Bureau of Labor Statistics, "Consumer Expenditures—2020," news release, September 9, 2021, *https://www.bls.gov/news.release/pdf/cesan.pdf.*

[13] U.S. Department of the Treasury, *The Economics of Child Care Supply in the United States,* September 2021, *https://home.treasury.gov/system/files/136/The-Economics-of-Childcare-Supply-09-14-final.pdf.*

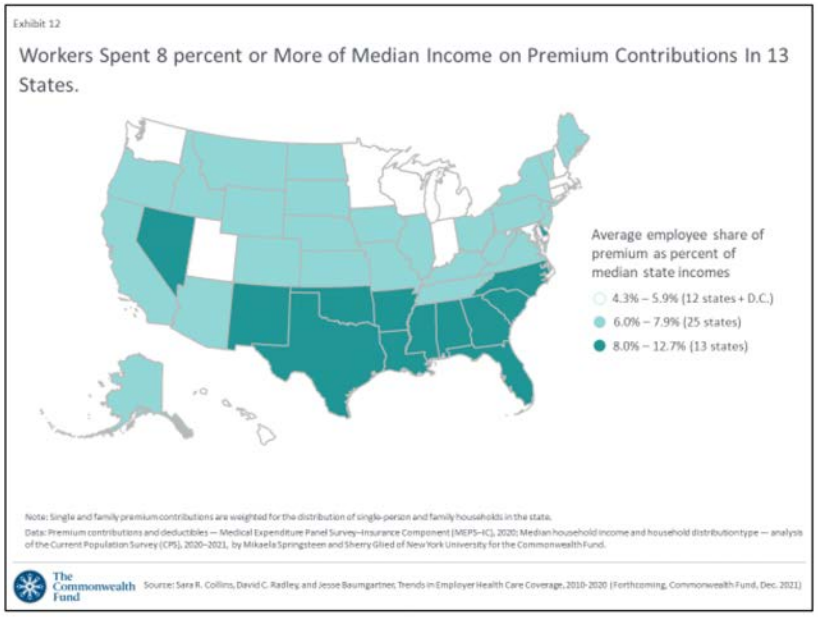


The Kaiser Family Foundation's annual survey of employer benefits finds that in lower wage firms, insured workers contribute a larger share of the premium for family plans than those in higher wage firms (Exhibit 11).[14] Non-unionized workforces contribute a larger share of the premium than do unionized workforces.



[14] Kaiser Family Foundation, Employer Health Benefits, 2020 Annual Survey.

Workers with the largest premium contributions relative to median income were concentrated in southern States. In Alabama, Arkansas, Delaware, Florida, Georgia, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, North Carolina, South Carolina, and Texas, premium contributions were 8 percent or more of median income, with a high of 12.7 percent in Mississippi (Exhibit 12).



DEDUCTIBLE GROWTH IS LEAVING MILLIONS UNDERINSURED

The Commonwealth Fund has found that insured people who have high out-of-pocket costs and deductibles relative to their income are more likely to face problems accessing care and paying medical bills than those who do not. We have defined someone who has been continuously insured over the last year as "underinsured" if their plan's deductible equals 5 percent or more of income or if their out-of-pocket costs over the past year are equal to 10 percent or more of income (5 percent or more if low income).[15]

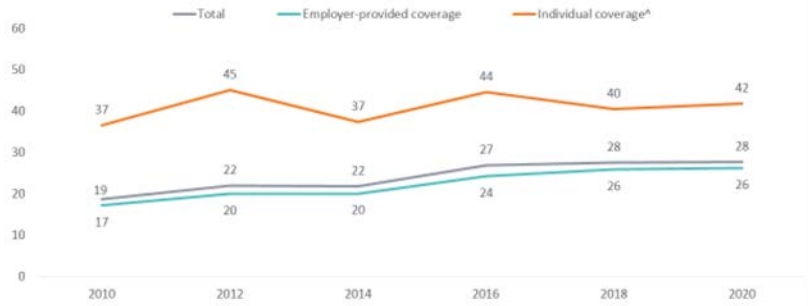
In 2020, about one-quarter of people in employer plans were underinsured by this measure (Exhibit 13). While rates were higher in the individual market, the largest growth has occurred in employer plans. This growth has been driven by growth in the size of deductibles relative to family income (Exhibit 14).

[15] Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, August 2020), *https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial.*

Exhibit 13

One-quarter of adults in employer plans are underinsured; individual market continues to be challenging

Percent of adults ages 19–64 insured all year who were underinsured



Notes: "Underinsured" refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Respondents may have had another type of coverage at some point during the year but had coverage for the entire previous 12 months. ^ For 2014–2020, individual coverage includes adults who got coverage in the individual market and the marketplaces.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016, 2018, 2020).

The Commonwealth Fund

Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, Aug. 2020).

Exhibit 14

Deductibles Have Grown Faster than Income Taking Up Larger Shares of Household Budgets, Leaving More People Underinsured

Percent adults ages 19–64 with private coverage who had deductibles that were 5% or more of income	2010	2012	2014	2016	2018	2020
Total	**7%**	**11%**	**13%**	**15%**	**16%**	**15%**
Insurance source at time of survey*						
Employer-provided coverage	6%	9%	11%	13%	15%	14%
Individual and marketplace coverage^	18%	29%	22%	24%	23%	27%
Firm size (base: full- or part-time workers with coverage through their own employer)^^^						
2–99 employees	7%	15%	20%	13%	18%	16%
100 or more employees	5%	6%	9%	13%	14%	14%

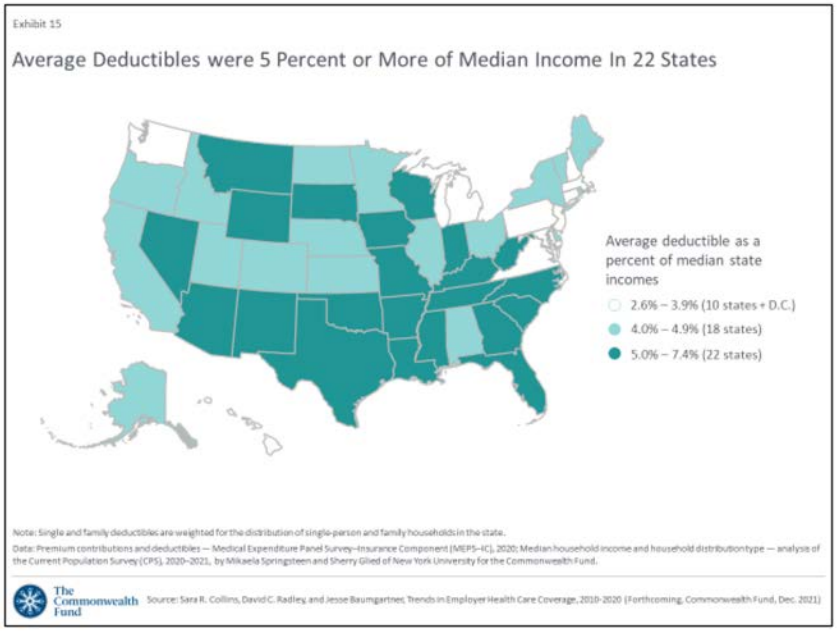
Notes: *Respondents may have had another type of coverage at some point during the year. ^For 2014-2020, individual coverage includes adults who got coverage in the individual market and the marketplaces. ^^^Does not include adults who are self-employed.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2010, 2012, 2014, 2016, 2018, 2020).

The Commonwealth Fund

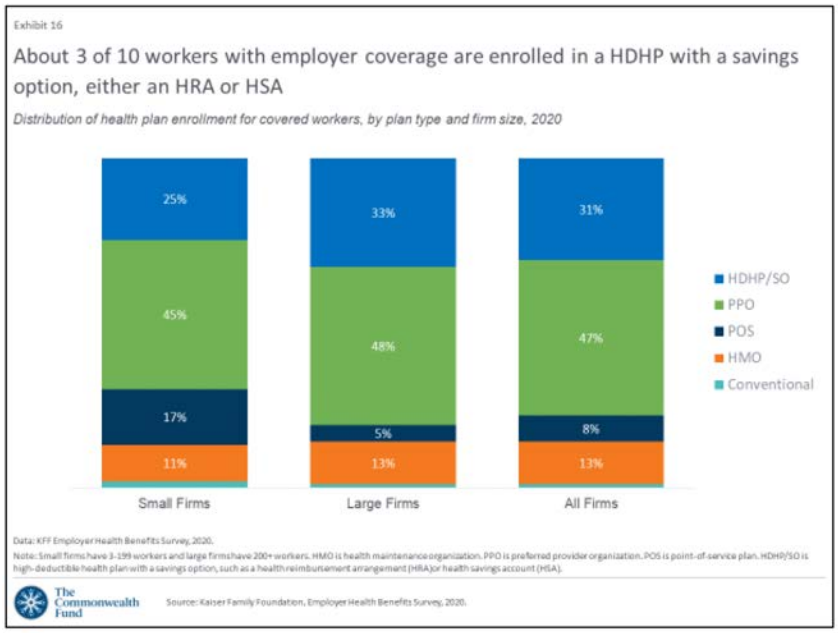
Source: Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability — Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, Aug. 2020).

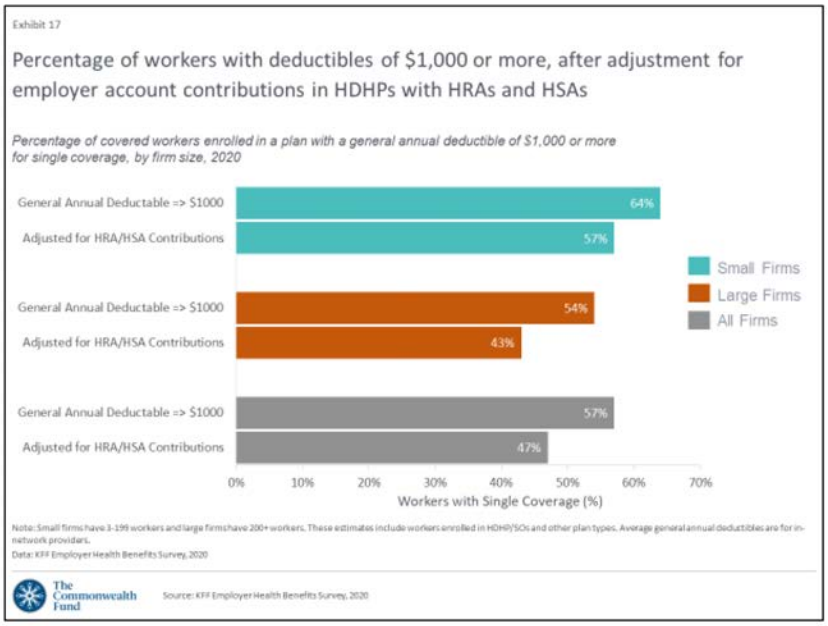
Across the country, average deductibles in employer plans relative to median income were 5 percent or more in 22 States (Arizona, Arkansas, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, Nevada, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, Wyoming) and ranged as high as 7.4 percent in New Mexico (Exhibit 15).



One reason for the growth in average deductibles is more workers are enrolled in high-deductible plans with savings accounts either health reimbursement arrangements (HRAs) or health savings accounts (HSAs). About three of 10 workers are enrolled in such plans (Exhibit 16).[16] About half of workers with HRAs and a quarter of those with HSAs receive employer contributions that reduce their deductibles to between zero and $1,000. Still, accounting for these contributions only reduces the share of workers across all single-coverage plans with deductibles of $1,000 or more from 57 percent to 47 percent (Exhibit 17).

[16] Kaiser Family Foundation, Employer Health Benefits, 2020 Annual Survey.

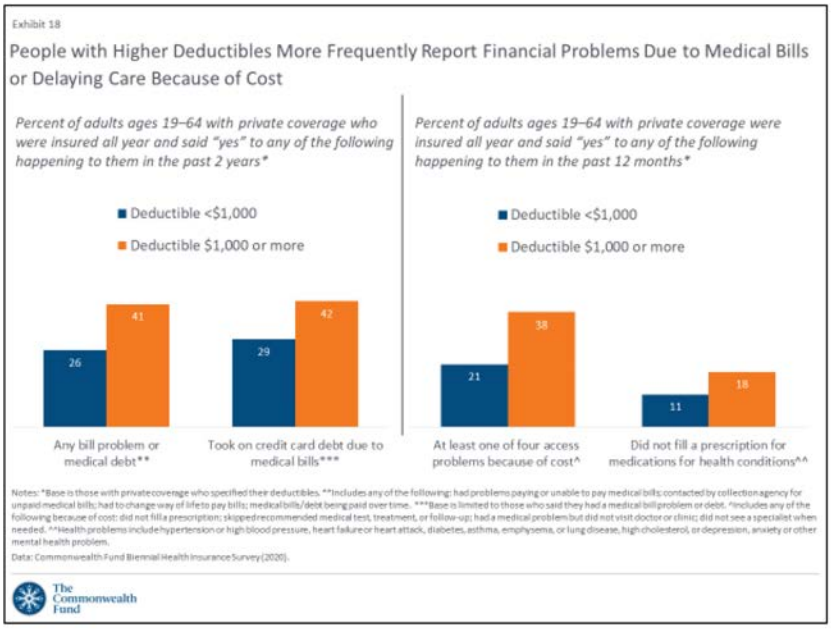




HIGH COST EXPOSURE IN COMMERCIAL PLANS DISTORTS CONSUMERS' HEALTH CARE DECISIONS AND LEADS TO FINANCIAL PROBLEMS

Research indicates that people who face high deductibles often avoid getting needed health care. A 2020 Commonwealth Fund survey found that among people in

commercial plans, more than one-third of those with a deductible of $1,000 or more said they had not gotten needed health care due to cost, including not filling a prescription, not going to the doctor when sick, not getting a follow up test or treatment recommended by a doctor, or not seeing a specialist (Exhibit 18).[17]



When people in high-deductible plans do get care, they are susceptible to racking up medical debt. Forty-one percent of adults with a deductible of $1,000 or more reported they had experienced problems paying medical bills, including not being able to pay a bill, being contacted by a collection agency about an unpaid bill, having to change their way of life to pay their bills, or paying off debt over time. Among those who were paying off medical debt, 63 percent said they were paying off bills worth $2,000 or more.

Medical bill problems and debt have become endemic in our health system. The media is awash in stories of patients receiving outlandish, uncovered bills.[18] A recent *JAMA* article found that 17.8 percent of people in the U.S. had medical debt in collections, with the highest shares in the South and in predominantly poor zip codes.[19] Between 2009 and 2020, the amount of medical debt in collections overtook that of nonmedical debt.

Medical debt has spillover financial implications. In a 2021 Commonwealth Fund survey, one-third of adults in employer-based plans reported problems paying their bills or that they were paying off debt over time (Exhibit 19).[20] Of those who reported these difficulties, 40 percent said that they had received a lower credit score because of their medical bills; 40 percent had taken on credit card debt to pay their

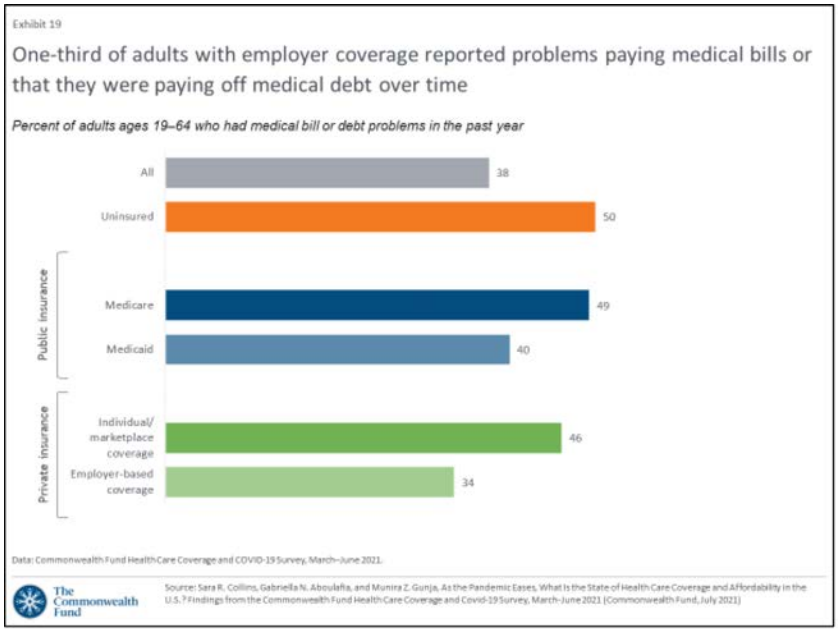
[17] Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, August 2020), *https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial*.

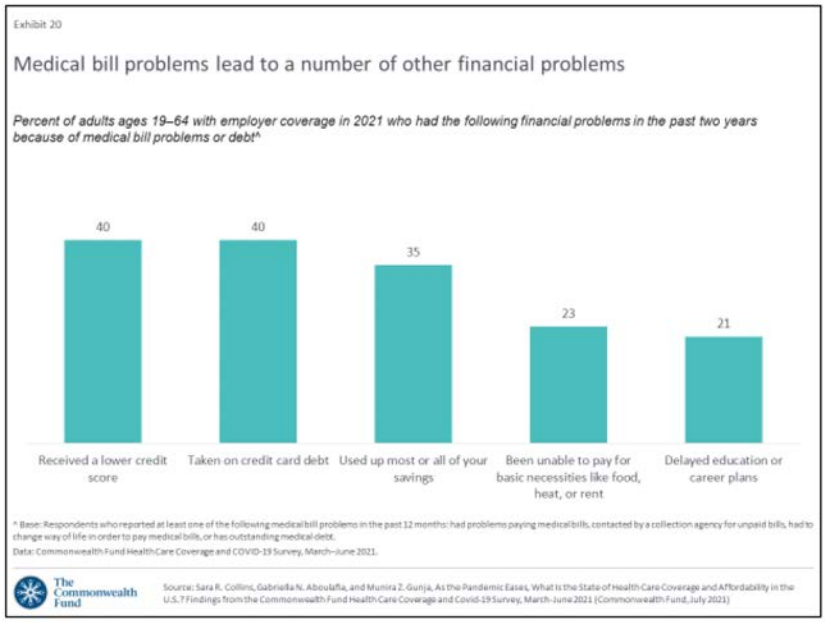
[18] *See* for example Kaiser Health News and National Public Radio's ongoing "Bill of the Month" series, *https://khn.org/news/tag/bill-of-the-month/*.

[19] Raymond Kluender, et al., "Medical Debt in the US, 2009–2020," *JAMA.* 2021;326(3):250–256. doi:10.1001/jama.2021.8694.

[20] Sara R. Collins, Gabriella N. Aboulafia, and Munira Z. Gunja, *As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID–19 Survey, March–June 2021* (Commonwealth Fund, July 2021), *https://doi.org/10.26099/6w2d-7161.*

bills; 35 percent had used up most or all their savings to pay their bills; 23 percent had been unable to pay for basic life necessities like food, heat, or rent; and 21 percent had delayed education or career plans (Exhibit 20).





POLICY OPTIONS

The ACA's subsidized marketplaces and Medicaid expansion have provided a safety net for people in unaffordable or skimpy employer health plans. Improving the affordability and cost protection of marketplace plans and expanding Medicaid in all States, increasing awareness of these coverage options among workers, and making it easier for eligible workers to enroll in them will relieve some of the problems highlighted in this testimony. Specific improvements include:

- Make the temporary ARPA marketplace subsidies permanent.
- Provide a zero-premium, zero-cost sharing insurance option for Medicaid-eligible adults in the coverage gap in the 12 States that have not yet expanded their programs.
- Inform workers with employer coverage of their options to enroll in subsidized marketplace plans and Medicaid and, if they lose employer coverage, that they are eligible for a marketplace special-enrollment period.
- Fix the "family coverage glitch." Under the ACA, families are ineligible for marketplace premiums if a family member has an offer of single-employer coverage that is affordable, (*i.e.,* premiums less than 9.83 percent of family income).[21] About 5 million people are caught in this glitch: they are in family plans with premium contributions that exceed that threshold, but are ineligible for marketplace subsidies.[22] The Biden administration could fix this administratively, saving families that switched to marketplace plans an average of $400 person; families with incomes under 200 percent of the Federal poverty level could save $580 per person.
- Lower the "employer firewall" threshold from 9.83 to 8.5 percent of income (*i.e.,* the ARPA premium contribution cap). When combined with the fix to the family coverage glitch, this change would mean that no one would have to spend more than 8.5 percent of income for their health insurance. Commonwealth Fund analyses indicate one-quarter of people with low incomes in employer plans who are not eligible for Medicaid in their States spend more than 8.5 percent of their household income on premiums (Exhibit 21).
- Rein in deductibles and out-of-pocket costs in marketplace plans. One proposal could eliminate deductibles for some people and reduce it for others by as much as $1,650.[23]
- The historic No Surprises Act passed by Congress in 2020 and set to go into effect in January 2022 will protect most consumers from surprise medical bills from out-of-network providers and some emergency transportation providers.[24] Other measures to protect consumers from the devastating consequences of medical debt include expanding the reach of the ACA's financial assistance policies for nonprofit hospitals to cover all hospitals and a broader range of providers, imposing stronger consumer protection rules for medical debt collection such as grace periods following illness or during appeals processes, and placing bans or limits on medical debt interest rates.[25]
- Address the high commercial provider prices that are the primary driver of employer premiums and deductibles. This could be pursued by adding a public plan option to the marketplaces, among other approaches.[26]

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[21] Timothy S. Jost, "Eliminating the Family Glitch," To the Point (blog), Commonwealth Fund, May 18, 2021, *https://doi.org/10.26099/gh5r-vm20.*

[22] Matthew Buettgens and Jessica Banthin, *Changing the "Family Glitch" Would Make Health Coverage More Affordable for Many Families* (Urban Institute, May 2021), *https://www.urban.org/sites/default/files/publication/104223/changing-the-family-glitch-would-make-health-coverage-more-affordable-for-many-families_1.pdf.*

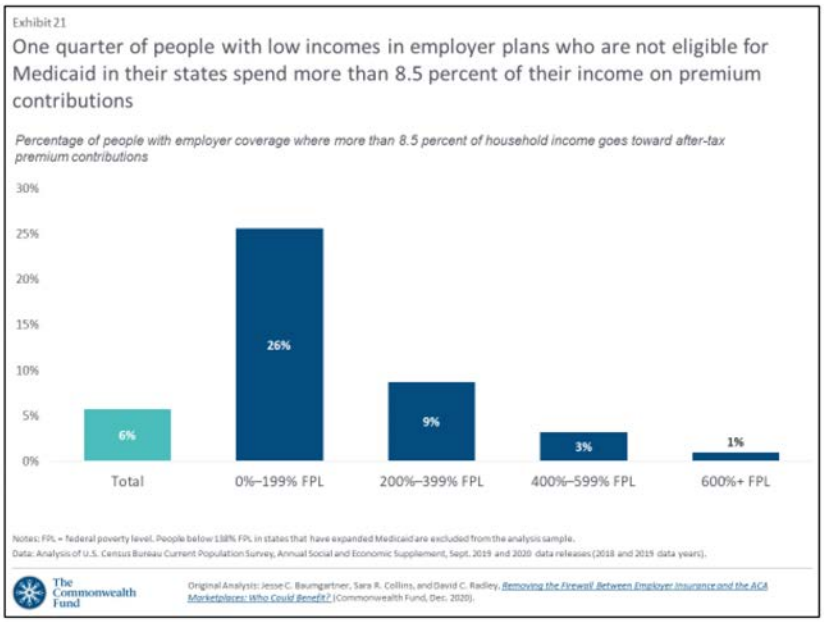
[23] *Improving Health Insurance Affordability Act of 2021,* S. 499, *https://www.congress.gov/117/bills/s499/BILLS-117s499is.pdf;* Linda J. Blumberg, et al., *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute, October 2019), *https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf.*

[24] Jack Hoadley and Kevin Lucia, "Putting Surprise Billing Protections into Practice: Biden Administration Releases First Set of Regulations," *https://www.commonwealthfund.org/blog/2021/putting-surprise-billing-protections-practice-biden-administration-releases-first-set,* To the Point (blog), Commonwealth Fund, July 14, 2021.

[25] National Consumer Law Center, *Model Medical Debt Protection Act,* September 2019, *https://www.nclc.org/images/pdf/medical-debt/model-medical-debt-protection-act-082017.pdf.*

[26] Linda J. Blumberg et al., *Comparing Health Insurance Reform Options;* John Holahan, Michael Simpson, and Linda J. Blumberg, *What Are the Effects of Alternative Public Option Proposals* (Urban Institute, March 2021), *https://www.urban.org/research/publication/what-are-effects-alternative-public-option-proposals;* Robert A. Berenson, et al., *Addressing Health Care Market Consolidation and High Prices,* The Urban Institute, January 2020, *https://*

- Develop an auto-enrollment mechanism to help people enroll and stay enrolled in comprehensive coverage. Creating a public plan as a default option would be essential to a national auto-enrollment program.[27]



The cost burden in commercial insurance is an enduring problem in U.S. health care that is undermining America's overall economic well-being. This year's U.S. Supreme Court decision reaffirming the constitutionality of the ACA paves the way for Congress to use the tools provided by the law to cover the remaining uninsured and make health care affordable to people covered by both public and commercial insurance. Doing so will help facilitate the country's postpandemic recovery and its future prosperity.

Thank you.

QUESTIONS SUBMITTED FOR THE RECORD TO SARA R. COLLINS, PH.D.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The enhanced premium tax credits (PTCs) from the American Rescue Plan (ARP) are already providing vital assistance to American families to help them afford health insurance coverage on the Affordable Care Act's (ACA's) Health Insurance Marketplaces. During the Special Enrollment period for Marketplace coverage this year, 2.8 million new customers signed up for coverage. The Centers for Medicare and Medicaid Services (CMS) estimates that consumers who returned to the marketplace to update their coverage during the Special Enrollment Period saw a 40-percent reduction in net monthly premiums on average, after accounting for the ARP's enhanced PTCs. The Congressional Budget Office (CBO) estimates that if the enhanced PTCs were made permanent and Congress closed the coverage gap in States that have not expanded Medicaid, 3.9 million fewer people would be unin-

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www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf; Sherry A. Glied and Jeanne M. Lambrew, *How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Health Insurance Plans* (*Health Affairs,* November 2018).

[27] Linda J. Blumberg, John Holahan, and Jason Levitis, *How Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues* (Commonwealth Fund, June 2021), *https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/how-auto-enrollment-can-achieve-near-universal-coverage.*

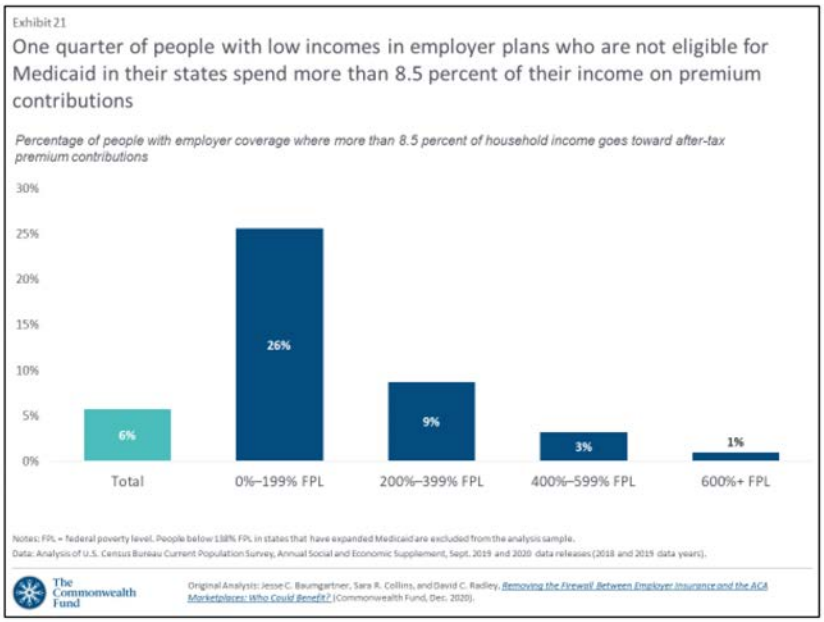
sured over the next decade, compared to current law. This includes 1.4 million people obtaining marketplace coverage who would otherwise be uninsured.

CBO also estimates that 1.6 million people with employer-based coverage would move to marketplace coverage. One of the reasons for that shift is that the Build Back Better legislation as marked up by the House would allow for people to qualify for PTCs if their employee share of job-based health insurance premiums exceeds 8.5 percent of their income. Under current law, individuals who have offers of job-based coverage are only eligible for PTCs if their employee share of the job-based health insurance premium exceeds 9.83 percent of their income.

Can you discuss the positive impact of allowing premium tax credit eligibility for workers who bear very high cost burdens in employer-sponsored coverage?

Answer. The employer affordability threshold has always been an important part of the ACA for middle- and lower-income workers, and lowering the threshold to 8.5 percent of income will mean that in theory no one in the U.S. will have to contribute more than 8.5 percent of their income towards premiums. A new analysis from the Commonwealth Fund of the Medical Expenditure Panel Survey shows that over the past decade, worker premium contributions and deductibles for employer plans have consumed a growing share of workers's incomes. In 2020, average employee premium contributions alone comprised more than 8.5 percent of median income in 8 States (Mississippi, New Mexico, Florida, Louisiana, Nevada, South Carolina, Oklahoma, Texas); a decade earlier in 2010, in only one State, Mississippi, were middle-class people spending that much of their income on employer premiums.[1]

As noted in my testimony, Commonwealth Fund research has shown that one-quarter of people with incomes between 0–199 percent of poverty who are in employer plans and not eligible for Medicaid spend more than 8.5 percent of their household income on after-tax premiums.[2]



Question. Improving access to behavioral health services is a longstanding issue that has become even more important during the COVID–19 pandemic. The pandemic has highlighted and worsened the weaknesses and gaps in the country's men-

[1] Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, *State Trends in Employer Premiums and Deductibles, 2010–2020* (Forthcoming Commonwealth Fund, December. 2021).

[2] Jesse C. Baumgartner, Sara R. Collins, and David C. Radley, *Removing the Firewall Between Employer Insurance and the ACA Marketplaces: Who Could Benefit?* (Commonwealth Fund, December 2020), *https://doi.org/10.26099/hg7v-dy10.*

tal health-care system, as the committee heard at our hearing on this topic in the summer. This is a bipartisan issue, as Ranking Member Crapo and I are working together to develop legislation to address the mental and behavioral health needs of Americans across the country. Among other policies, we are interested in policies that will ensure that health insurance companies are not erecting unnecessary barriers to mental and behavioral health care.

What do you think are the top two policies that this committee should consider to address mental health parity and reduce insurance barriers to mental health care?

Answer. The Affordable Care Act made historic strides in addressing the mental health and behavioral health needs of Americans through expanded eligibility for Medicaid, individual and small group market reforms that ban pre-existing condition exclusions and require coverage of mental health and substance abuse services as essential health benefits, and marketplace premium and cost- sharing subsidies. The law also applied previously passed mental health parity requirements to these plans. The literature shows that these expansions and reforms increased coverage among people with mental health needs and improved access to mental health services and reduced unmet need.[3] One study[4] found that living in a Medicaid expansion State was associated with a greater decline in cost-related access problems for low-income adults with depression. Multiple studies found[5] that living in a Medicaid expansion State was associated with relative reductions in poor mental health days for low-income adults.

For employer plans, the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[6] required all large-group employer insurance plans to cover mental health services at the same level as medical and surgical services, *if they offered them.* This is known as "parity," and means that there cannot be greater cost-sharing or other limitations for mental health services. But they are not required to offer mental health benefits, though most do.

Top policy options to improve coverage and access for people with mental health needs include: filling the Medicaid coverage gap in the remaining 12 non expansion States with zero premium and zero cost-sharing health coverage; extending mandatory essential health benefits to the large-group employer market; eliminating non-ACA-compliant plans that tend not to cover mental health benefits; and reining in deductibles and cost-sharing that leave millions of people in commercial health insurance plans underinsured.[7]

Question. Efforts to expand health insurance coverage to those who are uninsured is of paramount importance, but the committee must also focus on ensuring that the coverage that people do have does not expose them to sky-high out-of-pocket costs. To address growing deductibles and health insurance premiums faced by consumers in employer-based coverage and Marketplace coverage, we need to examine the underlying causes, including in particular the high prices that we pay for health-care services and medications.

What factors are most responsible for rising premiums and deductibles in job-based coverage? And what can we do to address them?

Answer. The United States has a health-care spending problem in the commercial insurance markets. This is demonstrated by the amount that the 180 million people with employer and individual market plans pay for their insurance and health care. New research from the Health Care Cost Institute show that among people with employer insurance, spending per person grew by 21.8 percent between 2015 and 2019, outpacing both inflation and GDP growth.[8] The data also show that average prices paid for health-care services and prescription drugs were the primary drivers, accounting for nearly two-thirds of overall growth. This is true across all service

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[3] Jesse C. Baumgartner, Gabriella N. Aboulafia, and Audrey McIntosh, "The ACA at 10: How Has It Impacted Mental Health Care?", To the Point (blog), Commonwealth Fund, April 3, 2020, *https://doi.org/10.26099/2ajx-qg59.*

[4] *https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201800181?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed.*

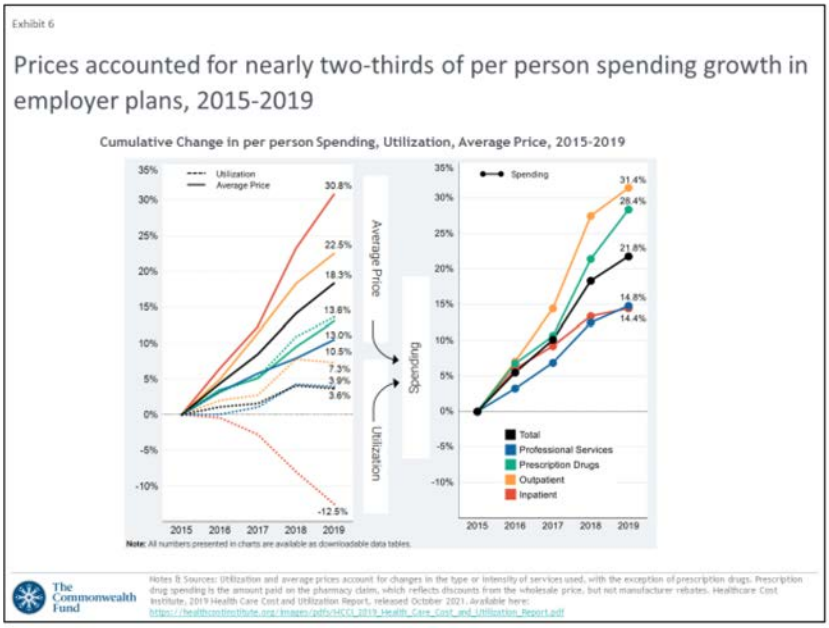
[5] *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6109019/.*

[6] *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.*

[7] Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2020* (Commonwealth Fund, August 2020).

[8] Health Care Cost Institute, 2019 Health Care Cost and Utilization Report, October 2021.

types—inpatient, outpatient, physician, and prescription drugs. We know this because commercial utilization across services has largely been flat or minimal (with inpatient visits decreasing) and prices increasing quite significantly year over year.



In surveys of employers, the two top drivers of spending[9] reported are (1) hospital spending and (2) drug spending. Hospitals make up the largest portion of spending so they are a particular concern. Drugs represent a smaller but growing portion of spending and their growth rate is a concern given the pipeline of products and their expected costs.

These prices are driving premiums in employer plans higher, employers share those costs with employees in the form of higher premium contributions, deductibles, and through wage concessions. This means that when people in these plans do need care they either avoid it or incur bills they cannot pay, ending up being pursued by hospitals who charged the high prices in the first place. These prices also increase the premium costs of marketplace coverage and thus federally financed subsidies.

To address this problem, policies at the Federal level include:

- Adding a public plan option to the marketplaces or otherwise capping provider prices paid by health plans.[10]
- Policies aimed at reducing drug prices.[11]

There is also considerable activity in States that can inform Federal policy:[12]

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[9] *https://sehpcostcontainment.chir.georgetown.edu/documents/SEHP-report-final.pdf.*

[10] Linda J. Blumberg et al., *Comparing Health Insurance Reform Options;* John Holahan, Michael Simpson, and Linda J. Blumberg, *What Are the Effects of Alternative Public Option Proposals* (Urban Institute, March 2021), *https://www.urban.org/research/publication/what-are-effects-alternative-public-option-proposals;* Sherry A. Glied and Jeanne M. Lambrew, "How Democratic Candidates for the Presidency in 2020 Could Choose Among Public Health Insurance Plans" (*Health Affairs,* November 2018).

[11] David Blumenthal, Mark E. Miller, and Lovisa Gustafsson, "The U.S. Can Lower Drug Prices Without Sacrificing Innovation," *Harvard Business Review,* October 1, 2021.

[12] Robert A. Berenson, et al., *Addressing Health Care Market Consolidation and High Prices,* The Urban Institute, January 2020, *https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_1.pdf.*

- Price transparency. Many States have now created all payer claims databases that can inform policy makers of the drivers of health-care spending.
- Increasing competition in consolidated markets. Many States are taking steps to increase competition in hospital markets such as experimenting with public plan options to enhance competition in consolidated markets (Washington and Colorado), challenging anticompetitive behaviors, and identifying vertical and cross market mergers.
- States are using existing regulatory structures to limit provider prices.
    - Montana and Oregon implemented price ceilings on hospital payment rates within their State employee health benefit plans. Such ceilings could be models for State price ceilings on provider payments in the commercial market.
    - Certificate of need laws.
    - Rhode Island empowers its insurance commissioner to review proposed premium rates, and review and approve hospital payment rate increases included in insurance contracts.
    - Maryland modified its rate-setting approach used to control hospital spending to setting all payer hospital budgets.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. We heard a great deal of testimony about our health-care system in general, the need to improve patient outcomes, access to care in certain communities and how to better address health equity. Last month, the Centers for Disease Control and Prevention (CDC) released State-by-State obesity rates. Specifically, the CDC called for "action at the policy and systems level to ensure that obesity prevention and management starts early, and that everyone has access to good nutrition, safe places to be physically active, and quality obesity clinical care."

Given the correlation between family income and physical activity, has the Commonwealth Fund examined the issue of wellness access?

For example, there is growing concern around a lack of physical activity in certain communities which are often attributed to unsafe streets, limited access to playgrounds and pay-to-play policies inside and outside school. Has the Commonwealth Fund studied these factors and their impact on underlying issues contributing to obesity, cardiovascular and behavioral health disorders?

Could modernizing the tax code to ensure physical fitness is treated as a form of preventative health care be helpful in this pursuit?

Answer. The Commonwealth Fund's Scorecard on State Health System Performance ranks State health system performance on the basis of 49 different health indicators.[13] Adult and childhood obesity are included in our "Healthy Lives" performance dimension. South Carolina has one of the highest childhood obesity rates (38 percent) in the country ranking it at 48th in performance on this measure. A similar share of adults are obese (35 percent), ranking the State at 34th in performance. This contributes to South Carolina's overall low health system performance ranking—37th in our 2020 Scorecard.

We have not investigated the drivers of obesity that you highlight in our work, all of which are certainly contributing factors. But at a minimum, having good health insurance, in particular, ACA compliant coverage, will enable people access to free preventive care and regular interaction with the health system that is a first step towards reducing obesity and its associated health problems.

Under the ACA, free preventive health services include obesity related care including obesity screening and counseling and diet counseling, in addition to screening for associated health problems (*e.g.,* cholesterol and blood pressure screening). Guidelines and counseling for physical activity could be made more explicit, per your recommendation.

The ACA also created new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces. These include programs that reimburse for the cost of a fitness center membership and those that have health incentives included, with

[13] David C. Radley, Sara R. Collins, Jesse C. Baumgartner, *2020 Scorecard on State Health System Performance,* Commonwealth Fund, September 2020, *https://www.commonwealthfund.org/publications/scorecard/2020/sep/2020-scorecard-state-health-system-performance.*

guidelines to prevent discrimination by health status. While these programs are very popular, with an estimated 63 million people in employer health plans that offer them in 2020, the evidence that they promote health is mixed.[14] Healthier and wealthier employees have been found to be more likely to participate than those in poorer health and less income.

Expanding Medicaid coverage in all States and getting people covered in the insurance they are eligible for is a necessary first step in addressing rising obesity, but clearly more work is needed to address the underlying drivers that you highlight.

Question. With the ongoing opioid epidemic, are overdose reversal drugs being required to be co-prescribed to Federal beneficiaries for all Federal health-care programs, and is naloxone covered as a formulary?

If a Federal beneficiary wants to use the State standing order, will the Federal health-care plan pay as an in plan drug not an out-of-pocket expense?

Answer. Medicaid coverage, and in particular, its coverage of naloxone, has been a critical part of the Nation's fight to control the opioid epidemic.[15] States that have expanded Medicaid eligibility under the ACA have had an advantage over those States that have not expanded their programs.[16] But some States have more restrictive access to prescription drugs in their Medicaid programs including more restrictive fill limits, that reduce access to naloxone.[17] Exempting naloxone from such fill limits would further aid States' ability to prevent opioid overdose mortality. Medicaid and Medicare beneficiaries can also face out-of-pocket costs for naloxone prescriptions, which States and the Federal Government could address.[18]

State laws mandating coprescription of naloxone have been associated with increased naloxone provision, but significant variation among States remains and analysis of Medicare data has shown low rates of coprescribing.[19]

Question. We are seeing tremendous progress with therapeutic and technological innovations that could soon cure diseases such as Sickle Cell Disease.

As the science outpaces policy, how can reimbursement arrangements and public programs evolve to ensure immediate patient access for one-time curative treatments?

Answer. This is a complicated question that first requires common definition of the terms "one-time curative" and "immediate." Congress could ask the National Academy of Medicine (NAM) to convene a consensus study to identify key parameters to help define these terms. Further, an expert body such as the NAM could offer recommendations for what conditions warrant government regulation or legislation in this critical area and what remedies may be appropriate.

Equity considerations are paramount in this discussion, which your example of Sickle Cell Disease, underscores. This is a condition that disproportionately impacts people of color and in which historically, treatments options have been limited. As potential "curative" treatments are developed and brought to market, it will be important to ensure that those that need the treatments are able to access and afford the treatment. Care must be taken to ensure that policies around access and reimbursement do not disproportionately disadvantage communities of color.

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[14] Katie Keith, "EEOC Will Advance New Wellness Regulations," Health Affairs Blog, June 17, 2020.DOI: 10.1377/hblog20200617.824130.

[15] Jesse C. Baumgartner and David C. Radley, "The Drug Overdose Mortality Toll in 2020 and Near-Term Actions for Addressing It," To the Point (blog), July 15, 2021, updated August 16, 2021, *https://doi.org/10.26099/gb4y-r129.*

[16] Richard G. Frank and Carrie E. Fry, "The Impact of Expanded Medicaid Eligibility on Access to Naloxone," *Addiction,* published online April 14, 2019, *https://doi.org/10.26099/by07-xs93.*

[17] A.R. Roberts, et al., *Medicaid prescription limits and their implications for naloxone accessibility,* Drug and Alcohol Dependence, Vol. 218, January 2021, *https://www.sciencedirect.com/science/article/pii/S037687162030520 2?via%3Dihub.*

[18] Gery P. Guy Jr. et al., "Vital Signs: Pharmacy-Based Naloxone Dispensing—United States, 2012–2018," CDC MMWR Vital Signs 68, no. 31 (August 2019): 679–86, *https://www.cdc.gov/mmwr/volumes/68/wr/mm6831e1.htm?s_cid=mm6831e1_w%22.*

[19] Traci C. Green et al., "Laws Mandating Coprescription of Naloxone and Their Impact on Naloxone Prescription in Five U.S. States, 2014–2018," *American Journal of Public Health,* 110, no. 6 (June 2020): 881–887, *https://pubmed.ncbi.nlm.nih.gov/32298179/;* Christopher M. Jones et al., "Naloxone Co-prescribing to Patients Receiving Prescription Opioids in the Medicare Part D Program, United States, 2016–2017," *JAMA,* 322, no. 5 (August 2019): 1–3, *https://jamanetwork.com/journals/jama/fullarticle/2740706.*

This is especially important as Medicaid programs weigh the patient needs and the costs of such treatments given their beneficiary mix. Uncertainty around pricing of high cost, potentially "curative" treatments presents a particularly difficult forecasting and budget challenge for Medicaid programs and State policymakers given the requirement to balance their budgets each year.

QUESTION SUBMITTED BY HON. JAMES LANKFORD

Question. The Affordable Care Act allows taxpayer funding for abortion on demand, but at the very least it acknowledged the right of States to prohibit abortion coverage on the exchanges and that abortion could not be required as an essential health benefit. Eleven of the 12 States that have chosen not expand Medicaid have also chosen to prohibit abortion coverage on the exchanges. As written, the Democrats' reconciliation proposal would override these State laws and mandate coverage of, and funding for, abortions on demand, and transportation services to acquire them, for those under 138 percent of poverty and without cost sharing in 2024. However, the bill refers to abortions in an underhanded way.

Do you agree that abortion coverage is mandated and funded by the proposed reconciliation bill's reference to family planning services "which are not otherwise provided under such plan as part of the essential health benefits package" (subsection (c) of section 137505)?

Answer. The ACA and Executive Order 13535[20] clarify that Federal funding (including premium subsidies and cost-sharing subsidies) cannot be used to pay for abortion services, unless to save the life of the mother or in the case of rape or incest. The ACA also cannot require health plans to provide abortion coverage. Many plans do offer abortion services, but coverage of those services cannot be financed with Federal dollars, unless to save the life of the mother or in the case of rape or incest. Several States do not allow health plans to cover abortion services at all.

The reconciliation bill would not change these facts for people who will become newly eligible for marketplace coverage.

PREPARED STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Thank you, Mr. Chairman, and welcome to our witnesses. I would especially like to thank Senator Scott for coming today and for highlighting the critical role States play in our health-care system, as well as how we can work to address affordability issues for all Americans.

As we look toward the future of our health-care system, we have a responsibility to enhance care quality, to increase affordability, and to improve access to lifesaving services and treatment options, from diagnostics to cutting-edge therapies. Any reforms we adopt moving forward should build on what works within our current system, in addition to addressing hurdles to high-quality, low-cost care.

We should look to the unprecedented success of Medicare Part D and Medicare Advantage, which empower consumers to choose what works best for them. In contrast with top-down, bureaucratic health-care models, these programs leverage choice and competition to expand coverage while lowering costs and enhancing care quality.

Outside of Medicare, these same core principles have driven a wide range of promising reforms. Employers, who provide coverage to roughly half of the population, have adopted diverse tools and models to incentivize workers to seek out lower-cost, higher-quality care options. States have adopted waivers and flexibilities to tailor their Medicaid programs to best meet their needs and strategic goals. Our health-care system has substantial room for improvement, but these creative and market-based models provide a compelling blueprint for bipartisan reform.

We have seen strong bipartisan backing for proposals to expedite Medicare coverage for cutting-edge devices, to avoid a telehealth access cliff for seniors, and to cap out-of-pocket spending under Part D. I have also worked with multiple members of this committee on both sides of the aisle to ensure Medicare beneficiary access to tests that detect dozens of cancers at an early stage, reducing mortality and al-

[20] *https://www.healthinsurance.org/faqs/do-health-insurance-plans-in-acas-exchanges-cover-abortion/*.

lowing for proactive care. These types of policies have the potential to lower consumer costs while improving health-care outcomes. Unfortunately, some of the proposals currently under consideration risk moving in the opposite direction, with potentially dire unintended consequences for Americans. In addition to exacerbating inflation and weakening our economic recovery, the trillions of dollars in taxing and spending proposed by House Democrats would advance a range of policies that could hinder health-care outcomes and drive up costs, with taxpayers bearing the burden.

The proposed drug price controls, imposed under the guise of negotiation, pose a threat to our global leadership in biomedical innovation. A recent University of Chicago study found that the price-fixing policies included in the bill would slash research and development funding by up to 60 percent, reduce the number of new drugs approved in the next 20 years by as many as 342, and trigger a loss of life as much as twenty times what the COVID–19 pandemic has inflicted on our Nation.

House Democrats have also proposed making their poorly targeted Obamacare premium subsidy hike permanent. This proposal does nothing to improve Obamacare plans or to address underlying health-care costs. The administration has also taken a series of steps that risk constraining consumer choices, delaying or weakening coverage and undermining innovation.

A number of States that had devoted months, if not years, to crafting comprehensive improvements to their Medicaid programs saw their hard work thrown away overnight as the administration rescinded their waivers, seemingly for political reasons. This approach undermines the State-Federal partnership at Medicaid's core and creates tremendous uncertainty, in addition to eliminating opportunities for innovation.

The administration also announced plans to roll back a popular rule aimed at expediting access to lifesaving medical devices for seniors. This regulation would be a game-changer for patients suffering from cancer, diabetes, and a broad range of other conditions. Disappointingly, it may never go into effect.

I stand ready and eager to work with the administration and members of both parties to pursue policies that improve health-care outcomes, expand access to lifesaving drugs and devices, and drive down costs for both the consumer and the taxpayer. From telehealth expansion to outcomes-based payment arrangements, there are endless opportunities for us to come together on common ground and meet the needs of the American people. We should set aside needless tax hikes and wasteful spending and instead take advantage of these opportunities.

I again thank the witnesses for their time. We look forward to hearing from you all.

PREPARED STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D.,*
PRESIDENT, AMERICAN ACTION FORUM

INTRODUCTION

Chairman Wyden, Ranking Member Crapo, and members of the committee, thank you for the opportunity to discuss health insurance coverage in America and the role of Federal programs. In this testimony, I hope to make three main points:

- The vast majority of Americans are covered by health insurance, with private insurance provided by employers being the leading source of coverage.
- During 2020, the onset of the pandemic slightly reduced private insurance, but public safety net programs offset the loss and left the fraction of Americans uninsured roughly unchanged.
- Despite this success, key public programs—Medicare and Medicaid—can benefit from reforms that raise the value of the care provided to their beneficiaries.

Let me discuss each of these in greater detail.

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*The views expressed here are my own and not those of the American Action Forum. I thank Margaret Barnhorst and Jackson Hammond for their assistance.

SOURCES OF HEALTH-CARE COVERAGE

Pre-COVID–19 Coverage

Released last month, the Census Bureau's report, "Health Insurance Coverage in the United States: 2020," describes the state of health insurance coverage from 2020, based on data collected in the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). The survey was conducted from February to April 2021 and asked participants about health insurance held at any time throughout 2020. Given the wording of the question, people are considered uninsured in 2020 only if they had no coverage at any time during the year, and they are instead counted in the coverage group for insurance they held at the beginning of the year, and potentially in more than one group if they transitioned. Ultimately, those who lost coverage in 2020 due to the COVID–19 pandemic are not included in the uninsured rate for 2020. Therefore, the 2020 report provides the most recent look at health insurance coverage in the United States just prior to the effects of the pandemic.[1]

According to the report, 66.5 percent of people in the United States had private coverage in 2020, 34.8 percent had public coverage, and 8.6 percent of people in the United States, or 28.0 million, did not have health insurance at any point during the year. Employer-sponsored insurance (ESI) remained the most common sub-type of health insurance, with 54.4 percent of the population covered for some or all of the calendar year, followed by Medicare (18.4 percent), Medicaid (17.8 percent), direct-purchase coverage (10.5 percent), TRICARE (2.8 percent), and coverage through Veterans Affairs (VA) or Civilian Health and Medical Program of the Department of Veterans Affairs (0.9 percent).

The report also details health insurance coverage across various demographic groups, displaying disparities in coverage that existed prior to the pandemic. In 2020, Hispanics, inclusive of all races, had the highest uninsured rate (18.3 percent), followed by Blacks (10.4 percent), Asians (5.9 percent), and non-Hispanic Whites (5.4 percent). Blacks had the highest rate of public coverage at 41.4 percent, while non-Hispanic Whites had the highest rate of private coverage (73.9 percent).

Adults aged 65 and older and children under age 19 were more likely to have coverage than those aged 19 to 64, given their age-eligible status for Federal programs. Only 1.0 percent of those aged 65 or older and 5.6 percent of those under age 19 were uninsured for all of 2020, compared to 11.9 percent of those aged 19 to 64.

Poverty and employment also contributed to disparities in health-care coverage in 2020. Those living in poverty, with an income below 100 percent of the Federal Poverty Level (FPL), were most likely to be uninsured for the entire calendar year at 17.2 percent, while those with incomes above 400 percent of the FPL were the least likely to be uninsured (3.4 percent). Additionally, among adults aged 19 to 64 years, 12.9 percent of those who did not work at least one week in the year were uninsured for the entire calendar year, compared to 8.4 percent of full-time, year-round workers. Many adults receive health insurance through their employer, and in 2020, 87 percent of full-time, year-round workers were covered by private insurance.

COVID–19 Impacts on Coverage

Since the second quarter of 2020, the COVID–19 pandemic has affected the United States economy and the health insurance market. Over half of the United States population received health insurance through their employer prior to the pandemic, leaving room for significant impacts on health coverage following the loss of 22.2 million jobs between March and April 2020. Last year, several studies attempted to predict pandemic-related losses in coverage, estimating between 3.5 to 5.7 million would become uninsured due to loss of ESI.[2,3] Given the ongoing nature of the pandemic and the lack of significant real-time data, there is still no finite gauge on the effects of the pandemic on insurance coverage, yet more recent preliminary estimates suggest that the effects have not been nearly as detrimental as initially feared.

Last month, researchers at Duke University and Indiana University-Purdue University Indianapolis released a report that found nearly 2.7 million people in the

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[1] *https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-274.pdf.*

[2] *https://www.urban.org/research/publication/changes-health-insurance-coverage-due-covid-19-recession.*

[3] *https://www.kff.org/coronavirus-COVID–19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/.*

United States lost their health insurance in the spring and summer months (April 23–July 21, 2020), based on data from the Census Bureau's 2020 Household Pulse Survey.[4] This change represented a decline of 1.36 percentage points over the 12-week period. By the fall and winter months (August 19–December 21, 2020), they found enrollment in other coverage types rose enough to offset the loss in ESI, resulting in an insignificant change in the uninsured rate in the fall and winter months of 2020.

Based on the same data from the 2020 Household Pulse Survey, the Urban Institute estimated that 3.3 million adults lost ESI and 1.9 million became uninsured from April 23–July 21, 2020. In their estimates, the overall uninsured rate increased by 1 percentage point in this time period but increased 3.8 percentage points among Hispanic adults and increased 1.6 percentage points among adults with a high school degree or less. Additionally, public coverage rose by 1.1 percentage points during this 3-month period.[5]

A December 2020 report from the Kaiser Family Foundation (KFF) reached similar numbers using employment rates and enrollment in the fully insured group market to extrapolate a rough estimate for the entire ESI market, concluding that approximately 2 to 3 million people lost ESI between March and September 2020.[6] They also note, however, that losses in ESI were largely offset by gains in Medicaid and marketplace enrollment.

A study from the Heritage Foundation, based on data from the National Association of Insurance Commissioners, found a 7 percent increase in Medicaid and Children's Health Insurance Program (CHIP) enrollment in the first three quarters of 2020, reflective of government measures to address pandemic-related loss of coverage, such as the temporary increase in Federal funding for State Medicaid programs and the maintenance of eligibility provisions in the Families First Coronavirus Response Act.[7] More recently, in June 2021, CMS championed record increases in Medicaid and CHIP enrollment, citing a 13.9 percent increase between February 2020 and January 2021.[8] It appears that countercyclical social safety net programs are meeting demand without expansion or increased Federal funding, though they should not become a primary source of health coverage for Americans.

While the pandemic may have led to a shift in the distribution of coverage across subtypes, overall coverage rates remained steady for several reasons. Those that lost employment were likely never enrolled in ESI; lower-wage workers are less likely to be covered by an employer plan, and pandemic-related job losses were most pronounced in industries with lower coverage rates.[9] People who did lose ESI as a result of job loss qualified for a special enrollment period for marketplace coverage, and low-income individuals or families may have become eligible for Medicaid or CHIP. Additionally, many employers continued to temporarily offer ESI or premium support to furloughed or laid-off employees, which further mitigated the pandemic's effects on overall coverage.[10]

If preliminary estimates are true and the uninsured rate has indeed remained steady, there are still around 28 million people without health insurance. Yet according to KFF, 57 percent of the typical non-elderly uninsured population are eligible for, but do not enroll in, free or subsidized coverage. Based on 2019 data, around 40 percent of the typical non-elderly, uninsured population are eligible for free insurance through either Medicaid (24 percent) or a marketplace bronze plan with a $0 premium (16 percent). In addition, 17 percent are likely eligible for subsidized coverage through marketplaces.[11] Using 2017 data, KFF estimated in another study that roughly 15 percent of the typical non-elderly uninsured population is ineligible for subsidies due to undocumented immigrant status, 14 percent declined an offer of ESI, and 7 percent had incomes above 400 percent of the FPL, making them ineli-

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[4] *https://jamanetwork.com/journals/jama-health-forum/fullarticle/2783874.*
[5] *https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf.*
[6] *https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/.*
[7] *https://www.heritage.org/public-health/report/covid-19-effects-the-response-health-insurance-coverage-and-claims.*
[8] *https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/april-2021-medicaid-chip-enrollment-trend-snapshot.pdf.*
[9] *https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/.*
[10] *https://www.bls.gov/brs/2020-results.htm.*
[11] *https://www.kff.org/policy-watch/millions-of-uninsured-americans-are-eligible-for-free-aca-health-insurance/.*

gible for subsidies.[12] Ultimately, it is not clear that expanding Federal programs would necessarily cover these populations. In January 2021, 2.2 million individuals fell in the coverage gap as a result of States electing not to expand their Medicaid programs under the Affordable Care Act.[13]

Much is still unknown about the future of COVID–19 and its lingering effects on health coverage. Looking ahead, policymakers should explore why people forgo viable coverage options, identify those that are truly without coverage options, and focus on the subset of individuals living in non-expansion States.

DRIVERS OF HEALTH-CARE COSTS

According to the 2019 National Health Expenditure Account from the Centers for Medicare and Medicaid Services (CMS), individuals, health insurers, and Federal and State governments spent a combined $3.8 trillion on health expenditures in 2019, accounting for 17.7 percent of the national gross domestic product (GDP).[14] From 2010–2018, national health expenditures have grown an average of 4.5 percent each year compared to the previous year, but spending remained around 17 percent of national GDP.[15]

In 2019, roughly 73 percent of total health expenditures, or approximately $2.77 trillion, was spent on health insurance: private health insurance spending accounted for 31 percent of total health expenditures, Medicare accounted for 21 percent, Medicaid accounted for 16 percent, and other health-care services (including VA, Department of Defense, and CHIP) made up 4 percent.[16] Based on this data, spending per beneficiary in 2019 was highest for Medicare ($13,276), followed by Medicaid ($8,485) and private health insurance ($5,927). The remaining 27 percent of total health expenditures was split between out-of-pocket (OOP) costs (11 percent), other third-party payers and programs (9 percent), investments (5 percent) and government public health activities (3 percent).[17]

A number of factors can drive health-care costs—including, but not limited to provider consolidation, rising prices of health services, a growing, aging, or sicker population—yet pouring more money into the issue will not necessarily improve coverage, especially in the case of Medicare. According to the Medicare trustees report released on August 31st of this year, the Medicare trust fund, which covers hospital services through Medicare Part A, will be depleted in 2026. In 2020, Medicare spending resulted in a $495.5 billion deficit, which accounted for 16 percent of the Federal debt. Despite the fact that it would require a nearly 33 percent increase in Medicare payroll taxes to cover the Part A cash shortfalls in 2020, progressives continue to push costly agendas to expand the program.

At the start of the pandemic in spring 2020, social distancing measures and attempts to mitigate the spread of the virus led to cancellations of elective procedures and outpatient appointments. Despite subsequent increases in health spending as demand grew for laboratory services and hospitals resumed procedures at the end of the year, overall health spending fell slightly in 2020, according to analysis from the Peterson-KFF Health System Tracker.[18] Total health spending in December 2020 was 1.5 percentage points lower than total health spending from December 2019. Yet GDP fell by 3.5 percent in 2020, meaning that total health spending likely represented a greater share of overall national spending for the year. The sustained decrease in the utilization of preventative services and chronic disease screenings may have long-term impacts on health outcomes and health costs.[19]

ROOM FOR IMPROVEMENT

While over half of the United States population receives health insurance through their employer, a significant portion of the population relies—for better or worse—

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[12] *https://files.kff.org/attachment/The-Uninsured-and-the-ACA-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-amidst-Changes-to-the-Affordable-Care-Act.*

[13] *https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.*

[14] *https://www.cms.gov/files/document/highlights.pdf.*

[15] *https://www.cdc.gov/nchs/data/hus/2019/044-508.pdf.*

[16] National Health Expenditures 2019 Highlights *(cms.gov).*

[17] The Nation's Health Dollar ($3.8 Trillion), Calendar Year 2019: Where It Came From *(cms.gov).*

[18] *https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start.*

[19] *https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidcostsuse_marchupdate—2.*

on Federal and State programs for health-care coverage. For these individuals, the future of health-care coverage should focus on enhancing existing Federal programs to balance costs and provide high value care.

Medicare Advantage

Medicare Advantage (MA) allows beneficiaries to enroll in plans managed by private insurers, as opposed to partaking in the traditional fee-for-service (FFS) Medicare program. MA's popularity continues to grow, because it provides beneficiaries with expanded choices of plans and coverage options at affordable prices.[20] In fact, MA has leveraged the power of competition to control costs. Average premiums for MA plans have continuously decreased since 2015, with average premiums at $21 a month this year.[21] Additionally, MA beneficiaries spend 40 percent less on OOP costs than FFS beneficiaries and nearly two-thirds of MA seniors are in $0 premium plans.[22] These savings are significant, especially when considering that more than half of all MA enrollees live on an annual income of less than $24,500.[23]

The average MA enrollee chooses from 33 plans offered by 8 different issuers in their geographic area,[24] and there is even some evidence that MA enrollment leads to better health outcomes: MA enrollees have 33 percent fewer emergency department visits and 23 percent fewer hospital visits than those in FFS Medicare.[25] MA beneficiaries also experienced lower COVID–19 hospitalization and mortality rates than FFS beneficiaries, perhaps in part due to coordinated care services for seniors that included vaccination support, meal delivery, and at-home testing.[26]

Enrollment in MA continues to grow, with 42 percent of current Medicare beneficiaries enrolled in MA as of March of this year and 51 percent of Medicare beneficiaries expected to be enrolled in MA by 2030.[27] MA beneficiaries are proportionally more diverse, lower income, and more complex than those in FFS: racial minorities make up a larger share of the MA population (33 percent) than they do of the FFS population (16 percent).[28] MA costs $7 billion more a year than traditional Medicare, largely because of the supplemental benefits MA plans offer, such as dental, hearing, and vision.[29] Yet, in the grand scheme of a $776-billion entitlement program, $7 billion amounts to less than 1 percent of total spending.[30]

Rather than pursuing costly agendas to expand supplemental benefits or lower the Medicare eligibility age, advocates for enhancing health-care coverage for the elderly should focus on bolstering MA.

Medicare Part D Reform

Medicare Part D provides Medicare beneficiaries with access to subsidized prescription drug coverage, and in 2021, 48 million seniors, or 77 percent of all Medicare beneficiaries, enrolled in Part D benefits.[31] While the program has been largely successful, it represents approximately a third of all drug spending in the United States, and its current structure, along with pricing incentives in the broader pharmaceutical market, creates perverse incentives for insurers and drug manufacturers to benefit from high-cost drugs.

Growing pharmaceutical expenditures in the past several years, driven by a significant increase in both the number of beneficiaries reaching catastrophic coverage and the costs that each of them incur, have led to a resounding push to reform Part D to realign incentives. Spreading the risk for high-cost beneficiaries to insurers and

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[20] *https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/.*

[21] *https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/.*

[22] Average annual beneficiary health-care costs for various Medicare coverage options *(milliman.com).*

[23] *BMA-Data-Brief-March-2021-FIN.pdf (bettermedicarealliance.org).*

[24] *https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/.*

[25] *https://avalere.com/press-releases/medicare-advantage-achieves-better-health-outcomes-and-lower-utilization-of-high-cost-services-compared-to-fee-for-service-medicare.*

[26] *BMA-Q3-Data-Brief-FIN-1.pdf (bettermedicarealliance.org).*

[27] *https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.*

[28] *BMA-State-of-MA-Report-2021.pdf (bettermedicarealliance.org).*

[29] *https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019/.*

[30] *https://www.pgpf.org/budget-basics/medicare#:~:text=Medicare%20accounts%20for%20a%20significant,of%20total%20federal%20government%20spending.*

[31] *https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-premiums-and-cost-sharing-in-2021/.*

drug manufacturers, while capping the liability of beneficiaries, could induce behavioral changes that lead to lower costs for all parties.

Reforms should include placing a true cap on beneficiary OOP expenditures, eliminating the coverage gap phase entirely and instead requiring drug manufacturers to pay rebates during the catastrophic phase, reducing the Federal Government's reinsurance rate, and increasing plans' liability in the catastrophic phase. Under a Part D redesign such as the one proposed by the American Action Forum in 2018, assuming a maximum OOP (MOOP) cap of $2,500, would collectively save beneficiaries $7.4 billion over 10 years (from 2020–2029). Each beneficiary would see an increase in their premiums of only $61 over the entire 10-year window, or an average monthly increase of $0.51. Across all beneficiaries, the reduced cost-sharing expenses would more than offset the increase in premiums paid.

In this same proposal, the Federal Government would be expected to save $23.4 billion over 10 years if a $2,500 MOOP were implemented in 2020 and a 5-percent reduction in brand drug spending occurred. While total premium subsidies would increase $637.4 billion, reinsurance expenditures would decline by $473.2 billion, and low-income subsidy cost-sharing subsidies would decline by $187.6 billion.

If the maximum OOP cap is increased, however, expected overall beneficiary savings would decrease while Federal Government savings would increase. With a $4,000 maximum OOP cap, the Federal Government would save $31 billion over the 10-year period, and beneficiaries would save $400 million over 10 years. In this scenario, premium increases would offset nearly all of the expected reductions in cost sharing.

Insurers will want to find ways to counter beneficiaries' loss of incentive to use lower-cost alternatives; such tools already at plans' disposal include requiring preauthorization or step therapy for coverage of higher-cost drugs. Beneficiaries may resist if the tools impose too much of a barrier to accessing their preferred drug. If policymakers take seriously the effort to reduce expenditures and use of low-value health-care products, however, they will have to make tradeoffs. Alternatively, current rules could be loosened to provide plans more options to control costs in ways that are less punitive or burdensome to beneficiaries. This approach could include greater formulary flexibility such as loosening the protected classes requirements and allowing more narrow coverage options in certain therapeutic classes, as recommended by MedPAC.[32]

That being said, restructuring the benefit design of Medicare Part D in a way that realigns incentives away from high-cost, high-rebate drugs may be the best option to reduce overall program costs as well as drug prices in other parts of the market.

Managed Medicaid

Medicaid managed care programs can assist States in reducing Medicaid costs and better utilizing health services to improve outcomes for Medicaid beneficiaries. While traditional FFS Medicaid encourages greater use of services and use of more expensive services as it reimburses providers for each service performed without any quality controls or value assessments of services, Managed Care Organizations (MCOs) are required to meet certain quality standards as part of their contract with the State and are paid a fixed amount for each enrollee, thus eliminating the incentive to provide unnecessary services. As of this year, 40 States and the District of Columbia use MCOs.

MCOs establish a network of providers and connect patients with a primary care provider, disincentivize overutilization of services or use of high cost services, and incentivize and encourage wellness and preventive services. These and other cost management strategies to discourage resource use, limit subspecialists and/or require approvals for referrals work very well for generally healthy populations with preventive and episodic health needs. Chronic complex populations, particularly children, have many specialized needs that must be closely integrated and delivered in a coordinated fashion, often on a daily basis, to be effective.

While all individuals can benefit from managed care programs, individuals with above-average health-care needs will benefit the most from the stricter regulations regarding quality of care and beneficiary protections. Future efforts to improve MCOs should focus on enrolling higher-cost populations. The aged and disabled are the costliest Medicaid beneficiaries, therefore their lack of enrollment in managed care programs (and thus their continued enrollment in FFS Medicaid) has resulted

[32] *http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf.*

in much of the potential benefit offered by such programs to go unrealized. Aged and disabled beneficiaries account for 60 percent of all Medicaid expenditures despite being only a quarter of the Medicaid population.[33] As such, despite 69 percent of Medicaid beneficiaries being enrolled in MCOs in 2018, only 46.2 percent of total Medicaid spending was spent on MCOs in 2019.[34]

Adults and children with chronic or complex medical conditions have expenditures far above the average for those without such conditions, yet many of these individuals with complex needs are not receiving the most appropriate or beneficial care, and they—and the Medicaid budget—are worse off because of it. A more integrated and coordinated approach through managed Medicaid would expand coverage for the most vulnerable populations while controlling costs and improving outcomes for all.

CONCLUSION

Collectively, Americans are getting older, living longer, and becoming increasingly burdened with chronic diseases.[35] Looking to the future, the Federal Government should focus on maximizing spending power and improving the value of existing programs to ensure sustainable and high-quality health care.

Thank you. I look forward to answering your questions.

QUESTIONS SUBMITTED FOR THE RECORD TO DOUGLAS HOLTZ-EAKIN, PH.D.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

Question. Included in this reckless tax and spending spree is a proposal to create a new Federal health benefit for individuals in States that chose not to adopt the optional Medicaid expansion. The legislative language, however, is incredibly broad.

Is it your understanding that this proposal, as drafted, would allow wide latitude to the Secretary of HHS to develop a program that would be akin to a public option?

Answer. As originally drafted, this proposal could have eventually become something akin to a public option if the program were later expanded.

Question. Furthermore, would it be in the Secretary's best interest to stand up a Nationwide program utilizing as few managed care plans as possible, similar to the operations of TRICARE?

Answer. Using fewer managed care programs would go against the grain of what States Nationwide have done. In Medicaid programs in 40 States and DC, officials have chosen to contract with managed care plans to provide lower costs and better-utilized services to Medicaid beneficiaries. Not using managed care programs could result in higher costs for the same or worse quality Nationwide.

Question. For the vast majority of people who purchase coverage on the Obamacare exchanges, the U.S. Treasury pays most of their premiums via direct payments to health insurers.

For 2021 and 2022, the American Rescue Plan Act (ARPA) increased the amount of those subsidies and lifted the cap on subsidy eligibility (which was at 400 percent of the Federal poverty line), sending Federal subsidies to people earning more than $100,000 and up to $500,000. The House Democrats' proposal seeks to permanently adopt these subsidy expansions.

CBO suggests that this subsidy expansion provides much greater support for upper-income households than for lower-income households. Do you agree with those findings?

Answer. Yes.

Question. If so, can you walk us through why that is the case?

Answer. It is true, practically by definition. Removing the cap on eligibility for subsidies benefits only higher-income individuals, while expanding the generosity

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[33] *http://kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[34] *https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.*

[35] *https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm.*

helps all income levels somewhat. The net impact is largely a benefit to the more affluent.

Question. The House Democrats' drug pricing proposal frames its price controls as negotiation, but the process it creates looks more like bureaucratic price-fixing. Their legislation would force life sciences manufacturers, roughly two-thirds of which are start-ups, to the table under the threat of an excise tax of up to 95 percent, raising grave constitutional questions.

The proposal would then cap prices based on an international benchmark, essentially importing top-down, one-size-fits-all programs from abroad, including many that rely on quality-adjusted life years, or QALYs. These metrics face strong resistance from advocates for aging Americans, as well as those with disabilities, since QALYs tend to treat their lives as less valuable. This system, in short, is a far cry from the market-based negotiations that currently occur in the Medicare Part D program.

Do you believe that the price-setting framework included in Speaker Pelosi's drug pricing bill would facilitate meaningful negotiation?

Answer. No. At a very basic level, the government would ultimately set the parameters for the negotiation. The government would determine whether a manufacturer had complied with those parameters. And the government would level substantial penalties on manufacturers who do not comply with its price concession demands. The more one drills down, the clearer it becomes that the process envisioned cannot be reasonably called a negotiation.

Question. The nonpartisan Congressional Budget Office relied on QALYs to model how the bill's price controls would work in practice, and many of the foreign price controls imported by the proposal are at least partially QALY-based.

What do you see as some of the potential drawbacks or tradeoffs from the use of QALYs in the context of drug pricing and health care more broadly?

Answer. QALYs assign an arbitrary dollar value to a year of one's life and the QALY methodology for drug pricing, especially to assess the value of rare disease drugs and new therapies, is also arbitrary and fails to account for societal or non-health benefits that result from improved health. These valuations necessarily require judgments about the value of a year of life—or fraction thereof—or the quality of that year. Decisions about value that have traditionally been made by patients and their doctors would be turned over to bureaucrats and academics. This type of evaluation system is typical of many countries with lower drug prices, where politicians have been willing to forego access to innovative treatments for their populations in order to limit health-care costs. Given the aforementioned limitations of QALY measurements for the elderly, disabled, and terminally or chronically ill, the Affordable Care Act banned their use in Medicare formularies. QALYs attempt to standardize measurements across diverse conditions and consider the value individuals place on their health care, but the health-care system is complex and difficult to replicate in a single model. Ultimately, QALYs make arbitrary assessments of the value of life and have the potential to limit access to new life-saving medicines and therapies.

Question. In 2003, Congress enacted bipartisan legislation that created Medicare Part D and modernized Medicare Advantage, or MA, as a market-based alternative to fee-for-service coverage for seniors. Both programs have achieved incredible success, with high satisfaction rates, dynamic enrollment growth, and a range of diverse choices for seniors.

What lessons can we take from Part D and MA as we look to enhance coverage, quality and access across other Federal programs and health-care markets?

Answer. Medicare Advantage (MA) has leveraged the power of competition to control costs and provide beneficiaries with expanded choices of plans and coverage options. The average MA enrollee chooses from 33 plans offered by 8 issuers in their geographic area, and there is evidence that MA enrollment leads to better health outcomes: MA enrollees have 33 percent fewer emergency department visits and 23 percent fewer hospital visits than those in fee-for-service (FFS) Medicare. Additionally, MA beneficiaries have experienced lower COVID–19 hospitalization and mortality rates compared to those in FFS Medicare, due in part to the comprehensive and coordinated care options. MA's popularity continues to grow as it provides beneficiaries with affordable prices. Average premiums for MA plans have continuously decreased since 2015, with average premiums at $21 per month in 2021. MA beneficiaries spend 40 percent less on out-of-pocket costs compared to FFS beneficiaries

and many MA enrollees have access to $0 premiums: In 2020, roughly 60 percent of MA enrollees paid no premium.

In Part D, direct negotiation by the Secretary of Health and Human Services has been expressly forbidden, yet the program nevertheless sees aggressive negotiation over the prices of medications between Part D plan sponsors and drug manufacturers. This competitive process is the key factor in the program's success to date. Today, Part D beneficiaries have access to 27 different plans, on average, enabling individuals to choose a plan that is tailored to their needs. Because there are a number of plan options for beneficiaries, individual plans have the ability to use preferential tiering strategies to negotiate discounts for specific drugs. If a beneficiary requires or desires a specific medication that is not on the preferred formulary (or covered at all) for one plan, they can choose to sign up for a different plan that provides the medication at a more desirable price. Total program expenditures for Part D came in far lower than initial CBO projections by about 48 percent. All that being said, however, Medicare Part D is still in need of reform to realign incentives by placing greater financial risk on insurers and drug manufacturers and protecting beneficiaries from catastrophic financial risk.

Question. What effects, from your perspective, would the House Democrats' drug price control proposals have on Part D moving forward?

Answer. The specific price control mechanisms, such as inflation penalties and the maximum price ceiling for Medicare negotiations, that have been misleadingly called "price negotiation" limit how much Medicare will pay for certain drugs. This could result in Part D plans losing access to some prescription drugs that do not make the formulary. Additionally, the very high levels of liability ascribed to manufacturers will reduce profits and therefor likely reduce research and development initiatives for new medicines—which will hurt all Americans, including Part D beneficiaries, but especially those with rare or complex conditions.

Question. Medicare's telehealth coverage and payment policies have drawn criticism from across the political spectrum, and for good reason. Prior to the COVID–19 pandemic, outdated statutory and regulatory requirements have made it nearly impossible for most seniors to access telehealth services in a meaningful way, exacerbating access gaps, particularly for rural and underserved communities.

Fortunately, last year, Congress acted to establish emergency flexibilities and ensure widespread telehealth availability for Medicare beneficiaries. This temporary relief, however, will expire at the end of the ongoing public health emergency, resulting in a coverage cliff for tens of millions of older Americans.

I am confident that we can develop long-term, responsible and bipartisan solutions to modernize Medicare's telehealth policies. That said, I was disappointed to see that the House Democrats' taxing and spending proposals would do nothing to address the impending access cliff. Seniors, health-care providers and innovators deserve certainty and stability on this front, and we should set aside partisan processes to tackle urgent issues like this one instead.

If Congress turns to telehealth in the coming months, what considerations should we bear in mind as we work to craft fiscally responsible policies that meaningfully expand access?

Answer. Equitable payments between telehealth and in-person visits are a potential concern. While telehealth visits may be appropriate and effective for certain behavioral health treatments like talk therapy, they are inherently less effective for other conditions, especially physical ailments. Additionally, the infrastructure necessary for telehealth, including broadband Internet, is lacking in rural areas and expensive to set up, so steps should be taken to ensure that telephones and cell phones are able to be used where broadband access is impractical.

Question. In an attempt to curb or reverse price increases, Speaker Pelosi's drug pricing bill would impose steep penalties for prescription drug price growth that exceeds general inflation.

How do you anticipate policies along these lines might impact the launch prices for new products coming to market, and what do you see as some of the tradeoffs that this approach might necessitate?

Answer. The primary flaw in efforts to restrict price increases to no more than the rate of inflation is that they do not work in the long run. Instead, policies that limit the ability of a company to increase prices over time simply result in increases in the initial list price of medications when they first come to market. Such anti-

market policies are punitive in nature, aimed more at punishing pharmaceutical companies for high prices than at meaningfully addressing health-care costs. The problem with seeking to punish drug companies for high prices is that in most cases the effects of these policies will simply lead to higher launch prices Nationwide and ultimately negatively impact American patients most of all.

Question. Historically, what types of unintended consequences have resulted from government-imposed price controls?

Answer. Historically, price increases have been largely correlated with the imposition or expansion of mandatory rebates and taxes. Drug manufacturers who have their drug covered by Medicaid are required by law to offer Medicaid the "best price" available to any other payer or provide a fixed rebate and the ACA extended this requirement in expansion States and to Medicaid managed care organizations, thus drug manufacturers became obligated to provide their drugs for roughly three-quarters of the price to nearly a quarter of the U.S. population. The result was predictable: a sharp increase in the value of manufacturers' rebates. In FY 2010, Medicaid drug rebates equaled 42 percent of gross Medicaid drug costs. Following the ACA's changes, rebates grew each year as a percentage of expenditures, and by FY 2013, Medicaid rebates equaled nearly 63 percent of the program's gross drug costs. Ultimately, these costs get passed to consumers in the form of higher list prices.

Question. On August 31, 2021—following a 5-month delay relative to the statutory reporting deadline of April 1st—the Medicare trustees issued their annual report on the financial status of the program. The trustees warn that the Medicare hospital insurance, or HI trust fund, will be bankrupt in 2026, at which time the program will no longer be able to pay full benefits for seniors and the disabled.

While the trustees predict that the HI trust fund will be depleted in 2026, there is substantial uncertainty behind their forecast. Current projections, for example, show a year-end HI surplus for the year 2025 that is only $27.4 billion. Given historic annual Medicare spending, that is an exceptionally low reserve amount.

It is, therefore, unclear whether the Medicare HI trust fund could remain solvent through the entirety of 2025.

Given these dire fiscal warnings, do you believe that Congress should be focused on preserving and protecting the Medicare program's long-term solvency if we want to keep the promises that we have made both to current beneficiaries and to Americans who are near retirement age?

Answer. Yes. Medicare is quickly running out of money to cover program costs and continuing with the Medicare status quo is unacceptable. Medicare's annual cash shortfall in 2020 represented almost 16 percent of the Federal deficit that year. Since 1965, Medicare's cumulative cash shortfall amounts to $5.95 trillion, and year-over-year Medicare shortfalls are now responsible for nearly one-third of national debt. Balancing Medicare's annual cash shortfalls under the existing system would prove devastating to seniors and require significant increases in annual Medicare payroll taxes and Medicare Parts B and D premiums. More specifically, to balance the 2020 Medicare Part A cash deficit, Medicare payroll taxes would need to increase 32.6 percent, from 1.45 percent to 1.9 percent. To balance the $307 billion deficit for Medicare Part B in 2020, seniors' premiums for physicians would need to increase by 276 percent, raising the average annual premium from $1,782 to $6531. To balance the Part D cash deficit of $89.2 billion in 2020, seniors' premiums for prescription drugs would need to increase by 565 percent, bringing the average annual drug premium from $392 to $2,610. With such unprecedented levels of cash shortfalls continuing through the budget horizon, maintaining the status quo ensures that Medicare will soon not exist for today's seniors, let alone future generations of Americans. These rising costs and the measures necessary to cover them will increasingly harm seniors if Medicare reform is not undertaken.

Question. Congress has historically looked to reform and adjust Medicare payments to providers in order to extend the life of the HI trust fund. However, the last time Congress enacted significant Medicare savings, the money was used to finance spending on Obamacare.

I remember when Obamacare was pushed through Congress without a single Republican vote. That law raided over $700 billion from a financially strapped Medicare program and spent it. Those savings are no longer available to help us preserve and protect the Medicare program.

Now here we are, more than a decade later, in a very similar situation.

If current proposals are enacted, hundreds of billions in Medicare savings will be spent at a time when the HI trust fund is projected to be insolvent in approximately 4 short years.

In your opinion, should Congress instead be focused on making sure that current Medicare benefits remain available and accessible to beneficiaries?

Answer. The 2021 trustees report provides a sense of what the future may look like should Medicare continue to remain unchanged. Sooner or later Medicare reform is inevitable, but progressive efforts to lower the Medicare eligibility age and add coverage for vision, hearing, and dental would only accelerate the program's collapse. The Obama administration oversaw a $2.4-trillion cash shortfall over 8 years (2009–2016), while the Trump administration oversaw its own $1.6-trillion Medicare cash shortfall during the past presidential term. The trustees project that by the end of 2021 the Biden administration will have overseen a $446-billion cash shortfall in its first year in office. The fiscal reality is that continuing the previous two administrations' Medicare policies and leaving Medicare unchanged all but guarantees bankruptcy. In 2026, the HI fund will only cover about 91 percent of its bills, and that gap will only grow larger in the years that follow as the population ages.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

PRICE CONTROLS, BIOPHARMACEUTICAL LEADERSHIP, AND CHINA

Question. For over a decade, the Chinese Government has targeted biopharmaceuticals as a key industry for development. The State Council has called on all levels of government to support expansions in research, development, and manufacturing capacity.

At the same time, Democrats are pushing for draconian price controls that threatened to slash U.S. biopharmaceutical research and development by as much as 60 percent and cut new drug approvals over the next 2 decades by as many as 342.[1]

Could you elaborate on the impact these price control proposals would have on the United States' leadership in the discovery, development, and delivery of new biopharmaceutical products?

Answer. The competitive, market-based approach to pharmaceuticals in the United States has allowed access to new and innovative therapies and medicines that have been unavailable in other developed countries as politicians abroad have been willing to forego access to innovative treatments in order to limit health-care costs. For example, the 14 reference countries included in the Trump administration's International Price Index proposal have significantly restricted access to treatments and reduced pharmaceutical innovation, compared to the United States. When adjusting for population, the 14 countries had access to only 51.5 percent of the 290 new drugs developed in the past 8 years and it took an average of 16 months after their initial global launch for the drugs to become available. In contrast, the United States gained access to 89 percent of the 290 new medicines within three months. Looking at cancer drugs specifically, 59.7 percent of the 82 new cancer drugs between 2017 and 2017 were available within 17.4 months in the 14 reference countries, compared to 96 percent of new cancer medicines available within three months in the United States.

DRUG PRICING

Question. The Democrats' drug pricing plan establishes an excise tax of up to 95 percent of the gross sales of a drug if the manufacturer does not negotiate or fails to reach an agreement on price. It seems to me this is more of a price control than since it is such a punitive measure.

Are you aware of a 95-percent excise tax anywhere else in U.S. law?

Answer. No, I am not.

Question. How might a policy like this impact the biopharmaceutical development?

Would you expect it to have any impact on the industry's ability to respond to the next world pandemic?

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[1] *https://cpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/d/3128/files/2021/08/Issue-Brief-Price-Controls-and-Drug-Innovation-Sep-23.pdf.*

Answer. The United States has persisted as a global leader in biotech and biopharmaceutical development for years thanks to market-based functions of research and development, yet such a policy would effectively allow the government to dictate the price that a company may charge for a drug and immediately halt funding of drug discovery and development. Manufacturers depend on investment capital, and Federal policies that dramatically curtail return on investment will have a detrimental effect on manufacturer's ability to attract the capital necessary to continue bringing new treatments to market. Investors and venture capital firms will stop investing in new therapies and will give up on medicines that have not yet been invented.

The market-based system in the United States allowed flexibility to respond to emerging threats of the COVID–19 pandemic in real-time. Without public-private partnerships and substantial amounts of funding invested in the biopharmaceutical industry in the early stages of the COVID–19 pandemic, it would have been far more challenging, if not impossible, to achieve the rapid and remarkable success we have seen for the development of innovative vaccines and treatments. Policies in the Build Back Better proposal claim to limit drug spending through restrictive government price controls, ultimately deciding that lower spending is more important than access to the range of innovative new drugs. Letting the government decide that Americans should not have access to new, innovative treatments in a timely manner because the value of those treatments is not worth the cost to taxpayers or private payers, would surely inhibit the country's ability to respond to the next pandemic.

BIOSIMILARS

Question. Biosimilars represent an opportunity to save billions of dollars in the cost of prescription drugs. Despite this great potential, the market is still lacking.

What policies do you think may be necessary to ensure a more robust biosimilars market?

Answer. History has proven the best way to reduce the price of a good for which there is growing demand is to increase its supply through competition. For drug pricing, that means bringing generics and biosimilars to market to compete with brand-name drugs. There are ongoing measures within the FDA that promote the approval and market entry of lower-cost drug options, including the Biosimilars Action Plan from 2018 for biosimilars and the Drug Competition Action Plan for generic drugs. The FDA is updating previous guidelines on the use of biosimilars to account for modernized technologies and is exploring the use of labeling carve-outs and provisions in the CREATES Act to increase supply of biosimilars and generics in the drug market and increase access to product samples.

Question. One idea to help unlock the potential savings of biosimilars is implementing a shared savings program where Medicare savings associated with prescribing a biosimilar would be shared with providers and ultimately lowering Medicare costs, and more importantly patients through reduced co-pays. Senator Bennet and I have introduced a bill that would create a shared savings program.

What do you think of this approach?

Answer. It looks promising.

Question. Many times you have argued that one of the best ways to bring down drug prices is to interject competition through generic drugs and biosimilars.

What should Congress be doing to bolster a biosimilars market where we are seeing lots of biosimilars approved, but uptake is lagging behind?

Answer. Instead of setting price controls that will stifle pharmaceutical innovation and further limit the creation of biosimilars, Congress should seek to reduce drug costs by increasing the utilization of biosimilars over higher-cost alternatives, by increasing patient and provider awareness of biosimilars and their associated benefits, as well as incentivizing providers to prescribe biosimilars through temporary reimbursement increases, both of which have historically garnered bipartisan support.

Question. Are there market forces making it difficult for biosimilars to achieve market share?

Answer. Biologics and biosimilars often treat rare diseases and are some of the most expensive drugs due to high development costs and a limited pool of potential users. Market share is further hindered by the complex approval process, which sometimes takes as long as 10 years, and difficulty in proving a biosimilar drug's similarity to the reference biologic. Several additional factors that have slowed mar-

ket growth of biosimilars include regulatory uncertainties, low demand from physicians and payers, and extensive patent litigation.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. Last week, the Bureau of Labor and Statistics released their Job Openings and Labor Turnover Summary indicating that Americans are quitting their jobs in record numbers. Additionally, the Bureau's September jobs report revealed weak employment numbers and slowing job growth. With higher-income individuals now eligible to receive ACA government subsidies due to the pandemic and proposals to make this permanent, I am concerned that this could lure individuals away from employer-based coverage, driving up employee premiums and undermining group coverage—especially if those drawn away are younger, healthier employees.

Given the concerning economic indicators we have seen, could the devaluing of employer-sponsored health care be another barrier for job creators, especially small businesses, to attract and retain talent?

Answer. More people leaving employer-based coverage may lead to higher premiums, but this heavily depends on the type of people leaving. Higher income levels of eligibility may be more likely to remove health insurance as a variable all together when an individual looks for work, rather than actively disadvantage job creators. Employer-sponsored health insurance is a financial burden on companies. Given a choice, employers might prefer to re-invest the money formerly spent on employees who left the company insurance into other benefits, such as higher salaries, bonuses, or retirement benefits in order to retain talent. As such, it may be a wash for companies when it comes to available resources to attract talent.

Question. According to a recent Kaiser Family Foundation report, out-of-pocket costs for Medicare enrollees "can run into the hundreds and even thousands of dollars for expensive dental treatment, hearing aids, or corrective eyewear" harming their retirement security. Private Medicare Advantage plans today offer hearing, dental, and vision services at little or no additional cost to enrollees and without putting the American taxpayer on the hook for these additional services.

How is that? Is the key here mandated benefits or flexibility and competition—in other words, one-size-fits-all versus the free-market?

Could we not just build on these high-performing, lower-cost private Medicare Advantage plans instead of cutting them to fund an expensive one-size-fits-all government expansion which would negatively impact nearly a third of Medicare patients in South Carolina during a pandemic?

Answer. Medicare Advantage (MA) offers beneficiaries plans managed by private insurers, as opposed to the traditional, one-size-fits-all Medicare fee-for-service (FFS) plans administered by the Federal Government. MA uses the power of competition to control costs and provide beneficiaries with expanded choices of plans and comprehensive coverage options. The average MA enrollee chooses from 33 plans offered by 8 issuers in their geographic area, and average premiums for MA plans have continuously decreased since 2015, with average premiums at $21 per month in 2021. MA beneficiaries spend 40 percent less on out-of-pocket costs compared to FFS beneficiaries, and many MA enrollees have access to $0 premiums. In 2020, roughly 60 percent of MA enrollees paid no premium.

The flexibility of the private market allows MA plans to offer more comprehensive benefits than FFS Medicare. Starting in 2017, MA plans began offering primarily health-related benefits, such as vision, dental, and hearing benefits, and in 2020, plans were allowed to offer non-primarily health-related benefits to those with chronic conditions. As of this month, 90 percent of MA enrollees are covered by a MA plan with Part D coverage (MA-PD plan), and as of this year, 98 percent of MA-PD plans covered vision care, 93 percent covered hearing benefits, and 87 percent covered dental services. MA plans currently cover 42 percent of the Medicare population, and that number is projected to increase to 51 percent by the end of the decade. As MA's popularity continues to grow, advocates for enhanced Medicare coverage should focus on bolstering MA, which already provides a range of tailored benefits to the Medicare population.

Question. As ranking member of the Special Committee on Aging, I recently released a report titled "Putting Patients First: Innovative Solutions for Prescription Drugs and Older Americans" examining how government-mandated drug prices

would stifle medical innovation, erode consumer choice, and restrict access to life-saving drugs for many patients.

What does the proposal to use government price-setting based on the VA mean for patient care decisions in Medicare (whether based on a domestic price or international reference price)?

Answer. It means Medicare beneficiaries will have less access to medications that will be excluded from the formulary and will either have to use less-optimal treatments or go without.

Question. The latest Medicare trustees report projects that the hospital trust fund will run dry in 2026. Additionally, I am increasingly hearing from worried Medicare providers regarding the financial uncertainty currently facing the Medicare physician payment system. As Medicare Open Enrollment began this week, I believe we ought to be focused on strengthening this vital program for current and future enrollees instead of exacerbating its challenges by hastily expanding it.

What is the cost to the American taxpayer of lowering Medicare's eligibility age to 60?

Answer. Modeling from AAF's Center for Health and Economy shows that if Medicare eligibility were extended to those age 60–64, an additional 3.9 million Americans would be insured at a cost to the Federal taxpayer between $379.6 billion and $1.8 trillion over 10 years, depending on employer behavior in response to the change.[2]

Question. We are seeing tremendous progress with therapeutic and technological innovations that could soon cure diseases such as Sickle Cell Disease.

As the science outpaces policy, how can reimbursement arrangements and public programs evolve to ensure immediate patient access for one-time curative treatments?

Answer. Programs need to be given the adequate regulatory flexibility to quickly adapt to and provide access to new technologies. This includes reducing red tape, as well as ensuring stakeholders have direct lines of communication to the agencies that oversee these programs.

QUESTIONS SUBMITTED BY HON. JAMES LANKFORD

Question. The Affordable Care Act allows taxpayer funding for abortion on demand, but at the very least it acknowledged the right of States to prohibit abortion coverage on the exchanges and that abortion could not be required as an essential health benefit. Eleven of the 12 States that have chosen not expand Medicaid have also chosen to prohibit abortion coverage on the exchanges. As written, the Democrats' reconciliation proposal would override these State laws and mandate coverage of, and funding for, abortions on demand, and transportation services to acquire them, for those under 138 percent of poverty and without cost sharing in 2024. However, the bill refers to abortions in an underhanded way.

Do you agree that abortion coverage is mandated and funded by the proposed reconciliation bill's reference to family planning services "which are not otherwise provided under such plan as part of the essential health benefits package" (subsection (c) of section 137505)?

Answer. Yes.

Question. As you know, one of the successes in Medicare Part D over the years has been the ability for plans to drive generic utilization, which provides savings for beneficiaries and the health system and taxpayer. However, the current structure of Part D has shifted to incentivize plans to favor rebates over lower-priced generic and biosimilar alternatives. As a result, we have seen the number of generics placed on the lowest-cost sharing tier drop dramatically in recent years. I'm concerned about this trend and working on legislation that would address this problem.

Can you provide more details on the importance of generic/biosimilar access in Part D and how this can meaningfully lower out-of-pocket costs for seniors?

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[2] *https://www.americanactionforum.org/research/lowering-the-medicare-age-to-60-cost-and-coverage-outcomes/*.

Answer. Generics and biosimilars benefit patients and the health-care system by introducing competition for high-priced drugs. In 2018, generic drugs accounted for 22 percent of all drug spending despite the fact that 90 percent of dispensed prescriptions were generic drugs. Additionally, the average co-pay of a generic prescription ($5.63) is nearly one-seventh that of a brand-name prescription ($40.65), offering significant savings potential for patients.[3] Markets for generic drugs are competitive and generic entry inherently increases the number of competitors in the market, which drives significant price reductions for brand name drugs compared to the original price prior to generic entry. However, given the competing financial incentives for insurers and manufacturers to cover biosimilar drugs under the current structure of Part D, future reforms should seek to ensure biosimilars are less costly for all involved stakeholders to encourage competition and utilization in the long run.

Question. While every member of Congress argues for increased access to quality health care, the Biden administration's new mandates that ban providers from participating in both Medicare and Medicaid unless their staff is fully vaccinated, will decrease the number of available Medicare and Medicaid providers. While we are still waiting to see the interim final rule from CMS on this requirement, many providers in my State have severe concerns.

Have you seen preliminary estimates on how many providers will lose their provider numbers or, on the contrary, how many trained professional care givers will be forced out of the market because of this mandate?

Answer. The Biden administration estimates the vaccine mandate will "cover approximately 17 million health-care workers across 76,000 health-care facilities."[4] A preliminary study from the COVID States Project (a joint research project of Northeastern University, Harvard University, Rutgers University, and Northwestern University) estimated that in July 2021, 73 percent of health-care workers were vaccinated, 27 percent were unvaccinated, and 15 percent of were vaccine resistant, based on a response that they "would not get the COVID vaccine if/when it is available to them.[5] Based on more recent estimates, it appears that health systems across the country are losing anywhere from 0.5 percent to 10 percent of their health-care workers due to COVID–19 vaccine mandates.[6]

QUESTIONS SUBMITTED BY HON. TODD YOUNG

Question. Over half of American workers are saving for retirement via a workplace retirement plan,[7] and the vast majority of those savers earn less than 400,000 dollars per year.[8]

Can you please explain how increasing corporate tax rates, resulting in reduced corporate profits and returns, can negatively impact Americans' retirement savings?

Answer. There are two main channels for negative impacts. First, the proposed corporate changes will reduce the future labor earnings of workers by reducing productivity growth, reducing real wage growth, and driving corporations overseas. Thus, workers will have fewer resource out of which to save for retirement. Second, higher corporate taxes will reduce the return to pension funds and the retirement earnings of individuals. This lowers the accumulated funds available to fund retirement needs.

Question. In your view, will increasing the corporate tax negatively impact American workers?

Answer. Yes.

Question. Professor Larry Summers, the former U.S. Secretary of the Treasury under President Clinton, the former Director of the National Economic Council

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[3] *https://accessiblemeds.org/sites/default/files/2019-09/AAM-2019-Generic-Biosimilars-Access-and-Savings-US-Report-WEB.pdf.*

[4] *https://www.whitehouse.gov/briefing-room/press-briefings/2021/11/04/background-press-call-on-osha-and-cms-rules-for-vaccination-in-the-workplace/.*

[5] *http://news.northeastern.edu/uploads/COVID19%20CONSORTIUM%20REPORT%2062%20HCW%20August%202021.pdf.*

[6] *https://www.fiercehealthcare.com/hospitals/how-many-employees-have-hospitals-lost-to-vaccine-mandates-numbers-so-far.*

[7] *http://www.pensionrights.org/publications/statistic/how-many-american-workers-participate-workplace-retirement-plans.*

[8] *https://www.bls.gov/ncs/ebs/benefits/2018/ownership/civilian/table02a.htm.*

under President Obama, and the Charles W. Eliot University Professor at Harvard, issued the following series of tweets on October 25, 2021:

> Yesterday on @CNN w @jaketapper, @SecYellen said I was wrong about my assertion we are more at risks of losing control of inflation than at any time in my career. She expressed confidence that inflation is decelerating and will be back to target levels by the end of next year. I hope she is right but I think it's much less than a 50/50 chance. When the administration formulated its budget in February, it expected 2 percent inflation in 2021, I was warning about inflation. Their forecast is no longer operative. In May and June, @SecYellen expressed confidence that inflation would be back to the 2 percent range by late 2021 or early 2022. Now this forecast is no longer operative. In @CNN interview, @SecYellen asserts twice that inflation has decelerated. This is a bit misleading as the 3 month and 12 month CPI inflation rates are both around 5 percent on an annual basis. And the trimmed mean and median inflation rates that exclude aberrant sectors (which used to be a stable of administration's rhetoric) are now accelerating. The TIPS market is suggesting inflation in 3 percent range over 5 years and more next year. Breakeven inflation over 5 years is up 40 bps in the last month. Expectations data are even more disturbing. This is part of why my alarm is increasing and Treasury should be as well. Given lags in indices, housing inflation is almost certain to soar in coming months. With super tight labor markets, rising strike activity and real wages having declined, increases in wage inflation are likely as well. I actually believe the gap between Treasury and Fed statements and the everyday experience of business and consumers in terms of inflation has widened in recent months. Until the Fed and Treasury fully recognize the inflation reality, they are unlikely to deal with it successfully.[9]

Question. Do you agree with Professor Summers' analysis and conclusions as set forth above?

Answer. I believe he has been unusually prescient in his concerns over inflation stemming from the American Rescue Plan and continued quantitative easing by the Federal Reserve. I share his concerns.

Question. How does the Democrats' proposed $3.5-trillion spending plan ensure that this rapid inflation will only continue?

Answer. The $1.9-trillion American Rescue Plan was passed at a time when the economy was growing at a 6.0 to 6.5 percent annual rate—poor timing—was far larger than the roughly $500-billion output gap—inappropriately large—and had all sorts of unrelated measures—bailouts of the multiemployer pension system are evidence of a poor design. The current reconciliation bill is heavily front-loaded in its spending and back-loaded in its pay-fors. It promises a repeat of the ARP policy error in the near-term and a dramatic rise in fiscal imbalances in the long term.

Question. What can Congress do (or refrain from doing) to prevent Professor Summers' forecast regarding the future inflation rate?

Answer. First, do no harm. Do not repeat the policy error and let the Fed get inflation under control.

Question. On October 16, 2021, when asked by CNN's Jake Tapper whether it sounded tone deaf to suggest that rising prices and empty grocery store shelves are "high-class problems," White House Press Secretary Jen Psaki responded, "A year ago, people were in their homes, 10 percent of people were unemployed, gas prices were low because nobody was driving, people weren't buying goods because they didn't have jobs. Now more people have jobs, more people are buying goods, that's increasing the demand. That's a good thing. At the same time, we also know that the supply is low because we're coming out of the pandemic. And because a bunch of manufacturing sectors across the world have shut down because ports haven't been functioning as they should be. These are all things we're working through. What people should know is that inflation will come down next year. Economists have said that. They're all projecting that."[10]

Do you agree with the White House's explanation for the inflationary environment America is currently facing? Why or why not?

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[9] *https://twitter.com/LHSummers/status/1452698999656534018.*

[10] *https://www.cnn.com/videos/politics/2021/10/15/jen-psaki-ron-klain-inflation-retweet-tapper-lead-vpx.cnn.*

Answer. I do not. The aspects of the recovery that she emphasizes were accomplished by bipartisan legislation in March and December 2020, as well as successful deployment of the vaccines. The legislation passed in 2021—the ARP—has done more harm than good by fueling inflation. It is true that there are supply-chain constraints, but supply is only meaningfully measured relative to demand, and the ARP excessively stimulated demand.

QUESTIONS SUBMITTED BY HON. JOHN BARRASSO

Question. Before coming to the Senate, I practiced medicine in Casper, WY for over 2 decades. At the medical practice where I worked, we cared for any patient that came through the door. It made no difference if the patient had private insurance, Medicare, Medicaid, or no coverage. We cared for everyone.

Medicare is a vitally important program for seniors in Wyoming and across the country. We must ensure Medicare can continue to meet the health-care needs of our Nation's seniors.

Right now, Democrats are proposing to add dental, vision, and hearing benefits to traditional Medicare.

Can you discuss how seniors can currently receive these benefits? In particular, can you focus on their access through Medicare Advantage?

Answer. Medicare Advantage (MA) allows beneficiaries to enroll in plans managed by private insurers, and 89 percent of MA plans also include Part D coverage (MA–PD plans). Starting in 2017, MA plans began offering "primarily health-related" benefits, including vision, dental, and hearing. In 2019, plans were allowed to expand those supplemental benefits to cover things such as transportation, meal service, and adult day care, as well as disease-tailored benefits to enrollees with specific medical conditions. Beginning in 2020, plans started offering "non-primarily health-related" benefits—for example, pest control services and air purifiers—for enrollees with chronic diseases. In 2020, 98 percent of MA–PD plans covered vision care, 93 percent provided hearing benefits, and 87 percent covered dental services. Additionally, 95 percent of MA-PD plans offered fitness benefits such as gym memberships, and 68 percent offered coverage for over-the-counter items such as sunscreen and first aid supplies.

Question. Can you discuss ways Congress could improve Medicare Advantage so more seniors could gain access to these plans?

Answer. Virtually all Medicare beneficiaries (99.7 percent) will have access to at least one MA plan in 2022, varying between 99.9 percent of beneficiaries in metropolitan areas and 98.4 percent of beneficiaries in non-metropolitan areas.[11] MA offers a consumer-driven and value-based model that encourages competition between plans and leads to expanded supplemental benefits and improved quality measures, and currently, 94 percent of seniors in MA plans are satisfied with the quality of care received.[12] Enrollment in MA is projected to reach 29.5 million people in 2022, up from 26.9 million in 2021, and average monthly premiums are predicted to decrease to $19 per month in 2022, down from $21 in 2021.[13] As the size of the MA market continues to grow, MA enrollment is likely to surpass FFS enrollment and has the potential to become the leading source of coverage for seniors.

Question. According to the Congressional Budget Office (CBO), making the increased premium tax credits permanent would cost $259 billion over 10 years. CBO estimates that over half (65 percent) of those benefiting from the provision have incomes above 400 percent of the Federal poverty level (FPL). CBO goes on to say that 20 percent will have incomes above 600 percent percent of FPL and 10 percent will be over 700 percent.

Do you think these subsidies are properly designed to lower health-care costs and help the neediest families?

Answer. No. Removing the cap on eligibility for subsidies benefits only higher-income individuals, while expanding the generosity helps all income levels somewhat. The net impact is largely a benefit to the more affluent.

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[11] *https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/*.
[12] *https://bettermedicarealliance.org/publication/future-of-medicare-factsheet/*.
[13] *https://www.cms.gov/newsroom/press-releases/cms-releases-2022-premiums-and-cost-sharing-information-medicare-advantage-and-prescription-drug.*

Question. As a doctor, I have seen firsthand the dramatic improvements in medical care over the last 30 years. Thanks to American innovation, patients are living longer and healthier lives.

Making sure seniors can continue to access cutting edge therapies should be the focus of prescription drug reforms. I am concerned current policies within Medicare Part D do not allow patients to receive the full benefit of the discounts that are already negotiated under Part D.

Can you please discuss policies you believe would lower the cost of prescription drugs at the pharmacy counter?

In particular, can you focus on policies that would allow seniors to more directly benefit from the discounts already negotiated under Part D?

Answer. The current structure of Medicare Part D's benefit design, along with pricing incentives in the broader pharmaceutical market, create perverse incentives for insurers and drug manufacturers to benefit from high-cost drugs, which have resulted in a rapid increase in spending in the catastrophic phase of the Part D program over the past decade, exposing taxpayers and high-cost beneficiaries to ever-increasing costs. Under current law, the mandatory discount decreases (as a proportion of the drug's price) as the price increases. To counter this undesirable effect, policies should instead require manufacturer rebates in the catastrophic phase, ensuring the mandatory discount increases along with a drug's price, and increase insurer liability in the catastrophic phase to put downward pressure on drug prices. Reforms should also establish an out-of-pocket (OOP) maximum for beneficiaries and reduce the government's open-ended insurance liability, providing greater protection to beneficiaries and taxpayers. Several bills introduced in Congress as well as a proposal introduced by AAF[14] have included these four necessary components—requiring manufacturer liability to increase along with a drug's price, decreasing the government's reinsurance liability, increasing insurer liability, and capping beneficiary OOP spending—to reform the Medicare Part D benefit structure, but slight differences in details lead to significant variations in their impact.[15]

Question. On October 19th, the Congressional Budget Office was able to provide preliminary cost information regarding the reconciliation bill. Since this legislation is still being drafted, there remain many unanswered questions.

Importantly, CBO was able to provide information regarding the cost and number of individuals who might gain health insurance under the reconciliation legislation.

According to CBO, the Democrats are spending over $550 billion dollars over 10 years on provisions meant to lower the number of uninsured individuals.

The result? According to CBO, 85 percent of the people uninsured now will remain uninsured under the Democratic proposal. Specifically, in 2031, over 20 million Americans will remain uninsured under this Democratic proposal.

Do you believe spending over $550 billion dollars to cover about 4 million people over 10 years is a good use of taxpayer money?

Answer. To provide some context, that is roughly $13,750 a year. The average cost for a family of four over a year is roughly $13,824 a year. For an individual, the average cost is over $5,500. This legislation is certainly not the most efficient way to spend taxpayer money to provide health coverage.

Question. Do you think there are better ways to spend $500 billion to lower the cost of health care?

Answer. We could get rid of the taxes on all of the various inputs for health care so that the underlying cost is reduced.

Question. President Biden has claimed the cost of his multi-trillion-dollar reconciliation bill is actually zero dollars.

Folks in Wyoming have a hard time understanding how legislation that was reported to cost upwards of $3.5 trillion one day can magically cost zero the next.

As the former director of the non-partisan Congressional Budget Office (CBO), can you please explain how President Biden could make sure a claim?

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[14] *https://www.americanactionforum.org/research/redesigning-medicare-part-d-realign-incentives-1/*.

[15] *https://www.americanactionforum.org/insight/analysis-of-the-competing-proposals-to-reform-medicare-part-d/*.

Answer. I cannot. The Senate should ask the White House to explain the claim.

Question. Do you believe such a claim is accurate?

Answer. Absolutely not. Most estimates put the price tag at $5.5 to $6 trillion if all the spending programs are made permanent, and the revenue raised at $2 trillion. There are no zero-dollar outcomes here.

PREPARED STATEMENT OF FREDERICK ISASI, J.D., MPH,
EXECUTIVE DIRECTOR, FAMILIES USA

INTRODUCTION

Chairman Wyden, Ranking Member Crapo, members of the committee, thank you for the opportunity to testify today. My name is Frederick Isasi, and I am the executive director of Families USA, a leading national, non-partisan voice for health-care consumers. For more than 40 years, Families USA has been dedicated to achieving high-quality, affordable health care and improved health for all.

It is an honor to be with you this morning. Thanks to extraordinary leadership by members of this committee, as well as your colleagues elsewhere in government, American families have experienced major gains in health coverage during the past decade. But as we all know, our work is not yet done. On behalf of Families USA, I urge you to seize every opportunity to legislate and continue our work to finally make sure that everyone in America can get the affordable health care they need to thrive.

RECENT HISTORY OF HEALTH INSURANCE IN AMERICA

As the 21st century dawned, the state of American health insurance was increasingly grim, with the number of people who had no health coverage steadily rising, year after year.[1] America's leaders finally turned the tide in 2010 by passing the Affordable Care Act. From 2010 through 2016, 20 million people gained health insurance,[2] many for the first time in their lives.

To be sure, the individual market still had problems after passage of the ACA, with too many people charged premiums and deductibles they couldn't afford. But the ACA took a terrible individual market and made it much, much better. For example, national surveys taken both before and after the law took full effect showed that people buying their own insurance experienced dramatic overall improvements:[3]

- Before the ACA, 60 percent of consumers trying to buy insurance in the individual market reported that it was "very difficult or impossible to find affordable insurance." The ACA cut that proportion to 34 percent.
- More than two out of five (43 percent) consumers trying to buy individual insurance before the ACA said that it was "very difficult or impossible to find the coverage they needed." After the ACA, just one in four (25 percent) experienced this problem.
- Altogether, just 46 percent of those who tried to buy individual coverage before the ACA wound up actually purchasing insurance. By contrast, two-thirds (66 percent) of people exploring the ACA's individual market bought coverage.

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 who get health care on the job; and slashed prescription drug costs for millions of senior citizens as the

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[1] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements. "Table HIB–1. Health Insurance Coverage Status and Type of Coverage by Sex, Race and Hispanic Origin: 1999 to 2012," *https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/hib/hihistt1b.xls.*

[2] 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.*

[3] Sara R. Collins, Munira Z. Gunja, Michelle M. Doty, and Sophie Beutel. "How the Affordable Care Act Has Improved Americans' Ability to Buy Health Insurance on Their Own" (New York, NY; The Commonwealth Fund, February 1, 2017), *https://www.commonwealthfund.org/publications/issue-briefs/2017/feb/how-affordable-care-act-has-improved-americans-ability-buy.*

infamous Medicare "prescription drug donut hole" shrank, then closed. Put simply, the Affordable Care Act provided the greatest advance in American health coverage since President Johnson signed Medicare and Medicaid into law in July 1965.

Starting in 2017, however, health coverage in America changed course. Trump administration policies led to reduced enrollment in Medicaid and marketplace coverage as Federal officials decimated funding for outreach and enrollment assistance and promoted the sale of so-called "junk" insurance plans that let insurance companies discriminate against people with preexisting conditions. The number of people without health insurance once again began rising, growing from 27 million in 2016 to nearly 30 million in 2019.[4] In a particularly shocking development, the number of children without any health insurance whatsoever rose for the first time since Congress, on a bipartisan basis, passed the Children's Health Insurance Program in 1997, 2 decades earlier.[5]

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.[6] The fallout would have been far worse, but thanks to Medicaid and health insurance marketplaces, 70 percent of people who lost employer-sponsored insurance were able to obtain other forms of coverage.[7] All told, the number of uninsured still rose by 1.8 million people in 2020. Notably, the only statistically significant increases in the number of uninsured people reported by the Census Bureau took place in States that had not extended Medicaid coverage as Congress authorized in 2010[8]—a problem Congress can and should fix, as I'll explain in a few moments.

Many of us weathered the storm, but many did not; this signals that our work to secure affordable and equitable health care is far from complete. Earlier this year, the members of this committee and other national leaders once again stepped forward to protect the American people. By passing the American Rescue Plan, you made health care substantially more affordable for people who buy their own insurance. You guaranteed that, through the end of 2022, no one in America will be forced to pay more than 8.5 percent of their income for benchmark private insurance.[9] At the same time, you dramatically lowered premiums charged to millions of hardworking families who buy their own insurance, unable to get health care on the job.

Almost before the ink was dry from President Biden's signature on the American Rescue Plan, families all across this Nation saw their health-care costs dramatically fall and their health security strengthen. During just the 6 months from February 15 to August 15, 2021, nearly 3 million people signed up for coverage through health insurance marketplaces—and no wonder![10] Average premium costs dropped by 50 percent, as nearly half of families coming to the Federal marketplace were charged

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[4] U.S. Census Bureau, 2008 to 2019 ACS, Table HIC–9 ACS.

[5] 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.*

[6] 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.*

[7] 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.

[8] Keisler-Starkey and Bunch. Health Insurance Coverage in the United States: 2020, Table A–1.

[9] American Rescue Plan Act of 2021, Pub. L. 117–2, March 11, 2021, section 9661, *https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf.*

[10] Centers for Medicare and Medicaid Services (CMS). 2021 Final Marketplace Special Enrollment Period Report. September 15, 2021, *https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.*

$10 or less in monthly premiums for health coverage.[11] The median deductible for families new to the Federal marketplace fell by 90 percent, from $750 to $50.[12]

Think about the impact on a family of four making $3,800 a month who, in the past, could afford nothing better than a plan with a $7,000 deductible for each insured family member. Today, by spending $38 on monthly premiums, that same family can buy insurance with a deductible of $800 instead of $7,000.[13] That's enormous progress.

And behind every one of these numbers is a real person's story:

- Kristen Black from Lufkin, TX lost her employer-sponsored health insurance in 2019 when she had to switch from working full time to part time because of a chronic health condition. Kristen worked with a local insurance navigator and found a gold plan that allowed her to access the doctors and medication she needs to manage her chronic condition. Two years later with the new American Rescue Plan subsidies, Kristen's plan went from costing her $333.10 per month to $177.10 per month. Saving over $150 every month is a huge help to Kristen. She is finally getting the care she needs at a price she can afford.
- Sheryl Hagen from Missouri couldn't afford the $300 premium her employer charged for health insurance, so she went without. Earlier this year, Sheryl had a health scare that led to a $1,300 bill, so she decided to sign up for insurance. She found a marketplace plan that cost her $73 a month. After President Biden signed the American Rescue Plan into law, Sheryl reapplied, and her monthly premium was cut to $0.
- April Henry, an Oregon-based writer who formerly worked in the health-care industry, and her husband began saving $700 a month on premiums after they went back to the marketplace following enactment of the American Rescue Plan. The two of them can now save more for retirement and help their 25-year-old daughter with upcoming dental surgery.

Your hard work earlier this year has already paid off for Kristen and Sheryl and April and millions of other struggling families. In 2010, Congress passed legislation that sought to guarantee all families affordable access to quality health care and protection from costs that deplete the family budget. That promise is closer to fruition than ever before. But all of the extra help hard-working families receive from the American Rescue Plan will come to an end in less than 14 months, unless you once again lead the way on American health care through Build Back Better legislation.

BUILDING BACK BETTER

Build Back Better legislation gives America's leaders an opportunity to finish the job we started in 2010, to finally make sure that everyone in this country is guaranteed access to affordable, high-quality health care. If you act boldly and decisively in the coming weeks, you can provide real relief to so many people in America who are currently forced to choose between feeding their family and filling their prescription.

Families USA supports a network of tightly linked proposals to strengthen American health care. Employer-sponsored insurance, the health insurance marketplace, and public programs like Medicare, Medicaid, and the Children's Health Insurance Program work together to provide a spectrum of coverage for people across the lifespan. We urge you to lower prescription drug costs for people in Medicare and the commercial market, improve coverage for children and postpartum women, help families provide long-term care at home or in the community for seniors and family members with disabilities, enroll the eligible uninsured into coverage, and finally

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[11] CMS. 2021 Final Marketplace Special Enrollment Period Report.

[12] CMS. 2021 Final Marketplace Special Enrollment Period Report.

[13] Before the ARP, a family of four at 175 percent of the Federal poverty level (FPL) purchasing coverage with premiums at national average levels would have had to pay $12 for bronze coverage and $204 for silver coverage. After the ARP, the cost of silver has declined to $38. Kaiser Family Foundation. Health Insurance Marketplace Calculator (undated), *https://www.kff.org/interactive/subsidy-calculator/*. In *healthcare.gov,* the average combined deductible for a single individual is $6,921 for a bronze plan and $800 for an 87 percent-actuarial value silver plan, which would be available to a family with income at 175 percent of FPL. Kaiser Family Foundation. Cost-Sharing for Plans Offered in Federal Marketplace for 2021. January 14, 2021, *https://files.kff.org/attachment/Cost-Sharing-for-Marketplace-for-2021.pptx.*

make sure that Medicare beneficiaries who worked hard all their lives receive essential coverage for dental, vision, and hearing care.

But the focus of today's hearing is Medicaid and marketplace coverage. I'm therefore going to center my remaining remarks on two proposals: guaranteeing essential health care to low-income adults who are uninsured because of their States' stubborn refusal to provide Medicaid to their poorest residents; and ensuring that the American Rescue Plan's dramatic improvements to the affordability of private insurance won't be taken away from the millions of families who now rely on them.

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.[14] It is the country's largest source of funding for substance use treatment and prevention, covering almost 40 percent of adults suffering from opioid use disorders.[15] Medicaid is America's leading source of coverage for long-term services and supports, serving six out of every ten nursing home residents.[16] 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 percent lower for children and 25 percent lower for adults.[17]

The Affordable Care Act built on that record of accomplishment, extending Medicaid coverage to adults with incomes up to 138 percent of the Federal poverty level, with very generous Federal financial support. In more than three out of every four American States, governors and State legislators from both parties have gratefully taken advantage of Federal financial incentives to implement this extension—and for good reason. An impressive research base now confirms that Medicaid expansion saves lives, protects people from cancer and other serious diseases, helps combat the scourge of addiction, prevents bankruptcy, saves money for State budgets, boosts employment, and keeps the doors open in rural hospitals.[18] And there is no clearer example of the whole community's need for health coverage than the COVID–19 pandemic: newly infected people without insurance delay seeking care because of cost, which lets the virus spread, undetected and untreated. Based on peer-reviewed literature, insurance gaps in Texas, Florida, Oklahoma, Georgia, and Mississippi

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[14] Manatt, Phelps and Phillips, LLP. Medicaid's Role in Children's Health. Robert Wood Johnson Foundation, February 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.*

[15] Manatt, Phelps and Phillips, LLP. Medicaid's Role in Fighting the Opioid Epidemic. Robert Wood Johnson Foundation, February 1, 2019, *https://www.manatt.com/Manatt/media/Media/Images/White%20Papers/Issue-6-Medicaid-s-Role-in-Fighting-the-Opioid-Epidemic.pdf.*

[16] Kaiser Family Foundation. Medicaid's Role in Nursing Home Care. June 2017, *https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/.*

[17] 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.*

[18] Madeline Guth and Meghana Ammula. Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. Kaiser Family Foundation, May 6, 2021, *https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/;* Madeline Guth, Rachel Garfield, and Robin Rudowitz. The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020. Kaiser Family Foundation, March 17, 2020, *https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.*

were linked to more than 40 percent of those coverage-gap States' COVID–19 deaths.[19] Truly, in places where many of us are uninsured, all of us are at risk.

More than 2 million adults in this country are currently uninsured because they have the misfortune of being poor while living in one of the dozen States that stubbornly refuse to extend Medicaid coverage to their lowest-income residents. In these States, parents cannot get Medicaid unless they have extremely low incomes. In Mississippi, for example, a working mom with two children can't get Medicaid unless she earns $115 a month or less.[20] And adults who are neither pregnant nor caring for dependent children are flatly ineligible for health care, no matter how low their income and how severe their need. This cruel exclusion denies health care to desperately poor people who are homeless, who have been diagnosed with a life-threatening illness, or are struggling with severe and untreated mental health or substance use disorders. It makes no sense to say that those who need help the most receive the least, but that is exactly what happens in coverage-gap States.

Many of us believe that public benefits should support rather than undermine work. But if that Mississippi mother sees her pay rise from $115 to $120 a week, she loses her health care. Closing the coverage gap is needed so struggling families can climb the economic ladder without losing their health insurance. If they earn more, they may need to pay more for health care, but never again will moms and dads be penalized with the loss of health insurance if they try to make a better life for their children.

This is not a hypothetical concern. Consider the stories of Della and Wendy.

Wendy is a restaurant manager from Metairie, LA. Like 70 percent of all Louisiana businesses that employ fewer than 50 people,[21] her restaurant doesn't provide health insurance. She applied for Medicaid before 2016 and was turned down. She worked so many hours that she made just a little too much money to qualify. When Louisiana became the first State in the Deep South to extend Medicaid to all low-wage workers, Wendy was one of more than 600,000 Louisianans who gained access to health-care coverage.[22]

That let her go to the doctor, who diagnosed Wendy as having a thyroid condition. The doctor quickly prescribed medication to keep it managed. As a result, she's healthier, feeling better, and losing weight. There is no telling how her health would have degenerated without Medicaid—quality coverage which she never believed was possible for her.

Just 500 miles away from Wendy, Della is a kidney transplant recipient living in Henry County, GA.

Georgia is one of the 12 States that stubbornly refuse to provide all their low-income residents with health care. As a result, Della earns $100 too much to qualify for Medicaid. Without this coverage, she couldn't afford to take daily immunosuppressant medication. As a result, her new kidney failed. She is now forced to undergo expensive and exhausting dialysis treatments, which limit her ability to work and are sending her deeper and deeper into medical debt.

In America, your health and financial self-sufficiency should not vary by zip code. Both Della and Wendy should be able to find the quality, affordable coverage they need to remain healthy and thrive, but Della is still stuck in the Medicaid coverage gap.

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[19] Stan Dorn. The Catastrophic Cost of Uninsurance: COVID–19 Cases and Deaths Closely Tied to America's Health Coverage Gaps. Families USA, March 2021, *https://familiesusa.org/wp-content/uploads/2021/03/COV-2021-64_Loss-of-Lives-Report_Report_v2_4-20-21.pdf.*

[20] Kaiser Family Foundation. "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty, as of January 1, 2021." *State Health Facts, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D;* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. HHS Poverty Guidelines for 2021, *https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references/2021-poverty-guidelines.*

[21] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. "Table II.A.2 Percent of private-sector establishments that offer health insurance by firm size and State: United States, 2020." 2020 Medical Expenditure Panel Survey-Insurance Component, *https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2020/tiia2.htm.*

[22] Office of the Governor of Louisiana. Governor Edwards Celebrates the 5-year Anniversary of Medicaid Expansion That Continues to Save Lives, Jobs, Rural Hospitals and Reduce the Number of Uninsured Louisianans. July 1, 2021, *https://gov.louisiana.gov/index.cfm/newsroom/detail/3253.*

And make no mistake: people of every race and ethnicity have their lives and economic security endangered by their States' refusal to offer them Medicaid. But families of color are in particular danger. Compared to white adults in non-expansion States, Black adults are 46 percent more likely and Latinos more than twice as likely to lack insurance because they fall into the coverage gap.[23] Put simply, anyone who believes in health equity must also be committed to closing the Medicaid coverage gap.

MAKING HEALTH CARE AFFORDABLE FOR PEOPLE WHO BUY THEIR OWN INSURANCE

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 that plan took effect, almost 75 percent of uninsured families said they lacked health care because they could not afford insurance.[24]

As I noted earlier, the American Rescue Plan cut families' average premium costs by 50 percent in the health insurance marketplace and lowered median deductibles by 90 percent.[25] The American people showed how much this improved their ability to afford health care for their families: During the COVID–19 special enrollment period that ended on August 15, the number of people insured through health insurance marketplaces shot upward by nearly 3 million, or 35 percent, in just 6 short months.[26]

People of all races and ethnicities need affordable health care, but working-class people in communities of color have a particularly large stake in making sure that American Rescue Plan's affordability assistance remains in place. Based on the most recent available Census Bureau data, Black and Latino adults are 50 percent more likely than White adults to qualify for financial help buying marketplace coverage and thus to benefit from the American Rescue Plan.[27]

By keeping affordability assistance in 2023 and beyond, you will be doing more than helping millions of families obtain affordable health care, vital though that goal is. You will also give peace of mind to nearly 170 million people who get health coverage on the job.[28] In America, if you lose your job, your family can lose its health insurance. By making it truly affordable for people to buy their own insurance, Build Back Better legislation can guarantee that a pink slip will no longer take away health insurance. As a result, parents will no longer spend sleepless nights worrying that, if they lose their job, they might not be able to take their sick child to the doctor, or may be forced to choose between paying the utility bills and paying for Dad's blood-pressure medicine that he needs to prevent another heart attack.

American entrepreneurship will also receive a much-needed boost. Instead of forcing people to stay in dead-end jobs just to keep their insurance, people can finally start that business they've always dreamed of, knowing that, if they go out on their

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[23] 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/*.

[24] The second most common reason given in response to the survey, ineligibility for coverage, was cited by only 25 percent 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/*.

[25] CMS. 2021 Final Marketplace Special Enrollment Period Report.

[26] 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-percent increase. CMS. 2021 Final Marketplace Special Enrollment Period Report.

[27] In 2019, the most recent year for which data are available, among citizens and lawfully present immigrants age 19–64, 10.0 percent of whites qualified for premium tax credits, including both those who enrolled in individual-market coverage and those who were uninsured despite qualifying for assistance. Among adults of color, 14.5 percent were eligible for premium tax credits and either uninsured or enrolled in individual-market plans, including 16.4 percent of Indigenous adults, 15.4 percent of African-American adults, 15.2 percent of Latino adults, and 11.4 percent of Asian-American/Pacific-Islander adults. Unpublished analysis of 2019 ACS data by the National Center for Coverage Innovation at Families USA, accessed through IPUMS USA, University of Minnesota, *www.ipums.org*.

[28] Kaiser Family Foundation. "Health Insurance Coverage of the Total Population (CPS): 2020." State Health Facts, *https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*.

own, they are guaranteed the ability to buy affordable health care. From 1978 through 2010, new business formation in America plummeted, falling from more than 15 percent of all companies to just 9 percent.[29] Since 2010 that number has stabilized, but now it's time to reverse the trend and galvanize the creation of new American businesses. One crucial step towards that end is making the American Rescue Plan's affordability improvements permanent. That will help people start their own companies by guaranteeing that, after they go out on their own, entrepreneurs will still able to get affordable health insurance for themselves and their families.

NOW IS THE TIME FOR ACTION

We face tremendous challenges as a country, but we also have an extraordinary chance to learn from the mistakes of the past and make an historic investment in our collective health and economic recovery. Improving access to affordable health care for every family in America is a cornerstone of that opportunity, and I urge every single member of this committee, and all of your colleagues in Congress, to put the needs of America's families first by immediately passing a bold and comprehensive Build Back Better Act.

QUESTIONS SUBMITTED FOR THE RECORD TO FREDERICK ISASI, J.D., MPH

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. When we assess ways to expand health insurance coverage and improve affordability for families, it is critical to remember the important role that States can play as innovators. That is why we established the State waiver process under section 1332 of the ACA. This process provides important flexibilities for States to improve coverage and affordability, while maintaining crucial guard rails. These guard rails ensure that the coverage provided is as comprehensive as it would be under the ACA, is as affordable as coverage would be under the ACA, covers as many people as would be covered under the ACA, and does not increase the Federal deficit.[1] States have used these so-called "1332 waivers" to stand up reinsurance programs that have helped reduce premiums on the Marketplaces. States are also using the waivers to pursue new approaches to lowering costs, including public option approaches.

Can you discuss how States have used section 1332 waivers to offer affordable health-care choices for families?

Answer. State waivers are essential tools to enable States to innovate to meet the needs of their residents who don't have adequate access to affordable care options. Most States (15 out of the 16 with Federal approval) have used 1332 waivers to fund reinsurance, which stabilized insurance markets and lowered premiums for those who buy insurance without help from premium tax credits.[2] Recently, States like Nevada, Colorado, and Washington are using such waivers to jump start price competition by introducing new, lower-cost plans, including publicly administered coverage, as an option for consumers.

Question. What can Congress do to allow more States to leverage 1332 waivers to expand affordable coverage in their States, while still meeting the critical guardrails that section 1332 requires?

Answer. Congress could do more to make these waivers effective. In particular, America faces a huge enrollment gap. Many would be surprised to know that two-thirds of uninsured people qualify for Medicaid, CHIP, or premium tax credits but are not enrolled, and roughly half of them are eligible for zero-premium coverage.[3]

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[29] U.S. Census Bureau, Business Dynamics Statistics, "Rate of establishments born during the last 12 months," Business Dynamics Statistics: Establishment Age: 1978–2019, downloaded on October 10, 2021, from *https://data.census.gov/cedsci/table?q=BDSTIMESERIES.BDSEAGE&tid=BDSTIMESERIES.BDSEAGE&hidePreview=true.*

[1] Patient Protection and Affordable Care Act § 1332 (Pub. L. 111–148, as amended by Pub. L. 111–152).

[2] J. Pitsor, S. Scotti, "State Roles Using 1332 Health Waivers," National Conference of State Legislatures, July 2021, *https://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx,* (accessed 11/09/21).

[3] Matthew Rae, Cynthia Cox, Gary Claxton, Daniel McDermott, and Anthony Damico, How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured. Kaiser Family Foundation, March 25, 2021, *https://www.kff.org/health-reform/*

People of color are particularly likely to fall into this enrollment gap.[4] The deficit neutrality guard rail in the 1332 statute has been interpreted to bar Federal funding for State policies that increase enrollment of uninsured people who qualify for premium tax credits (PTCs). If a waiver would improve participation rates among PTC-eligible consumers, the State would need to pay the full resulting increased costs. As a practical matter, this means that States cannot go forward with such innovation. A technical change to the statutory language in section 1332 would let States experiment with innovative methods for enrolling the eligible uninsured, putting 1332 waivers on the same footing as Medicaid 1115 waivers and SNAP waivers, which keep Federal funding in place when States increase enrollment of eligible people.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Please elaborate on your oral testimony that self-employed and small business owners cannot currently access high-quality affordable health insurance and would benefit from the availability of a public option.

How can Congress design a public option to meet the challenges that prevent these populations from accessing health insurance on the exchanges?

Answer. For many years, small business employers have lagged behind larger firms in providing their employees with health coverage. All companies struggle with high and rising health-care prices, but small employers have less leverage to obtain coverage on favorable terms. Comparing companies with 100 or more employees to those with fewer than 50, people at small firms were roughly half as likely to be covered by employer-based insurance in 2020 (27.8 percent versus 57.0 percent).[5] For individuals who do receive an offer of coverage through their employer, premiums are higher than those of their colleagues at larger businesses ($7,045 and $7,197 for companies with fewer than 50 and those with 100 or more workers, respectively), and deductibles were more than 30 percent higher at smaller firms ($2,376 versus $1,814).[6]

Between 2014, when the Affordable Care Act's (ACA) main coverage provisions took effect, and 2019, previous losses in small-employer coverage came to a halt.[7] But more progress is possible. In particular, Congress could allow employers to purchase coverage offered on the exchange, including public-option coverage. Massachusetts has used this approach, combining the State's individual and small-group market and letting small firms buy relatively inexpensive coverage. In that case, the public program involved selective contracting with plans to serve low- and moderate-income people on the exchange, generally relying on managed care organizations that began by serving Medicaid beneficiaries. Alternative approaches could involve publicly administered provider pricing, with requirements for providers to participate in public-option networks or be excluded from other State-managed coverage systems, including Medicaid and public employee insurance. The key would be using public purchasing to leverage lower premiums while assuring robust provider participation, then making these lower-premium, publicly managed plans available in the small-group market.

Question. How will a public option offered on the individual exchange benefit not only those who enroll in the public option plan, but also those who purchase private insurance coverage from the exchange?

Answer. A public option offered on the exchange would give its private health insurance competitors new incentives to negotiate better health-care prices and thereby lower premiums and other costs. As prices decrease in both the public option and private coverage, health-care costs would fall for consumers throughout the market.

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issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/ (accessed 11/11/21).

[4] S. Artiga, L. Hill, K. Orgera, Health Coverage by Race and Ethnicity 2010–2019, Kaiser Family Foundation, July 2021, *https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/* (accessed 11/09/21).

[5] G. Edward Miller and Patricia Keenan. Trends in Health Insurance at Private Employers, 2008–2020. Agency for Healthcare Research and Quality, July 2020, *https://www.meps.ahrq.gov/data—files/publications/st536/stat536.pdf* (accessed 11/11/21).

[6] Miller and Keenan. Trends in Health Insurance at Private Employers, 2008–2020.

[7] Miller and Keenan. Trends in Health Insurance at Private Employers, 2008–2020. In 2020, the number of workers receiving employer-sponsored insurance fell at firms of all sizes, due to the COVID–19 economic crash.

To achieve this goal, it is essential to establish strong guardrails that prevent the public option from eroding advance premium tax credits (APTCs), which are based on the second-lowest cost silver plan. Last year, health researchers at the RAND Corporation, working in collaboration with Families USA and two leading actuarial firms, estimated the impact of offering a public option in health insurance marketplaces, with and without APTC guard rails.[8] They found that, with measures that prevented the public option from directly eroding APTC values, consumers at all income levels would experience significant health-care cost reductions due to the public option. By contrast, without such guardrails, only higher-income consumers ineligible for APTCs would benefit, and many lower-income consumers would experience cost increases due to erosion in the purchasing power provided by APTCs.

Families USA strongly supports Federal policy that would add a public option to health insurance exchanges. In addition to APTC guardrails, the policy should have strong incentives for providers to serve beneficiaries of a public option, thereby meeting provider network standards and making the public option a viable choice for consumers. It also will be essential for a public option to provide real financial security for consumers and access to care by covering comprehensive benefits, including but not limited to services classified as essential health benefits under the ACA. Full parity of coverage between mental and physical health care is likewise fundamental, as are limits on consumer premium and out-of-pocket costs.

QUESTION SUBMITTED BY HON. TIM SCOTT

Question. We are seeing tremendous progress with therapeutic and technological innovations that could soon cure diseases such as Sickle Cell Disease.

As the science outpaces policy, how can reimbursement arrangements and public programs evolve to ensure immediate patient access for one-time curative treatments?

Answer. There is no simple answer to this question. Fundamentally, our Nation should ensure fairness in access to lifesaving treatments—no one's health should depend on their wealth. Yet, as it stands, almost one in three people can't fill prescriptions because of cost.[9] Congress must allow the government to be a better steward of the dollars being spent on all pharmaceuticals, to ensure resources are available to invest in high-value treatments, even when expensive. To that end, Congress must empower the government to negotiate for fair drug prices, either at launch of the drug or as prices go up (*e.g.,* annually). Politically there is tremendous support for this idea from the public, with nearly nine in 10 people (88 percent) in favor of allowing the Federal Government to negotiate for lower prices, including more than three-fourths (77 percent) of Republicans, nine in 10 independents (89 percent) and 96 percent of Democrats.[10]

In addition, policymakers should look to the Medicaid program. Medicaid provides health coverage for millions of Americans, including many with complex health needs. Prescription drug coverage is a key component of Medicaid for many beneficiaries, and Federal law requires manufacturers who want their drugs covered under the program to rebate a portion of drug payments to the government, referred to as the Medicaid Drug Rebate Program. It also includes an inflationary component that requires additional rebates when average manufacturer prices for a drug increase faster than inflation. Because of this, Medicaid covers almost all FDA-approved drugs produced by those manufacturers with an open formulary—meaning patients have access to novel, lifesaving medicines.

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[8] S. Dorn, "Public Options and Other Policies to Lower Health Insurance Premiums Need Guardrails to Protect Low- and Moderate-Income Consumers," Families USA, June 2020, *https://familiesusa.org/resources/public-options-and-other-policies-to-lower-health-insurance-premiums-need-guardrails-to-protect-low-and-moderate-income-consumers/* (accessed 11/09/21).

[9] Fishman, Eliot. "Too Many People Are Skipping or Changing Medications Because They Are Too Expensive." Families USA, June 14, 2021, *https://familiesusa.org/resources/too-many-people-are-skipping-or-changingmedications-because-they-are-too-expensive/*.

[10] Kirzinger, Ashley, Audrey Kearney, Mellisha Stokes, and Mollyann Brodie. "KFF Health Tracking Poll—May 2021: Prescription Drug Prices Top Public's Health Care Priorities." KFF, June 3, 2021, *https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-may-2021/*.

QUESTION SUBMITTED BY HON. JAMES LANKFORD

Question. The Affordable Care Act allows taxpayer funding for abortion on demand, but at the very least it acknowledged the right of States to prohibit abortion coverage on the exchanges and that abortion could not be required as an essential health benefit. Eleven of the 12 States that have chosen not expand Medicaid have also chosen to prohibit abortion coverage on the exchanges. As written, the Democrats' reconciliation proposal would override these State laws and mandate coverage of, and funding for, abortions on demand, and transportation services to acquire them, for those under 138 percent of poverty and without cost sharing in 2024. However, the bill refers to abortions in an underhanded way.

Do you agree that abortion coverage is mandated and funded by the proposed reconciliation bill's reference to family planning services "which are not otherwise provided under such plan as part of the essential health benefits package" (subsection (c) of section 137505)?

Answer. I believe that access to a free and safe abortion is an essential component of women's health care, and that women should be trusted to make their own health-care decisions. It is critical that we repeal the Hyde Amendment and ensure coverage for the full spectrum of reproductive health care under Medicaid and marketplace plans. That said, the reconciliation text does not mandate or fund abortion coverage beyond the Hyde Amendment's limited scope of permitted services.

SUBMITTED BY HON. TIM SCOTT, A U.S. SENATOR FROM SOUTH CAROLINA

United States Senate

WASHINGTON, DC 20510

October 15, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure:

We write to express our support for the Medicare Advantage (MA) program and our commitment to work with the Centers for Medicare and Medicaid Services (CMS) to ensure the program continues to provide high-quality, affordable care to over 26 million seniors and enrollees with disabilities who qualify for Special Needs Plans.[1]

Medicare beneficiaries, including many in rural communities, have access to more MA coverage options nationwide today than at any time during the last decade.[2] MA's consistently high rates of beneficiary satisfaction and its growing enrollment are a demonstration of its value. Today, MA provides coverage to approximately 42 percent of all Medicare beneficiaries across the country, with enrollment in over half of the U.S. States meeting or exceeding this national average.

Payment stability is critical to protecting and strengthening this popular choice for seniors, particularly since these seniors have paid into the Medicare program and expect to continue to receive the excellent, reasonably priced care offered by MA. As Congress and the Administration work together to find opportunities to promote better access to care and reduce costs, ensuring that MA's care delivery model remains strong and stable should remain a priority. The MA program is essential to fulfilling the CMS's commitment to improving and delivering high-quality, accessible, affordable, and equitable care choices to Medicare beneficiaries.

MA delivers first-rate coverage to an increasingly diverse population. According to a recent analysis, growth in MA enrollment from 2009 to 2018 was greatest among Black and Latino Americans, as well as, individuals dually eligible for Medicare and Medicaid. The latter group currently accounts for 31 percent of MA beneficiaries

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[1] *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData.*

[2] *https://connect.kff.org/medicare-advantage-enrollment-has-more-than-doubled-over-the-past-decade-see-the-latest-data-and-trends.*

from a racial or ethnic minority, compared with 21 percent of racial or ethnic minority beneficiaries enrolled in Medicare Fee-for-Service (FFS).[3] Diversity in enrollment is partly growing in response to the comprehensive benefits MA offers to its beneficiaries, including an expansion of zero premium plans, the addition of supplemental benefits aimed at addressing social determinants of health, and the establishment of Special Needs Plans. The increasing participation in MA of Black, Latino, and dual-eligible individuals underscores the critical importance of continuing to support coverage options that address the unique needs of a diverse beneficiary population and further improve health equity.[4]

The comprehensive and innovative MA clinical care model promotes primary care and is providing seniors with value-based care that can be of a higher quality than Medicare FFS, resulting in improved health outcomes and cost savings. MA offers financial protections from high out-of-pocket costs not available in Medicare FFS, which is an important benefit for the more than half of MA beneficiaries that have low fixed incomes of less than $30,000 annually.[5] The MA model prioritizes care coordination, early diagnosis, and treatment of chronic conditions, and is strengthened by MA's ability to offer benefits aimed at addressing social determinants of health including vision, dental, hearing, telehealth services, transportation, meal services and delivery, in-home support services, and other wellness benefits.

During the ongoing COVID–19 pandemic, MA is protecting and supporting seniors and individuals with disabilities by providing more care in the home through meal delivery, providing personal protective equipment, multifaceted beneficiary engagement, vaccine education, and delivery services to underserved communities. MA plans are also supporting beneficiaries by utilizing telehealth visits.

To ensure this continuum of care, we stand ready to protect MA from payments cuts, which could lead to higher costs and premiums, reduce vital benefits, and undermine advances made to improve health outcomes and health equity for MA enrollees.

We look forward to partnering with you to fulfill CMS's commitment to improving health-care access, quality, and affordability, and to advancing health equity. We are committed to building on the progress already made by protecting proven health-care coverage options like MA for the program's more than 26 million beneficiaries—including the millions of seniors we represent in our States.

Sincerely,

Kyrsten Sinema
U.S. Senator

Gary C. Peters
U.S. Senator

Jon Tester
U.S. Senator

Jacky Rosen
U.S. Senator

Joe Manchin III
U.S. Senator

Jeanne Shaheen
U.S. Senator

Angus S. King, Jr.
U.S. Senator

Tim Scott
U.S. Senator

Shelly Moore Capito
U.S. Senator

Todd Young
U.S. Senator

Marco Rubio
U.S. Senator

Deb Fischer
U.S. Senator

Mark Kelly
U.S. Senator

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[3] David J. Meyers, Vincent Mor, Momotazur Rahman, and Amal N. Trivedi. Growth in Medicare Advantage Greatest Among Black and Hispanic Enrollees. *Health Affairs,* 40, no. 6 (2021): 945–950.

[4] David J. Meyers, Vincent Mor, Momotazur Rahman, and Amal N. Trivedi. Growth in Medicare Advantage Greatest Among Black and Hispanic Enrollees. *Health Affairs,* 40, no. 6 (2021): 945–950.

[5] *https://www.ahip.org/wp-content/uploads/MA_Demographics_Report_2019.pdf.*

Putting Patients First: Innovative Solutions for Prescription Drugs and Older Americans

U.S. Senate
Special Committee on Aging
Senator Tim Scott (R–SC)
Ranking Member

SEPTEMBER 2021

EXECUTIVE SUMMARY

"God uses a lot of different things to get you where you need to be," said James Deer, a lawn care businessman from Ulmer, SC, who, at the age of 59, faced a rare bone marrow cancer diagnosis.[1] As he quickly discovered, treatments are scarce. Now 62, Mr. Deer is doing better after participating in a trial to treat his cancer with medication called AG–120. It produced a complete response.

For Mr. Deer and countless others, particularly older Americans, access to treatments and the innovation that drives them makes all the difference, often, between life and death. Today's biomedical innovations bring about modern miracles that have extended lifespans by millions of years over the last 4 decades, which is cause for celebration, particularly for the United States Senate Special Committee on Aging.[2] These advances ought to inspire wonder, appreciation, relief, and hope. They also deserve policymakers' support.

As part of their $3.5-trillion tax and spending plan, the Biden administration and Congressional Democrats are including H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. This proposal reflects the very best of intentions—a commitment to care for each other, to support the most vulnerable, to better the lives of the suffering and the forgotten—by helping patients afford lifesaving medicine. The problem is that the Democrats' plan endeavors to remedy the current situation through price controls. In other words, Democrats propose the Federal Government should be in charge of deciding the price of treatments, instead of a competitive free marketplace sustained by companies driving innovation.

This report serves to inform policymaking debate by exploring the consequences of H.R. 3 and price controls, which include long-term drug shortages (an almost 50-percent decline in access to medicines);[3] shattered innovation (a 50- to 90-percent decline in new medicines);[4] and bankrupt businesses (an economic loss in the trillions of dollars).[5] Further, this report outlines policy options that will lower drug prices and expand access to treatment by way of four key mechanisms:

1. Allowing seniors to have lower out-of-pocket costs for Medicare drugs;
2. Expanding choices for older Americans through Medicare Part D;
3. Supporting fair insulin prices in Medicare; and,
4. Increasing individualized care like value-based arrangements.

These policies will help older Americans find affordable treatments that meet their needs while maintaining the market dynamism that makes new medicine available in the first place. For Mr. Deer and those like him, innovation is hope.

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[1] Birch, J. (2021, July 8). Clinical trial gives cancer patients new hope. MUSC. Retrieved July 29, 2021, from *https://hollingscancercenter.musc.edu/news/archive/2021/07/08/musc-hollings-clinical-trial-gives-cancer-patients-new-hope.*

[2] Kurczy, S. (2019, February 12). Calculating the Benefits of Drugs. Ideas and Insights, *https://www8.gsb.columbia.edu/articles/ideas-work/calculating-benefits-drugs.*

[3] PhRMA. Analysis of IQVIA Analytics Link and U.S. Food and Drug Administration (FDA), European Medicines Agency (EMA), Japan Pharmaceuticals and Medical Devices Agency (PMDA), Australia Therapeutic Goods Administration (TGA) and Health Canada data. April 2021.

[4] Vital Transformation. International Reference Pricing Under H.R. 3 Would Devastate the Emerging Biotechnology Sector, Leading to 56 Fewer New Medicines Coming to Market Over 10 Years.

[5] Tabarrok, A. (2011). Launching The Innovation Renaissance: A New Path to Bring Smart Ideas to Market Fast (TED Books Book 8). TED Books.

INTRODUCTION

Research shows that since 1982, new drugs provided an extra 150 million years of life—and that the United States led the way with 719 new drugs.[6] This is nothing short of miraculous. For seniors, and for all Americans, it is impossible to put a price on living longer and living better. Sadly, that is exactly what H.R. 3 would do, to tragic effect.

Consider James Deer of South Carolina, whose life has been improved by innovative cancer medicine: gains from cancer treatments make up 73 percent of the advances in surviving over the past 3 decades, and 1.3 million people have survived cancer since 2000 because of new drugs.[7, 8] The first section of this report explains how H.R. 3 would place decades of medical advances at risk; the second section posits how Congress can affordably preserve and advance our nation's tremendous rhythm of developing breakthrough, lifesaving medical achievements.

H.R. 3, Pricing Out Innovation

By institutionalizing Democrats' driving mechanism for lowering drug costs—Federal regulation of drug price caps—H.R. 3 is a compassionate idea that would lead to a disastrous outcome. Sadly, this proposal is a core component of their $3.5-trillion tax and spending plan to remake the economy. Here is how it would work: the Federal Government would tell manufacturers how much they can charge for medicine. The price could not exceed 1.2 times the average price in the United Kingdom, Canada, France, Germany, Australia, and Japan. Price controls would also be enforced.

Enforcing Price Controls

The Federal Government would set prices below this limit for some number of drugs in a given year. Manufacturers would pay a tax—as high as 95 percent—if they did not comply. If the federal government decided that manufacturers had asked for too high a price for a treatment in the past, they would be forced to pay even more. The six countries on which the plan bases its regulations and taxes strictly control drug prices to lower them. The hope is that the same would happen in the U.S. Historically, there is good reason to believe this hope is misplaced.

The Problem With Price Controls

Patients and families need lower prices and more options. Controls produce the opposite effect. Price controls limit consumer choice by forcing industry to cut investment in critical business aspects such as research and development, innovation compliance costs, and ultimately manufacturing and production. This has happened repeatedly throughout history. When the U.S. put price controls on oil and gas in the 1970s, production fell, and working people spent hours (and their paychecks) in long lines waiting to fill their tanks.[9] The controls failed to lower prices, but prices did fall when President Reagan repealed the regulations. For economists, this is common sense.

Lessons Learned: Good Intentions, Bad Policy

Today, economists consider the United States' experiment with price controls on gas a canonical example of well-intentioned but counterproductive regulation.[10] In extreme cases, like Venezuela or the Soviet Union, price controls can ruin the economy.[11] While H.R. 3 alone is not an extreme case, it is a step in the wrong direction that could lead to extreme and harmful effects for seniors in need. Policymakers should remember history's lessons—price controls limit the availability of goods and services, and would restrict access to prescription drugs.

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[6] Cowen, T. (2019, April 23). Frank Lichtenberg and the cost of saving lives through pharmaceuticals. Retrieved July 29, 2021, from *https://marginalrevolution.com/marginalrevolution/2019/04/-frank-lichtenberg-and-the-cost-of-saving-lives-through-pharmaceuticals.html.*

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[9] Rafuse, J. (2018, August 24). History 101: Price controls don't work, *chicagotribune.com. https://www.chicagotribune.com/news/ct-xpm-2007-06-07-0706061080-story.html.*

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[11] The Economist. (2021, February 11). Cuba and Venezuela open up, hesitantly, to the market, *https://www.economist.com/the-americas/2021/02/11/cuba-and-venezuela-open-up-hesitantly-to-the-market.*

The Same Shortage Story for Prescription Drugs

In 21 countries using price controls, according to one review, access to treatments is limited.[12] Cancer drugs are limited in Canada.[13] Cardiology drugs are denied to patients in France, and multiple sclerosis treatments to patients in the United Kingdom.[14] In Australia, patients are left with outdated drugs.[15] Over 400 new medicines were available to almost 90 percent of Americans in the last decade, compared to only 52 percent of the H.R. 3 countries.[16] U.S. patients have access to 95 percent or more medicines for rare diseases, cancer, vision, mental illness, HIV, Parkinson's, epilepsy, cystic fibrosis, and multiple sclerosis. Patients in the H.R. 3 countries can access 70 percent or less of these medicines.[17] These shortages point to significant declines in future innovation.

SHORTING THE FUTURE: INNOVATION, MEDICINE, AND THE INVISIBLE PATIENT

In public policy, the future lives affected by medicine innovation should not be invisible.[18] Hundreds of thousands more may have died during the pandemic without the innovation of American vaccines. Dorothy Nielsen, 88, from Mt. Pleasant, SC writes, "[t]he biopharmaceutical industry has really done amazing work creating not just one, but multiple vaccines. The research and development these amazing scientists have created should make all of us proud."[19] She adds, "[i]t is important that these companies continue to strive for innovation on other diseases that will remain once COVID–19 has been tamed." The Congressional Budget Office (CBO) says that H.R. 3 would prevent a substantial amount of new drugs from coming to market.[20] Price controls could cost businesses almost $2 trillion, a death sentence—unless they severely slash investment in new treatments.[21] As a result, consumers would lose access to more medications than the CBO predicts.[22] Lost access would have dire consequences for seniors.

The Tragedy of Lost Innovation

Price controls led to 25-percent fewer new drugs, and 2 years of lost life expectancy, according to one study.[23] New drugs also reduce disability by up to 30 percent, ac-

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[12] Kanavos, P., Fontrier, A.M., Gill, J., and Efthymiadou, O. (2019). Does external reference pricing deliver what it promises? Evidence on its impact at national level. The European Journal of Health Economics, 21(1), 129–151, *https://doi.org/10.1007/s10198-019-01116-4.*

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[16] PhRMA. Analysis of IQVIA Analytics Link and U.S. Food and Drug Administration (FDA), European Medicines Agency (EMA), Japan Pharmaceuticals and Medical Devices Agency (PMDA), Australia Therapeutic Goods Administration (TGA) and Health Canada data. April 2021.

[17] PhRMA. (2021). Analysis of IQVIA Analytics Link and U.S. Food and Drug Administration (FDA), European Medicines Agency (EMA), Japan Pharmaceuticals and Medical Devices Agency (PMDA), Australia Therapeutic Goods Administration (TGA) and Health Canada data.

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[23] Moreno, G., van Eijndhoven, E., Benner, J., and Sullivan, J. (2017). The Long-Term Impact of Price Controls in Medicare Part D. Forum for Health Economics and Policy, 20(2), *https://doi.org/10.1515/fhep-2016-0011.*

cording to another.[24] Research discovered that in 30 countries, drug innovation made up three-fourths of a 1.74-year increase in life expectancy.[25] For older Americans in particular, these are not dry academic numbers on a spreadsheet; they are marked improvements in the quality of daily life. Innovative drug breakthroughs represent precious time on our livelihood and mortality clocks, the sacrifice of which would be an immeasurable tragedy.

Pricing Economic Growth Out of the Market

Research suggests that if cancer mortality fell by 10 percent, Americans would gain $5 trillion—and maybe more if new drugs drove the decline.[26] Yet H.R. 3 would curtail that innovation, forfeiting trillions. It would hurt small businesses that make new medicines the most. The investments on which they rely would dry up as regulations reduced their income by almost 60 percent.[27] Price controls would eliminate 4 percent of pharmaceutical jobs.[28] On top of overall economic decline, new drugs from small businesses would fall by 90 percent, which means 16 fewer medications for ovarian cancer, prostate cancer, leukemia, and breast cancer; 10 fewer for hypertension, pulmonary fibrosis, and brain cancer; and two fewer for diabetes and COPD.[29] On the ground, the magnitude of this impact becomes even clearer.

H.R. 3 on the Ground: South Carolina

The biopharmaceutical sector contributes almost $7 billion to South Carolina's economy every year, and nearly 25,000 jobs.[30] The state has 28 cutting-edge plants involved in creating new medicines.[31] H.R. 3 would put them in jeopardy. It would do the same to over 18,000 South Carolinians who participated in clinical trials in 2017, and to the $290 million in yearly tax revenue generated by industry.[32] For South Carolina seniors, price controls would even impact retirement—three-quarters of company shares are held by mutual funds, endowments, and pension funds. Policymakers should also keep in mind that the lives of everyday Americans are the driving concern behind these figures.

A Name Behind the Numbers

William Donevant, 71, of Georgetown, SC said, "[w]e haven't gone fishing in a while."[33] Three years into retirement, he was diagnosed with a rare cancer. As is too often the situation, his case was hard to treat. He is in remission thanks to CAR-T-cell therapy, which changes genetics in the immune system. He now finds happiness in resuming his life, and in time spent with his granddaughter. "Without chemotherapy, it will set me free."

Policy should not curb the innovation that gets Mr. Donevant his life back. It should help him resume activities he loves, like fishing.

Fortunately, there are common-sense, achievable paths forward.

POLICY SOLUTIONS

Americans are blessed with the best medicine in the world. What older Americans need and deserve is more of it, at lower prices and a quicker pace. Instead of pur-

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[27] Vital Transformation. International Reference Pricing Under H.R. 3 Would Devastate the Emerging Biotechnology Sector, Leading to 56 Fewer New Medicines Coming to Market Over 10 Years.

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[29] Vital Transformation. International Reference Pricing Under H.R. 3 Would Devastate the Emerging Biotechnology Sector, Leading to 56 Fewer New Medicines Coming to Market Over 10 Years.

[30] TEConomy Partners. (2019). The Economic Impact of the Biopharmaceutical Industry: U.S. and State Estimates.

[31] NDP Analytics. (2021). Analysis of the US FDA's Drug Establishments Current Registration Sit.

[32] TEConomy Partners. (2019). The Economic Impact of the Biopharmaceutical Industry: U.S. and State Estimates.

[33] Birch, J. (2021, June 18). Cancer patients get second chance at life, thanks to new CAR-T-cell therapy. Retrieved July 29, 2021, from *https://hollingscancercenter.musc.edu/news/archive/2021/06/18/cancer-patients-get-second-chance-at-life-thanks-to-new-car-t-cell-therapy.*

suing a rigid pricing dictate, Congress and the Administration should adopt practical, achievable strategies for promoting innovation and lower consumer costs, including:

- An out-of-pocket cap for Part D;
- Allowing plan sponsors to offer more plan options;
- Codifying the insulin demonstration program to lower insulin prices introduced under President Trump's Administration; and
- Modernizing value-based arrangements.

Medicare Part D: The Value of Choice

Created in 2006, Medicare Part D provides seniors access to private, stand-alone prescription drug plans or Medicare Advantage prescription drug plans that cover a wide range of medication. Part D is a bipartisan success story, keeping costs low by empowering patients through choice and a market-oriented structure, not heavy-handed bureaucracy. In fact, research finds that Part D's market mechanisms are responsible for its low costs.[34] This is exactly the kind of initiative to which policymakers should look when considering the affordability of medicines for older Americans. Some practical steps to modernize Part D would lead to significant gains for patients.

Out-of-Pocket Cap for Part D

Part D beneficiaries pay a monthly premium, an annual deductible, and copayments or coinsurance. Their relative share of overall costs is low. The lack of an annual cap on out-of-pocket spending, however, can expose them to dramatic costs, according to a new analysis. In 2019, nearly 1.5 million beneficiaries paid above the catastrophic threshold. Over 3.6 million older Americans faced that hardship in the last decade.[35] For seniors, the majority of whom live on fixed incomes, establishing a reasonable, annual cap on out-of-pocket costs would help better support their finances and deliver more peace of mind. Enhancing seniors' access to Part D plans would similarly contribute to lower overall costs.

Increase Plan Choice for Part D Beneficiaries

Part D works best for seniors because of time-tested principles like choice, flexibility, and a fair role for the market. Unfortunately, Obamacare shrunk the number of available Part D plans offered, thereby curtailing choice by limiting older Americans to only one basic plan benefit and two enhanced plans per service area. Because of this arbitrary cap, seniors now lack access to innovative, flexible plans. Repealing this intrusive regulation would give them more options—plans that best fit their needs, not the interests of distant bureaucrats, improving access to medicines. Supporting patients' unique health needs was also the inspiration for President Trump's cost-cutting insulin initiative.

Codify the Trump Administration Insulin Demonstration Program

As seniors throughout the country know all too well, diabetes is becoming an increasingly pressing health challenge. It is affecting more Americans in recent years. In 2018, 34 million adults (13 percent) had diabetes—including 27 percent of those aged 65 years and older.[36] This impacts costs for many vulnerable seniors. A recent study found that Part D beneficiaries' spending on insulin products quadrupled between 2007 and 2017, rising from $236 million to $934 million. While coverage of insulin products varies across Part D plans, the problem is generally in the coverage gap, which has a coinsurance rate of 25 percent. This coverage gap pushes out-of-pocket costs for older Americans as high as $100 per insulin prescription.[37]

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[34] Decarolis, F., Polyakova, M., and Ryan, S. P. (2020). Subsidy Design in Privately Provided Social Insurance: Lessons from Medicare Part D. Journal of Political Economy, 128(5), 1712–1752, *https://doi.org/10.1086/705550.*

[35] Millions of Medicare Part D Enrollees Have Had Out-of-Pocket Drug Costs High Enough to Exceed the Catastrophic Threshold Over Time. (2021, July 23). KFF, *https://www.kff.org/medicare/press-release/millions-of-medicare-part-d-enrollees-have-had-out-of-pocket-drug-costs-high-enough-to-exceed-the-catastrophic-threshold-over-time/*.

[36] Centers for Disease Control and Prevention. National Diabetes Statistics Report 2020: Estimates of Diabetes and Its Burden in the United States, *https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf#page=4.*

[37] Cubanski, J., Neuman, T., True, S., and Damico, A. (2020, June 22). Insulin Costs and Coverage in Medicare Part D. KFF, *https://www.kff.org/medicare/issue-brief/insulin-costs-and-coverage-in-medicare-part-d/*.

Responding to this price spike, President Trump created a voluntary Part D benefit allowing seniors to access insulin for $35 or less a month.[38] Absent this flexibility, they would have to pay much more. According to the Kaiser Family Foundation, President Trump's program cut older Americans' insulin costs by almost 30 percent.[39] This is a remarkable gain for seniors' mental, physical, and financial well-being, and policymakers should make it permanent to address their health needs in a flexible manner. They should also endorse broader measures to expand flexibility in Medicare, such as value-based arrangements (VBAs).

Modernize Value-Based Arrangements

Traditionally Medicare pays "fee-for-service." It reimburses for each item or service provided. By incentivizing hospitals, physicians, and other providers to focus on service quantity over quality, the fee-for-service model better serves limited healthcare access than it does older Americans. VBAs help address this problem.

VBAs reward providers who focus on quality over quantity. They prioritize individual care and patient outcomes. They also reduce costs for taxpayers, no longer on the hook for perverse incentives. By expanding and modernizing the number of Medicare VBAs, policymakers can help ensure that seniors are receiving the very best care, at affordable cost, tailored to their needs.

Reform for the future

"I do hope that when the pandemic is over," economist Alex Tabarrok, a George Mason University health expert, said, "we don't forget that for patients with life-threatening diseases, it's always been an emergency."[40]

Mr. Tabarrok echoes South Carolina's Dorothy Nielsen in this sentiment, which is worth emphasizing: the Food and Drug Administration's (FDA) imposition of overbearing standards interferes with access to vastly more treatments than COVID vaccines. Innovation saves lives, now and in the future.

Streamlining the FDA's review process, boosting patient voice in its decisions, and allowing innovative trial designs will encourage the growth of lifesaving treatments. It is imperative for Congress and the administration to constantly search for effective measures that achieve this kind of regulatory fairness and flexibility—one of the best possible ways to put patients first.

CONCLUSION

For James Deer, Dorothy Nielsen, and William Donevant, and for so many older Americans across the country, metrics indicating a higher quality of life or better life expectancy are not just statistics. They represent the most valuable resource we have: time—more time to share with a grandchild, laugh with a spouse, or just go fishing.

Putting patients first by expanding access to quality treatments is and should be an urgent goal for policymakers. Sharing the medical innovation miracle's bounty is a moral priority. There are strategies and paths available to achieve this goal—to help seniors and all Americans live well, and with dignity—that avoid the pricing pitfalls of H.R. 3. Quality, affordable treatments can be available for patients without sharp shortages, diminished innovation, and economic losses. Policy today can and should effectively support patients, taxpayers, and the competitive marketplace that has extended and improved so many lives in the United States. Let us work to diligently legislate precious time back to ourselves and our loved ones for the chance to enjoy more tomorrows together.

SUBMITTED BY HON. JOHN THUNE, A U.S. SENATOR FROM SOUTH DAKOTA

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

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[38] Max Richtman. (2020, June 8). Trump's $35 Insulin Plan: A Nickel Solution to a Billion-Dollar Problem. Morning Consult, *https://morningconsult.com/opinions/trumps-35-insulin-plan-a-nickel-solution-to-a-billion-dollar-problem/*.

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[40] Tabarrok, A. (2021b, July 30). Welcome to the Club. Retrieved August 2, 2021, from *https://marginalrevolution.com/marginalrevolution/2021/07/welcome-to-the-club.html.*

Phillip L. Swagel, Director

October 19, 2021

Honorable Jason Smith
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Re: Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage of People Under Age 65

Dear Congressman:

This letter responds to your request for information about the Congressional Budget Office's cost estimates for specified health-care provisions contained in the reconciliation legislation being considered by the House of Representatives. The relevant sections would extend eligibility for and increase the amount of premium tax credits and cost-sharing reductions available for health insurance through the marketplaces established under the Affordable Care Act (ACA). They also would establish a federal Medicaid program for States that have not expanded Medicaid under the ACA.

The reconciliation process stems from S. Con. Res. 14, the Concurrent Resolution on the Budget for Fiscal Year 2022, which instructed 13 committees to recommend legislative changes that would affect deficits over the 2022–2031 period.[1] As part of that process, the House Committee on Ways and Means and the House Committee on Energy and Commerce approved legislation on September 15, 2021. On September 27, 2021, the House Committee on the Budget combined the recommendations of the committees and reported H.R. 5376, a bill to provide for reconciliation pursuant to title II of S. Con. Res. 14.

CBO has not yet completed a cost estimate of H.R. 5376 as a whole. This letter provides estimates for the provisions in that bill for which you have requested additional information.

Estimated Federal Costs and Changes in Health Insurance Coverage

You asked how the reconciliation legislation would affect health insurance coverage for people under age 65. CBO and the staff of the Joint Committee on Taxation (JCT) have analyzed the following provisions:

- Section 137501—Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers;
- Sections 137504, 137505, and 30701: provisions affecting coverage for people with low income, particularly those whose income is below 138 percent of the federal poverty level (FPL)—Temporary Expansion of Health Insurance Premium Tax Credits for Certain Low-Income Populations, Ensuring Affordability of Coverage for Certain Low-Income Populations, and Closing the Medicaid Coverage Gap;
- Section 137507—Special Rule for Individuals Receiving Unemployment Compensation; and
- Section 137502—Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit.

CBO and JCT estimate that enacting those provisions would increase deficits by $553.2 billion over the 2022–2031 period (see Table 1). Estimates for all provisions account for interactions with section 137501.

Over the 2022–2031 period, CBO and JCT estimate, enacting the provisions discussed here would result in a net decline of about 3.9 million people without health insurance. The components of that change (which do not sum to the total because of rounding) would be as follows:

- 4.0 million increase in Medicaid enrollment;
- 3.6 million increase in subsidized nongroup enrollment;

[1] Section 2002 of S. Con. Res. 14 instructed 12 committees in the House of Representatives to recommend legislation that would increase the deficit by up to $1.975 trillion and instructed the Committee on Ways and Means to recommend legislation that would decrease the deficit by at least $1 billion. For more information, *see* Megan S. Lynch, *S. Con. Res. 14: The Budget Resolution for FY 2022,* Report R46893, version 2 (Congressional Research Service, September 1, 2021), *https://go.usa.gov/xMF57.*

- 1.0 million decrease in unsubsidized nongroup enrollment; and
- 2.8 million decrease in enrollment in employment-based coverage.

CBO and JCT estimate that under the legislation, in 2031, 23.6 million people under the age of 65 would be uninsured—a reduction from the current-law total of 27.7 million people.

CBO and JCT classified people who do not have health insurance into mutually exclusive groups on the basis of the most heavily subsidized option available to them.

Of those who would be uninsured under the bill's provisions, CBO and JCT estimate, 24 percent would be eligible for Medicaid or the Children's Health Insurance Program (CHIP), 18 percent would be eligible for a premium tax credit with a dollar value greater than zero through the marketplaces, 30 percent would have access to employment-based coverage, and the remaining 28 percent would be ineligible for subsidized coverage.

Background

Since the ACA was enacted, 38 States and the District of Columbia have expanded Medicaid eligibility to all adults under the age of 65 whose income is up to 138 percent of the FPL. People generally are not eligible for subsidies through the health insurance marketplaces under current law if their income is below 100 percent of the FPL ($12,880 for a single person or $26,500 for a family of four in 2021).

Under current law, people with a modified adjusted gross income between 100 percent and 400 percent of the FPL who are lawfully present in the United States are eligible for premium tax credits if they are not eligible for public coverage (through Medicaid or CHIP, for example) and if they do not have an affordable offer of employment-based coverage. For 2021 and 2022, however, the American Rescue Plan Act of 2021—enacted in March 2021—expanded eligibility for the tax credits to include people whose income is above 400 percent of the FPL.

Under current law, people can use those credits to lower their monthly out-of-pocket costs for premiums. The amount is calculated as the difference between the benchmark premium for health insurance (that is, the premium for the second lowest cost silver plan available in the region) and a specified maximum contribution, expressed as a percentage of income.

For most people, a silver plan pays about 70 percent of the total cost of covered benefits. (That "actuarial value" of the plan would require enrollees to pay out-of-pocket costs of about 30 percent, on average). Cost-sharing reductions (CSRs) effectively increase the actuarial value of silver plans for people whose income is between 100 and 250 percent of the FPL, as follows:

- Between 100 percent and 150 percent of the FPL, the actuarial value increases to 94 percent;
- Between 150 percent and 200 percent of the FPL, the actuarial value increases to 87 percent; and
- Between 200 percent and 250 percent of the FPL, the actuarial value increases to 73 percent.

Because there is no appropriation under current law to pay for CSRs, most insurers use "silver loading"—they charge higher premiums for silver plans offered through the marketplaces.

Basis of Estimate

The provisions considered in this estimate would cause a net increase in the deficit, as follows:

- $209.5 billion under section 137501, Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers;
- $323.1 billion under sections 137504, 137505, and 30701, which concern coverage for people with low income;
- $10.6 billion under section 137507, Special Rule for Individuals Receiving Unemployment Compensation; and
- $10.8 billion under section 137502, Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit.

Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers. Section 137501 would extend the enhanced premium tax credits provided by the American Rescue Plan Act. For 2023 and beyond, the legislation would

increase subsidies for people whose income is below 400 percent of the FPL and extend eligibility to people whose income is above that level (see Table 2).

CBO and JCT estimate that section 137501 would increase Federal deficits by $209.5 billion over the 2022–2031 period as the result of increased direct spending of $119.7 billion and revenue reductions of $89.8 billion. Those net effects primarily reflect a $259.0 billion increase in premium tax credits for health insurance obtained through the marketplaces partially offset by higher revenues. Those revenues would increase because taxable wages would increase as employment-based coverage declines. CBO and JCT estimate that about 10 percent of the estimated increase in premium tax credits would stem from the enrollment of people whose income is above 700 percent of the FPL.

CBO and JCT expect that section 137501 would have a twofold effect on health insurance coverage obtained through the marketplaces. First, most enrollees who have subsidies under current law would be eligible for enhanced subsidies that would lower their out-of-pocket costs for premiums. Second, subsidies would be extended to include some people who will lose eligibility after 2022 under current law. CBO and JCT anticipate that, in addition to reducing current enrollees' out-of-pocket premium costs, the enhanced subsidies would attract more enrollees to the marketplaces. CBO and JCT estimate that those additional enrollees would account for $167.2 billion of the increase in premium tax credits and that current-law enrollees would account for the remaining $91.8 billion.

CBO and JCT estimate that enacting section 137501 would increase the number of people who have coverage through the marketplaces by 3.4 million, on average, over the 2022–2031 period. The agencies also estimate that the income of 65 percent of those who would not have enrolled without that provision would be above 400 percent of the FPL. For people whose income is more than 600 percent and 700 percent of the FPL, those estimates are 20 percent and 10 percent, respectively.

The estimated increase in marketplace enrollment consists of 1.4 million fewer uninsured people, 600,000 fewer people with nongroup coverage purchased outside of the marketplaces, and 1.6 million fewer people with employment-based coverage. The estimated reduction in employment-based coverage is primarily driven by a reduction in offers as a response to the increased subsidies for coverage through the marketplaces. CBO and JCT estimate that 200,000 people would enroll in coverage through Medicaid and CHIP as a result of that reduction in offers of employment-based coverage.

Provisions Affecting Coverage for People With Low Income. Beginning in 2022, the bill would extend subsidized coverage to people whose income is below 100 percent of the FPL who otherwise meet eligibility requirements.

For each year from 2022 to 2024, sections 137504 and 137505 would:

- Expand access to subsidized coverage through the marketplaces by extending eligibility for premium tax credits and CSRs to people whose income is below 100 percent of the FPL;
- Expand eligibility for premium tax credits and CSRs to people whose income is below 138 percent of the FPL who have access to an offer of employment-based coverage that is considered affordable under the ACA;
- Modify the subsidy recapture and tax-filing requirements for people whose income is below 138 percent of the FPL; and
- Appropriate funds for outreach and education.

For 2023 and 2024, section 137505 also would increase CSRs for eligible enrollees whose income is below 138 percent of the FPL from the current-law actuarial value of 94 percent to 99 percent. Because funding for CSRs has not been appropriated under current law, most insurers use silver loading to cover those costs. Under section 137505, the Federal Government would directly reimburse insurers for a portion of the cost of CSRs for eligible people whose income was below 138 percent of the FPL in 2023 and 2024. CBO and JCT expect that most insurers would continue to use silver loading to finance the remaining costs.

For 2024 only, section 137505 would provide marketplace enrollees whose income was under 138 percent of the FPL with additional benefits, such as subsidies for transportation to medical appointments, that currently are covered by State Medicaid programs but not required for marketplace plans.

Starting in 2025, section 30701 would establish a federal Medicaid program to provide coverage to adults whose income is up to 138 percent of the FPL and who reside in a State that has not expanded its program. The Secretary of the Department of Health and Human Services would be required to administer the program through third-party entities and under contracts with Medicaid managed care organizations. The Federal program would be required to provide health-care services and enrollee protections that are consistent with the services and protections provided to adults residing in States with programs as expanded under the ACA.

In addition, the section would require States to maintain their Medicaid expansions or pay the Federal Government an amount approximately equal to the expenditures associated with maintaining expansions. That requirement would apply to States that had expanded their Medicaid programs as of January 1, 2022, but subsequently terminate those expansions. CBO expects that such a requirement would cause most States to maintain their expansion programs rather than have the new Federal program cover their adult residents. As a result, CBO estimates that over the 2025–2031 period, States that continued their expansion programs would spend $86.6 billion to operate those programs; States that terminated their expansion programs would pay the Federal Government $3.6 billion.

After accounting for the effects of section 137501, CBO and JCT estimate that enacting sections 137504, 137505, and 30701 would increase Federal deficits by $323.1 billion over the 2022–2031 period: An increase in direct spending of $335.6 billion would be partially offset by an increase in revenues of $12.5 billion. Those effects reflect a $390.0 billion net increase in Medicaid outlays and $27.2 billion in administrative costs, partially offset by a $75.6 million net decrease in subsidies for health insurance obtained through the marketplaces along with other smaller effects.

CBO and JCT estimate that enacting sections 137504, 137505, and 30701 would increase the number of adults who enroll in Medicaid, on average, by 3.8 million annually over the 2022–2031 period. That increase would result, on average, in 2.3 million fewer uninsured people per year, 700,000 fewer people with nongroup coverage, and 900,000 fewer people with employment-based coverage. The estimated effect on the number of people with employment-based coverage is primarily driven by fewer people taking up an offer of health insurance coverage.

CBO and JCT estimate that over the 2022–2024 period, during which eligibility for marketplace subsidies would be extended to people whose income was below 100 percent of the FPL, enrollment in nongroup coverage would increase by 2.3 million people annually, on average. The estimated increase consists of 1.7 million fewer uninsured people, 300,000 fewer people with employment-based coverage, and 200,000 fewer people enrolled in Medicaid.

After establishment of the Federal Medicaid program, Medicaid enrollment would increase by 5.6 million, on average over the 2025–2031 period, CBO and JCT estimate. That projected increase consists of an estimated 6.4 million people enrolling in the Federal Medicaid program established by section 30701, partially offset by a decrease of 800,000 people enrolled in State-expanded Medicaid programs. The estimated reduction is associated with CBO's expectation that States that would have expanded after 2021 (according to the agency's baseline projections) would not do so and that few States that already have expanded would terminate their expansions once the Federal program was implemented. CBO and JCT expect that people in those States would instead enroll in the Federal Medicaid program. According to CBO and JCT's estimates, the net increase in Medicaid enrollment would result in 2.5 million fewer people being uninsured, 1.9 million fewer people having nongroup coverage, and 1.1 million fewer people with employment-based coverage.

Special Rule for Individuals Receiving Unemployment Compensation. Under current law, eligible people may receive a premium tax credit for health insurance through the marketplaces that equals the difference between the benchmark premium and a maximum contribution specified as a percentage of household income. (CBO and JCT estimated the effects of section 137507 relative to section 137501; for the maximum income contribution percentages for 2031 under section 137501, *see* Table 2 at the end of this estimate.)

Section 137507 would increase the amount of the premium tax credit for people who receive unemployment benefits for any length of time in a year between 2022 and 2025. Under that provision, people whose household income was above 100 percent of the FPL after excluding unemployment benefits, and who are otherwise eligible for premium tax credits, would receive the same credit available to them if their income was 150 percent of the FPL in the year they receive unemployment benefits.

After accounting for the effects of section 137501, CBO and JCT estimate that section 137507 would increase Federal deficits by $10.6 billion over the 2022–2031 period as a result of an increase in outlays of $4.9 billion and a decrease in revenues of $5.7 billion. Those effects would stem primarily from the increase in premium tax credits for health insurance obtained through the marketplaces.

CBO and JCT estimate that 2.0 million people receiving unemployment compensation would be eligible for enhanced premium tax credits under section 137507 if they meet other eligibility requirements. The agencies estimate that, on average in each year from 2022 to 2025, roughly 500,000 people who already would be expected to enroll in marketplace coverage under section 137501 would receive an increased subsidy under section 137507. CBO and JCT estimate that, on average, about 500,000 people would newly enroll and receive a premium tax credit if section 137507 was enacted. The agencies estimate that most of those people would have otherwise been uninsured.

Modification of Employer-Sponsored Coverage Affordability Test. Section 137502 would modify the criteria used to determine an affordable offer of employer-sponsored health insurance for purposes of premium tax credit eligibility. Under current law, unaffordable offers are those that require employees to contribute more than 9.5 percent of their income (indexed annually for inflation) for self-only coverage. Section 137502 would modify that affordability threshold from an indexed 9.5 percent to a nonindexed 8.5 percent of income. If an employee's contribution exceeded 8.5 percent of household income, they and their dependents would be able to purchase subsidized coverage through the marketplaces.

After accounting for the effects of section 137501, CBO and JCT estimate that enacting section 137502 would increase Federal deficits by $10.8 billion over the 2022–2031 period as a result of an increase in outlays of $12.1 billion and an increase in revenues of $1.2 billion. Those effects would stem primarily from an increase in premium tax credits for health insurance obtained through the marketplaces, partially offset by higher revenues stemming from higher taxable wages that would result from a reduction in employment-based coverage.

CBO and JCT estimate that, on average over the 2022–2031 period, 300,000 more people would enroll in nongroup coverage under the section. That increase consists of estimated reductions of fewer than 100,000 people without insurance and fewer than 300,000 people with employment-based coverage. The estimate of the reduction in employment-based coverage is driven primarily by the expectation that fewer people would take up an employment-based offer. Those choosing to take up nongroup coverage instead would do so because the premium tax credits for plans available through the marketplaces would make those plans less expensive than employment-based plans.

I hope this information is useful to you.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable John Yarmouth
Chairman
Committee on the Budget

Identical letters sent to the Honorable Kevin Brady, Ranking Member, Committee on Ways and Means; the Honorable Cathy McMorris Rodgers, Ranking Member, Committee on Energy and Commerce; and the Honorable Virginia Foxx, Ranking Member, Committee on Education and Labor.

Table 1. Estimated Budgetary Effects of Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage for People Under Age 65

By Fiscal Year, Millions of Dollars

	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022–2026	2022–2031
Increases or Decreases (−) in Direct Spending												
Sec. 137501—Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers												
Budget Authority	1,463	19,949	12,519	11,521	11,110	10,867	11,347	12,199	13,815	14,939	56,562	119,729
Estimated Outlays	1,463	19,949	12,519	11,521	11,110	10,867	11,347	12,199	13,815	14,939	56,562	119,729
Sec. 137504, 137505, and 30701—Provisions Affecting Coverage for People With Low Income												
Budget Authority	8,330	16,942	17,055	27,433	36,562	39,003	44,334	47,456	48,488	50,034	106,322	335,637
Estimated Outlays	8,330	16,942	17,055	27,433	36,562	39,003	44,334	47,456	48,488	50,034	106,322	335,637
Sec. 137507—Special Rule for Individuals Receiving Unemployment Compensation												
Budget Authority	1,309	1,821	1,419	1,139	−778	0	0	0	0	0	4,910	4,910
Estimated Outlays	1,309	1,821	1,419	1,139	−778	0	0	0	0	0	4,910	4,910
Sec. 137502—Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit												
Budget Authority	671	1,824	1,493	1,264	982	1,060	950	1,276	867	1,672	6,234	12,059
Estimated Outlays	671	1,824	1,493	1,264	982	1,060	950	1,276	867	1,672	6,234	12,059
Interactions[a]												
Budget Authority	−131	−176	−95	−53	40	0	0	0	0	0	−415	−415
Estimated Outlays	−131	−176	−95	−53	40	0	0	0	0	0	−415	−415
Total Changes in Direct Spending												
Budget Authority	11,642	40,360	32,391	41,304	47,916	50,930	56,631	60,931	63,170	66,645	173,613	471,920
Estimated Outlays	11,642	40,360	32,391	41,304	47,916	50,930	56,631	60,931	63,170	66,645	173,613	471,920
Increases or Decreases (−) in Revenues												
Sec. 137501—Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers												
Total Revenues	499	197	−9,761	−9,518	−9,068	−10,529	−11,408	−12,367	−13,259	−14,592	−27,651	−89,806
On-budget Revenues	332	−275	−10,640	−10,790	−10,464	−12,018	−12,991	−14,080	−15,101	−16,517	−31,837	−102,544
Off-budget Revenues	167	472	879	1,272	1,396	1,489	1,583	1,713	1,842	1,925	4,186	12,738
Sec. 137504, 137505, and 30701—Provisions Affecting Coverage for People With Low Income												
Total Revenues	53	−1,586	−3,560	−1,908	3,105	3,211	3,224	3,243	3,315	3,399	−3,896	12,496
On-budget Revenues	−28	−1,819	−3,824	−2,753	2,037	2,143	2,152	2,160	2,211	2,277	−6,387	4,556
Off-budget Revenues	81	233	264	845	1,068	1,068	1,072	1,083	1,104	1,122	2,491	7,940
Sec. 137507—Special Rule for Individuals Receiving Unemployment Compensation												
Total Revenues	21	−916	−1,645	−1,566	−1,577	2	2	0	0	0	−5,683	−5,679

On-budget Revenues	10	−944	−1,683	−1,615	−1,592	2	2	0	0	0	−5,824	−5,820
Off-budget Revenues	11	28	38	49	15	0	0	0	0	0	141	141
Sec. 137502—Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit												
Total Revenues	106	159	−170	−120	83	174	137	241	128	474	58	1,212
On-budget Revenues	52	−71	−457	−390	−178	−80	−126	−56	−206	59	−1,044	−1,453
Off-budget Revenues	54	230	287	270	261	254	263	297	334	415	1,102	2,665
Interactions [a]												
Total Revenues	−4	119	152	103	103	0	0	0	0	0	473	473
On-budget Revenues	−2	123	156	106	104	0	0	0	0	0	487	487
Off-budget Revenues	−2	−4	−4	−3	−1	0	0	0	0	0	−14	−14
Total Changes in Revenues	675	−2,027	−14,984	−13,009	−7,354	−7,142	−8,045	−8,883	−9,816	−10,719	−36,699	−81,304
On-budget Revenues	364	−2,986	−16,448	−15,442	−10,093	−9,953	−10,963	−11,976	−13,096	−14,181	−44,605	−104,774
Off-budget Revenues	311	959	1,464	2,433	2,739	2,811	2,918	3,093	3,280	3,462	7,906	23,470
Net Increases or Decreases (−) in the Deficit												
Sec. 137501—Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers												
Effect on the Deficit	964	19,752	22,280	21,039	20,178	21,396	22,755	24,566	27,074	29,531	84,213	209,535
On-budget Deficit	1,131	20,224	23,159	22,311	21,574	22,885	24,338	26,279	28,916	31,456	88,399	222,273
Off-budget Deficit	−167	−472	−879	−1,272	−1,396	−1,489	−1,583	−1,713	−1,842	−1,925	−4,186	−12,738
Sec. 137504, 137505, and 30701—Provisions Affecting Coverage for People With Low Income												
Effect on the Deficit	8,277	18,528	20,615	29,341	33,457	35,792	41,110	44,213	45,173	46,635	110,218	323,141
On-budget Deficit	8,358	18,761	20,879	30,186	34,525	36,860	42,182	45,296	46,277	47,757	112,709	331,081
Off-budget Deficit	−81	−233	−264	−845	−1,068	−1,068	−1,072	−1,083	−1,104	−1,122	−2,491	−7,940
Sec. 137507—Special Rule for Individuals Receiving Unemployment Compensation												
Effect on the Deficit	1,288	2,737	3,064	2,705	799	−2	−2	0	0	0	10,593	10,589
On-budget Deficit	1,299	2,765	3,102	2,754	814	−2	−2	0	0	0	10,734	10,730
Off-budget Deficit	−11	−28	−38	−49	−15	0	0	0	0	0	−141	−141
Sec. 137502—Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit												
Effect on the Deficit	565	1,665	1,663	1,384	899	886	813	1,035	739	1,198	6,176	10,847
On-budget Deficit	619	1,895	1,950	1,654	1,160	1,140	1,076	1,332	1,073	1,613	7,278	13,512
Off-budget Deficit	−54	−230	−287	−270	−261	−254	−263	−297	−334	−415	−1,102	−2,665
Interactions [a]												
Effect on the Deficit	−127	−295	−247	−156	−63	0	0	0	0	0	−888	−888
On-budget Deficit	−129	−299	−251	−159	−64	0	0	0	0	0	−902	−902
Off-budget Deficit	2	4	4	3	1	0	0	0	0	0	14	14
Total Effect on the Deficit	10,967	42,387	47,375	54,313	55,270	58,072	64,676	69,814	72,986	77,364	210,312	553,224

Table 1. Estimated Budgetary Effects of Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage for People Under Age 65—Continued

By Fiscal Year, Millions of Dollars

	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022–2026	2022–2031
On-budget Deficit	11,278	43,346	48,839	56,746	58,009	60,883	67,594	72,907	76,266	80,826	218,218	576,694
Off-budget Deficit	−311	−959	−1,464	−2,433	−2,739	−2,811	−2,918	−3,093	−3,280	−3,462	−7,906	−23,470

Data sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

[a] Estimates for all provisions account for interactions with Section 137501; the estimated interaction effects between other provisions are shown in this line.

Table 2. Comparison of Maximum Household Contributions for Premium Tax Credits in 2031

Percentage of Federal Poverty Limit	Percent of Income	
	Under Current Law[a]	Under Section 137501
100–133	2.1	0
133–150	3.1 to 4.2	0
150–200	4.2 to 6.6	0 to 2.0
200–250	6.6 to 8.5	2.0 to 4.0
250–300	8.5 to 10.0	4.0 to 6.0
300–400	10.0	6.0 to 8.5
400+	n.a.	8.5

Data source: Congressional Budget Office.
n.a. = not applicable.

[a] Reflects CBO's current-law estimate of the maximum income contributions in 2031.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

Senate Democrats are on the cusp of moving major legislation that will transform American health care, helping consumers get relief from getting clobbered at the pharmacy window, promoting innovations, and delivering quality, cost-effective home and community-based services to older people and people with disabilities. As we look to these exciting future developments, today the committee will examine the state of health-care coverage in America.

Health care in America got far better the day that the Affordable Care Act eliminated the insane and insidious discrimination against those with preexisting health conditions. In one fell swoop, that change brought security to millions of people who otherwise worried that if they or a loved one had a condition like diabetes, there would be no quality, affordable coverage available to them. The Affordable Care Act significantly advanced the proposition that health care is a human right, but Americans who still lack insurance coverage cannot exercise that right fully.

I'm thrilled that the committee is joined this morning by Senator Reverend Warnock, who has become the conscience of the Senate on this issue. He was a crusader for health care long before he was a member of the Senate. His home State of Georgia is one of a handful of States where Republican leaders have blocked the expansion of Medicaid. Instead of getting health coverage to many of the most vulnerable people in their States, they are clinging to a decade-old political grudge against the Affordable Care Act. It is a morally bankrupt choice.

That's one aspect of the health coverage challenge the committee will discuss today. The committee will also talk about building on what worked in the response to COVID–19.

Earlier this year, reversing course on a Trump administration policy that made it harder for people to get health care during a pandemic, President Biden announced a special enrollment period for health insurance so that people who'd lost their jobs could get covered. It was a lifeline for people who needed health-care security during the pandemic, and nearly 3 million people signed up for coverage. As part of the American Rescue Plan that passed in March, Democrats in Congress made signing up for insurance much more affordable by expanding the ACA's tax credits for health-care premiums.

All in all, consumers who updated their health coverage during the special enrollment period are saving on their net monthly premiums by an average of 40 percent. Nearly two out of three consumers can get a plan with zero premium, after tax credits. Extending those improvements, in my view, is a no-brainer. It's a way to improve health coverage and put money back in Americans' pockets at the same time.

In addition to expanding insurance coverage, today's hearing is also an opportunity to discuss how Medicare, while a lifeline for tens of millions, still has key gaps in what it covers. For example, Democrats are working on updating the Medicare guarantee to cover dental care, vision, and hearing for seniors. It's just unthinkable that there are seniors on Medicare, people who've worked hard for a lifetime and done everything right, who can't afford teeth cleaning, eyeglasses, or a hearing aid. Similarly, this committee is working on a plan to allow seniors and people with disabilities to get the care they need in the place where they're most comfortable, at home.

Before I wrap up, I also want to briefly address some of the key facts that have been distorted in health-care debates. None of the plans I've talked about will reduce the solvency of Medicare's hospital insurance trust fund at all—not one bit. Those benefits will have different sources of funding. They will not be part of Medicare Part A, which is what the trust fund covers.

History shows Republicans trot out this insolvency argument every time Democrats propose significant improvements to our Federal health-care programs—and it's never true. The Affordable Care Act extended the solvency of Medicare by 12 years, but Republican political campaigns falsely claimed it would do the opposite. They continued to make that claim even after it was fully, repeatedly debunked.

Republican Senators' stated concern over Medicare didn't stop them from attempting to repeal the ACA, which would have devastated Medicare's finances had they succeeded. The Trump tax law even reduced payments into Medicare's trust fund.

Shoring up the Medicare hospital insurance trust fund ought to be a bipartisan proposition in order to guarantee that seniors continue receiving the benefits they've earned. That would require Republicans to stop using solvency as a political weapon, creating yet another artificial, unnecessary crisis.

The record shows that Democrats have worked again and again to improve Medicare's finances while upholding its promise of guaranteed benefits for seniors. In campaign ads and in the Congress, Republicans have done just the opposite.

So there's a lot for us to discuss today. I'm expecting a lively hearing. Once again, I want to thank our friend Senator Reverend Warnock for being here along with all our witnesses. I'm looking forward to Q&A.

COMMUNICATIONS

AMERICANS FOR PROSPERITY

Senator Wyden, Senator Crapo, and distinguished members of the Committee, thank you for giving Americans for Prosperity this opportunity to submit our views on how best to improve health care and coverage in the United States.

AFP's Health Care Vision

Americans for Prosperity is a national, grassroots activist organization whose thousands of members across the country work to empower every person to earn success, contribute to his or her community, and live a productive, meaningful life. Among many other projects, we work to create a health-care system that continuously delivers better care at lower cost through markets, not mandates. That means a system in which doctors, nurses, and hospitals are free to compete and offer the best health-care products and services at the best prices that meet the needs of their patients. We call this vision a "personal option," and in this submission for the record, we would like to outline some of the principles and reforms we believe are essential to making it a reality.[1]

The Status Quo

When it comes to health-care reform, Americans have historically been cautious, preferring incremental over radical change. That is still true today. Our polling finds 75 percent of Americans are generally satisfied with their current health-care arrangements, and a similar percentage of Americans are not in the market for major changes or disruptions, preferring instead to fix what's broken in our system while preserving what works.[2]

And what works? For one thing, the quality of care. The quality of American health care is generally very high. In many respects, it's the best in the world. Our cancer survival rates, for example, are good[3] and continuously getting better. We also tend to have shorter surgery wait-times.[4]

For another thing, access to basic coverage. Universal coverage has been effectively achieved in the United States. That's right. Some 98 percent of Americans today are either covered by or eligible for some form of comprehensive, government-subsidized health insurance. While about 9 percent of Americans are officially uninsured, 7 percentage points of that group are eligible for public or private insurance but simply not enrolled. Just 2 percent of Americans are truly uninsured.[5]

And yet, for all its strengths and marvels, our system is not perfect. It is notoriously too costly and too complicated. It provides too little price transparency and too many negative surprises for patients.

We believe these flaws arise because, in our country, patients are treated more like products than customers. Too many important decisions are made for patients instead of by them. We cater too much to insurance companies and government bureaucracies and not enough to the true end-users of care and the medical professionals they trust.

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[1] *https://americansforprosperity.org/personal-option/.*
[2] *https://americansforprosperity.org/voters-want-more-choice-control-health-care-survey/.*
[3] *https://www.healio.com/news/hematology-oncology/20180131/us-cancer-survival-rates-remain-among-highest-in-world.*
[4] *https://fee.org/articles/america-outperforms-canada-in-surgery-wait-times-and-its-not-even-close/.*
[5] *https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.*

Why do these problems exist? Because a number of well-meant but misguided government policies shift power and responsibility from patients to third parties, principally in the tax code, but also in the structure and incentives of various government programs. The remedy seems fairly obvious: reform these policies to shift power back to patients.

By making health care more like other markets, where the end-user controls the dollars and the essential decisions, we can increase choice and competition, and thus the quality and the abundance of medical goods and services, and thus the health and happiness of patients and their families.

To put it more succinctly, we must empower patients to act as customers, and remove the barriers standing between them and their doctors. This is the formula for success. This is how we fix what's broken and preserve what works.

What do we Americans want from our health-care system? Based on our polling and conversations with voters, it's clear that we Americans want:

- Good insurance at an affordable price.
- Access to the latest life-saving drugs at a reasonable price.
- To see the doctor of our choice, conveniently and affordably.
- To know how much our care will cost, up front, before we pay for it.
- The choice to try experimental treatments.
- And strong government safety nets that protect the vulnerable.

In a nutshell, we want a personal option. A personal option gives people the choice and control they want, with the quality they deserve, at prices they can afford, from the medical professionals they trust.

Solution: A Personal Option

So how do we get there? What reforms are needed?

Help People, Not Insurance Companies

Health care exists for patients. Government health insurance assistance should go directly to patients, rather than to insurance companies, similar to the way food stamps go directly to low-income families rather than to farmers or food producers. Congress should adopt more voucher-like approaches to existing health insurance subsidies, including Medicaid, Medicare, and the Affordable Care Act. It could, for example, start by adopting such an approach to fill in the so-called Medicaid coverage gap, the 2 million or so individuals who live in States that have not expanded Medicaid and who are not eligible for any form of government-subsidized health insurance. We could take some of the money we currently spend on Medicaid and deposit it directly into a tax-free Health Savings Account owned and controlled by the enrollee. Congress would require that this assistance be used to pay for health insurance premiums and legitimate out-of-pocket expenses, but would not otherwise dictate how the recipient uses the funds. This approach would be more compassionate than current, top-down subsidy structures because it would be more efficient and dignified for the recipient.

Promote Price Transparency

In every market, consumers get to see the price up front—except in health care. We would never tolerate this at the gas station or grocery store. Unable to shop for value, patients grope in the dark and get hit with excessive charges and pay for needless middlemen and waste. Health care costs will not come down until we can see real prices. But how to get there? Some people favor top-down government mandates, forcing hospitals, insurers, and drugmakers to publish their list prices and their privately negotiated rates. The Trump Administration tried to do so through aggressive regulatory actions. While we strongly support price transparency, we do not believe a mandatory approach will actually help consumers in the long run. The only sure path to price transparency is to empower consumers to make the important purchasing decisions. When consumers are spending their own money, they shop for value, and prices become transparent naturally—just as they do at the gas station and the grocery store. A good place to start is to expand and strengthen special accounts that patients can use to save and pay for health care, tax-free. Such accounts help level the tax code playing field, effectively giving consumers the same kind of generous tax break for health care and coverage purchases that currently only employers receive.

Expand and Strengthen Tax-Free HSAs

Tax-free Health Savings Accounts help 30 million American families pay their out-of-pocket medical expenses tax-free. Why not every family? An HSA is a tool that

saves you anywhere between 10 to 40 percent off, each time you make a health-care purchase. And it gives you greater control of your medical decisions. Studies show HSAs help reduce health-care costs.[6, 7, 8] Expanding this option is a prime way to put consumers in the driver's seat and bend the health-care cost curve downward. Unfortunately, today only about 10 percent of Americans are able to have an HSA, because the law requires HSA owners to buy a narrowly defined, high-deductible health plan or HDHP. By removing this needless restriction, we can allow all Americans to save for health care, tax-free. It would also be desirable to significantly increase how much people can save in these accounts, as well as the array of items and coverage options they can buy with them, including, for example, direct primary care subscriptions and health insurance premiums. Examples of good bills that include these kinds of reforms include Senator Rubio's and Senator Tim Scott's Health Savings Act (S. 380, 2021), Senator Cruz's Personalized Care Act (S. 153, 2021), and Senator Paul's Health Savings Accounts for All Act (S. 4367, 2020).

Strengthen Individual Coverage HRAs

Current policy allows employers to set up, and employees to benefit from, special spending accounts known as individual coverage health reimbursement arrangements or ICHRAs. In addition to facilitating employees' out-of-pocket purchases using pre-tax dollars, these innovative accounts also enable employees to use tax-free money from their employer to buy health insurance that is personally owned and portable. This is a godsend, including for patients with costly pre-existing medical conditions. Thanks to ICHRAs, employees can now have the peace of mind that comes from knowing that they don't have to lose their health insurance coverage when they change jobs. Congress should reject efforts to eliminate or water down ICHRAs, and should facilitate educational efforts to increase employers' awareness and use of this exciting option.

Reduce Mandates to Make Health Insurance Affordable

Insurance today is often a poor value for money. Thanks to well-meant but misguided mandates, federal and state, premiums in recent years have doubled, deductibles have tripled, and access to doctors and hospitals has dramatically narrowed. Happily, with some sensible insurance reforms we can reverse these harmful trends and actually bring down premiums while preserving protections for people with pre-existing conditions. Specifically, Congress should repeal costly, frivolous benefit mandates and ease or eliminate age-based community-rating price controls, so that more young, healthy people sign up voluntarily.

Reduce Hospital Market Consolidation

Hospital services represent about 40 percent of all health expenditures in the United States. In recent years, hospital market consolidation has accelerated, reducing choice and quality, driving up prices, and tilting the playing field against physicians. Addressing and reversing this troubling trend requires legislative, judicial, and regulatory action, including modifications of antitrust laws, or at least modifications of their specific application. But there are other policy reforms that can help to reduce hospital market consolidation, and thus to improve the cost, quality, and abundance of hospital services.[9] Such reforms include the repeal of local certificate of need laws and reforms of Medicare to provide for site-neutral payments and an end to the moratorium on physician-owned hospitals. The latter two reforms are discussed more specifically, below.

Lift the Federal Moratorium on Physician-Owned Hospitals

Section 6001 of the Affordable Care Act places an effective moratorium on participation in Medicare for new and expanded physician-owned hospitals (POH).[10] This prohibition is unjustified and should be repealed. Studies show that it unduly and needlessly limits competition and increases costs. For example, a recent literature review finds, among other things, that orthopedic and cardiac "focused factory" POHs offer consumers comparable or lower costs and higher quality care compared to other hospitals; patients with a wide range of serious conditions experience lower in-hospital and 30-day mortality rates in specialty POHs; patients with orthopedic

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[6] *https://www.nber.org/papers/w21031.*

[7] *https://www.actuary.org/sites/default/files/pdf/health/cdhp_may09.pdf.*

[8] *file:///C:/Users/DClancy/OneDrive%20-%20Stand%20Together/dean%20files/policy/hc/hc%20-%20payment%20-%20decentralized%20-%20tax%20-%20hsa/hsa%20-%20studies%20etc/HSA%20effect%202019%20PA%20study.pdf.*

[9] *https://www.heritage.org/health-care-reform/report/how-congress-can-help-reverse-hospital-market-consolidation.*

[10] *https://www.healthaffairs.org/do/10.1377/hblog20210408.980640/full/.*

conditions receive a greater number of conservative preoperative therapies prior to invasive procedures and experience shorter stays and lower risk-adjusted complication rates; general surgery POHs offer higher quality services compared to their competitors; and the cost and quality of general acute care POHs is not inferior to competitors.[11]

Move to Site-Neutral Payment in Medicare

Medicare payment structures are built around the kind of facility in which care is delivered, rather than how efficiently and effectively it is delivered. Congress should move to site-neutrality, so that the Medicare payment for a medical service is the same whether it is delivered in a physician's office, a clinic, or a hospital setting. The Centers for Medicare and Medicaid Services issued a rule to accomplish site-neutrality on a limited basis.[12] Congress should codify this site-neutrality policy and expand it to level the playing field among providers and remove the financial disabilities for medical professionals who would compete with hospital systems.

Modernize Medicare

Medicare is a popular but expensive and in critical ways outdated insurance product that fails to protect seniors from catastrophic costs and negatively distorts health-care markets. We can do better by America's elderly and disabled citizens. Reform need not be partisan or polarized. There are incremental reforms that modernize and strengthen Medicare to give seniors more freedom and better access to doctors and therapies at lower cost. Because the private, competitive Medicare Advantage option often offers superior service with extra benefits at no or low out-of-pocket cost, more than 43 percent of Medicare enrollees have voluntarily opted into it. To increase competition within Medicare, we believe all new Medicare enrollees should be auto-enrolled into an affordable Medicare Advantage plan in their area, with a right to opt into original, fee-for-service Medicare if they wish. To increase competition within the over-65 market more generally, we believe seniors should be allowed to choose private coverage in lieu of Medicare without penalty, with reasonable policies to govern how and when they can opt back in, if they wish. Senator Braun's Fair Care Act (S. 4796, 2020) includes a provision to do just that, as does Senator Cruz's Retirement Freedom Act (S. 275, H.R. 1166, 2021). We also endorse Representative Latta's Stop Penalizing Working Seniors Act (H.R. 5563, 2021), which enable seniors enrolled only in Medicare Part A to save for and pay out-of-pocket health-care costs, tax-free, through a personally owned and controlled Health Savings Account.

Make Medicaid Reform a National Priority

If there's something both sides of the aisle ought to be able to agree on, it's that we must eliminate waste in federal programs. Medicaid's improper payment rate has ballooned from 9 percent in 2018 to nearly 15 percent in 2019 and all the way to 21 percent in 2020—possibly as high as 25 percent. Officially, Medicaid wastes on the order of $70 billion a year—enough to pay for health care for 12 million adults or 3.6 million disabled Americans for an entire year.[13] Unofficially, the program probably wastes in excess of $100 billion a year. About 80 percent of these improper payments are due to payments to ineligible persons.[14] Meanwhile, the quality of care delivered by Medicaid has long been known to be inferior. Clearly, this broken program cries out for reform. Medicaid was never meant to be a middle-class entitlement that displaces private insurance options and busts the federal budget. It was meant to be a safety net. Congress should reform it to keep it focused on those who truly need help paying for health care. Congress should also help the working poor by using some of the money we currently spend on Medicaid as direct deposits into tax-free HSAs for low-income families.

Unleash the Potential of Telehealth

Telehealth technologies empower health professionals to remotely consult, diagnose, and treat patients without meeting in-person. Providers can safely and effectively deliver an array of health services through telehealth including primary care, mental health services, and emergency care. Patients can connect with health-care workers through a variety of telehealth technologies including video conference apps, re-

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[11] *https://www.mercatus.org/publications/healthcare/cost-and-quality-care-physician-owned-hospitals-systematic-review.*

[12] *https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf.*

[13] *https://thehill.com/blogs/congress-blog/healthcare/568825-medicaids-improper-payments-show-why-the-program-needs-reform.*

[14] *https://nypost.com/2020/11/28/medicaid-hemorrhaging-100b-on-americans-ineligible-for-the-program/.*

mote monitoring devices, instant messages, and audio phone calls. The pandemic has dramatically revealed how telemedicine can reduce costs and infections and ensure that people, especially in underserved rural and urban communities, can access health care in a timely manner. Prior to the COVID–19 pandemic, only 134,000 Medicare enrollees received virtual care every week. After the pandemic emergency reforms took effect, the number of enrollees receiving telehealth increased to 10.1 million, roughly one-third of all fee-for-service Medicare enrollees. Overall, Medicare enrollees purchased eight percent fewer primary care services between January and June 2020.[15] From February to December 2020, the number of telehealth services delivered to privately insured patients increased over 1,500 percent. As a share of all health-care services, virtual care increased from one percent to 21 percent during this period. Expanding access to telehealth lowers health-care spending by providing patients a low-cost alternative to expensive in-person care. The popular telehealth platform Teladoc reports the average telehealth consultation costs just $40. By comparison, the typical cost of an in-person primary care visit is $160. Virtual care also reduces costs by helping patients avoid expensive hospitalizations. Ascension Health, America's 2nd largest hospital system, found 60 percent of its telehealth patients would have visited an urgent care clinic or emergency room if they did not offer virtual care. This decreased costly outpatient services by 33 percent for Ascension's patients.[16] Unfortunately, these important reforms are limited to the COVID–19 public health emergency. As soon as state and federal officials declare the pandemic over, these harmful telehealth barriers will resume and patients will lose access to essential virtual care.

1. *Remove barriers on patient locations.* Under changes implemented by the CARES Act, CMS authorized health-care providers to deliver care to patients located in any zip code and setting, including their home.[17] Prior to this reform, patients could only receive telehealth services from select health-care facilities in rural areas.

2. *Remove barriers on provider locations.* Under the CARES Act, CMS announced that health-care practitioners can deliver telehealth from an expanded array of facilities, including Federally Qualified Health Centers, Rural Health Centers, and their own homes.[18]

3. *Expand the list of telehealth services.* Starting March 1, 2020, CMS announced that health professionals can deliver approximately 240 additional telehealth services to Medicare recipients, including mental health consultations, home health visits and emergency care.[19]

4. *Expand the list of telehealth providers.* Prior to COVID–19, federal law authorized only nine types of health-care providers to deliver telehealth services.[20] Fortunately, the agency expanded the list of telehealth provider-types to include all practitioners who are currently authorized to deliver in-person care to Medicare recipients, including physical therapists, occupational therapists, and speech language pathologists.[21]

5. *End technology restrictions on telehealth.* Under the Cares Act, CMS authorized practitioners to deliver telehealth through audio-only phone calls.[22] In addition, the Office for Civil Rights (OCR) issued guidance allowing health-care providers to deliver telehealth through any non-public facing telecommunication platform, including Zoom, Apple FaceTime, and Skype.[23]

6. *Allow telehealth across state lines.* Prior to COVID–19, federal law prohibited health-care practitioners from delivering telehealth to patients across state lines.[24] Fortunately, CMS issued a waiver allowing health-care providers to deliver tele-

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[15] *http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch14_sec.pdf?sfvrsn=0.*
[16] *https://connectwithcare.org/wp-content/uploads/2020/08/Ascension-Telehealth-Data.pdf.*
[17] *https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.*
[18] *https://www.cms.gov/files/document/covid-rural-health-clinics.pdf.*
[19] *https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes.*
[20] *https://www.law.cornell.edu/cfr/text/42/410.78.*
[21] *https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.*
[22] *https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf.*
[23] *https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.*
[24] *https://www.law.cornell.edu/cfr/text/42/410.78.*

health in States that explicitly authorize out-of-state providers to provide virtual care without an additional license.[25]

7. *Empower insurers to offer comprehensive telehealth coverage.* Before COVID–19, federal law prohibited insurers from waiving deductibles for telehealth services for individuals with high-deductible health plans (HDHPs). Fortunately, the CARES Act allows insurers to offer telehealth services free of deductibles for individuals covered by these plans.[26]

Examples of positive legislation in this area include Sen. Manchin's Protecting Rural Telehealth Access Act (S. 1988, 2021), Senator Tim Scott's Telehealth Modernization Act (S. 368, 2021), and Senator Schatz's CONNECT for Health Act of 2021 (S. 1512, 2021).

Allow Association Health Plans

Letting individuals and businesses band together to buy affordable coverage at group rates should be a no-brainer. Large businesses get such discounts, why not small businesses as well? Unfortunately, a federal court recently ruled that the U.S. Department of Labor does not have authority to clarify existing rules to permit AHPs federally. Therefore, congressional clarification is needed. Examples of good bills to do so include Senator Kennedy's Association Health Plans Act (S. 896, 2021) and Senator Paul's American Healthshare Plans Act (S. 3610, 2020).

Allow "Truth in Medicine"

The U.S. Food and Drug Administration imposes a speech restriction on drug manufacturers barring the sharing of scientific information with doctors about possible uses of drugs outside the current limits of the drugs' labeling—even when the information is truthful, non-misleading, and potentially life-saving. Congress should rescind this harmful gag rule.[27]

Speed Up FDA Drug Approvals

The pandemic and Operation Warp Speed have shown that a speedier FDA gets more life-saving drugs and medicines to people more quickly. It takes 10 to 15 years and $2.6 billion on average to bring a new drug to market.[28] Some drugs are approved in the United States only many years after they were approved overseas. Patients suffer and die needlessly. We can reduce this needless suffering and expense without harming patients by requiring FDA to recognize drugs and devices that have been approved by advanced countries we trust. Senator Cruz's RESULTs Act (S. 154, 2021) would do just that. Another excellent proposal is Senator Braun's Promising Pathway Act (S. 1644, 2021).

Improve Medicare Drug Coverage

There is bipartisan support for helping Medicare enrollee's deal with prescription drug costs by capping their total Part D out-of-pocket cost exposure and eliminating the infamous "donut hole" coverage gap. AFP supports these sensible reforms to help make prescription drugs more affordable.

Promote Generic Drug Competition

Robust generic competition is critical to ensuring that costly medications and therapies become affordable, without harmful government price controls or infringing the just rights of inventors. It's time to end pay-for-delay schemes, patent evergreening, and abuse of FDA citizen petitions. Good places to start include Senator Crapo's Lower Costs More Cures Act (H.R. 19, 2021)[29] and Senator Wyden's and Senator Grassley's Prescription Drug Price Reduction Act (S. 2543, 2019, and S. 4199, 2020).[30]

Legalize Drug Importation

Another way to put downward pressure on pharmaceutical costs is to legalize drug importation from abroad. The current restrictions on such importation unduly limit Americans' choices. While the pharmaceutical industry objects that such a reform would merely "import foreign price controls" into our country, it would actually put pressure on those countries to relax their price controls, which would be good for

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[25] *https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.*
[26] *https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf.*
[27] *https://goldwaterinstitute.org/free-speech-in-medicine/.*
[28] *https://www.phrma.org/policy-issues/research-development.*
[29] *https://republicans-energycommerce.house.gov/wp-content/uploads/2021/04/HR-19-Section-by-Section.pdf.*
[30] *https://www.finance.senate.gov/imo/media/doc/PDPRA%20Committee%20Report%20092519%20FINAL.pdf.*

everyone. Importation should be allowed for individuals and importers, and not just governments.

False Solution: Price Controls

America leads the world in access to breakthrough treatments, and Americans get the latest medicines before the rest of the world. That doesn't come cheap. This creates an unavoidable tradeoff between profitability and life-saving innovation. Allowing the government to set drug prices would only tilt that further away from innovation. In a December 2019 report, the White House Council of Economic Advisers estimated that H.R. 3 would reduce the pharmaceutical spending on research and development by $75 billion to $200 billion over the next decade. If price controls were to reduce R&D by $200 billion over the next 10 years, the CEA concluded, the industry will introduce as many as 100 fewer products over that period. Instead of 300 new drugs, Americans would see 200. According to the CEA, Americans would be less healthy and less economically productive. The $34.5 billion in annual savings that the federal government would realize from price controls would reduce annual economic output by $375 billion to $1 trillion, imposing a cost to society 10 to 30 times the federal savings.[31] Price controls have failed in other areas of the globe. In the European Union, price controls have led to drug shortages.[32] Meanwhile, while Americans enjoy access to 89 percent of new drugs, Canadians only have access to about half, because its government deems most new drugs "too expensive." Here's an example, In the United Kingdom, the National Institute for Health and Care Excellence or NICE has recommended that Tafamidis, an extremely costly drug (which in the U.S. costs about $250,000 a year, or $25,000 a year in out-of-pocket costs to a patient) not be covered at all: "The cost-effectiveness estimates are higher than what NICE normally considers an acceptable use of NHS resources."[33] The Canadian Drug Expert Committee, which makes reimbursement recommendations that provincial health plans use to determine whether they will cover a drug, determined a price reduction of more than 92 percent would be required for Tafamidis to be considered "cost-effective at a willingness-to-pay threshold of $50,000 per [quality-adjusted life-year]." A quality-adjusted life-year, or QALY, is a bureaucratic way to quantify the value of a human life in monetary terms and attempts to answer the question, "Is paying for this treatment a good use of taxpayer money?" Implicitly, this question disfavors patients who are sick, elderly, or disabled. A pharmaceutical company facing the prospect of foreign QALY boards setting prices for new drugs to treat rare diseases—in this case a 90 percent price cut or no coverage at all—is surely going to be loath to invest in future such efforts. Rather, it will prefer to tweak and repackage existing drugs that are already profitable. A Congressional Budget Office working paper finds that 60 fewer new cures would be approved if federal drug price controls like those proposed in the bill H.R. 3 were enacted.[34] A more recent analysis by economist Tomas Philipson of the University of Chicago finds that such price controls would lead up to a 60 percent reduction in drug company research and development from 2021 to 2039, resulting in 167 to 342 fewer new FDA approvals.[35] The upper end of that range (342 drugs) is more than half the total number of drugs approved by the FDA over the past 20 years (644 drugs).

Encourage Pro-Consumer State-Level Reforms

Not all reforms can be achieved solely at the federal level. Some require action by the States. The following state-level reforms are included in this discussion, not only for completeness, but because, in many cases, Congress can help support the States.

Liberate Direct Patient Care

Direct patient care, also known as direct primary care, is a great new option that lets patients pay a flat fee for unlimited access to a primary care doctor and preventive services, with no insurance-company middle man. It's like a monthly Netflix subscription to your most trusted doctors. AFP supports legislation to legalize DPC at the state level, and encourages Congress to enact federal legislation to allow people to use their tax-free HSA and HRA funds to pay for DPC subscriptions out-of-pocket.

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[31] *https://republicans-energycommerce.house.gov/news/in-the-news/100-fewer-lifesaving-drugs/.*

[32] *https://www.politico.eu/article/europe-still-coming-up-short-on-drug-supplies/.*

[33] *https://www.nice.org.uk/guidance/ta696/documents/final-appraisal-determination-document.*

[34] *https://www.cbo.gov/system/files/2021-08/57010-New-Drug-Development.pdf.*

[35] *https://cpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/d/3128/files/2021/08/Issue-Brief-Price-Controls-and-Drug-Innovation-Philipson.pdf.*

Strengthen Access to Short Term Renewable Health Plans

Short term renewable health insurance plans can be dramatically more affordable than traditional plans, up to 50 to 80 percent more affordable, because they are offer a streamlined, temporary option unburdened by excessive government mandates that drive up costs. While not a substitute for permanent coverage, these federally defined and state-regulated plans are an important option that everyone should have access to. About a dozen States have restricted them so severely, they are either unavailable or unaffordable. Five States have essentially outlawed them. Yet a recent study shows the only States where individual market premiums have increased since 2018 are the five that effectively prohibit these plans (California, Massachusetts, New Jersey, New York, and Rhode Island). Meanwhile, that States that allow short-term plans have lost fewer enrollees in the individual market, have had far more insurers offer coverage in the market, and have had larger premium reductions since 2018.[36] Those hostile laws should be repealed, and we encourage States to conform their policies to current federal policy, which allows a plan duration of up to 12 months and renewable for a total of 36 months. Congress, meanwhile, should codify that existing policy while also allowing tax-free HSA and HRA funds to be used for short term plans.

Liberate Hospitals to Expand and Compete

You shouldn't need a government permission slip or a political connection to provide a new medical service, purchase hospital equipment, or build a new facility. Local CON laws require government approval before private entities can do these things. Often, existing market participants have a veto over new entrants. Such protectionism harms patients and reduces the resilience we need to respond quickly to a crisis like COVID–19. A veritable mountain of studies and papers show that CON laws drive up costs and reduce quality, and that repealing them saves lives.[37] While Congress wisely repealed the federal CON law back in the 1980s, and thus has no cause for federal legislation in this area, it can and should provide oversight on the issue, as well as moral support for state-level efforts to end this harmful protectionism.

Let Nurses Deliver the Care They're Trained For

The nearly 80 million Americans who do not have sufficient access to a health-care provider would be served better if medical professionals like nurse practitioners were allowed to practice to the full extent of their education and training without having to pay a physician for the privilege. Senator Paul's Coronavirus Regulatory Repeal Act (S. 969, 2021) would make this and similar pandemic reforms permanent, while giving Congress and federal regulators a chance to carefully review and block changes that would not be in patients' best interest.

Let Doctors and Nurses Practice Across State Lines

The pandemic showed the vital importance of allowing doctors and nurses to care for out-of-state patients, including via telehealth. State and federal policies that effectively limit health-care professionals to practicing within the borders of a single state reduce consumer choice, interstate competition, and the quality of care. States should amend their laws to automatically recognize out-of-state health professional licenses. And while federal programs including Medicare should respect state jurisdiction and policy choices, such programs should be reformed where possible to facilitate interstate care delivery. For example, Congress should make permanent Medicare policies adopted during the pandemic that allow state-licensed doctors and nurses to treat patients in and from other States.

False Solution: Single-Payer

Some people believe the only way to get affordable care is for the government to provide it, or what they call a "public option" or "Medicare for All." But that approach has been tried many times, and the results are not encouraging. During the pandemic, we saw government failures that made it harder to get people the help they needed—things like providing testing kits that did not work, mask and ventilator shortages for frontline workers, and rigid state laws that kept hospitals from adding capacity and prevented doctors and nurses from going where they were needed. The bright spots of the pandemic—vaccines developed in record time, hospitals expanded overnight, nurses and doctors practicing across state lines, a telehealth revolution—came about because policymakers wisely removed unhelpful government

[36] *https://galen.org/2021/individual-health-insurance-markets-improving-in-states-that-fully-permit-short-term-plans-2/.*

[37] *https://www.mercatus.org/publications/corporate-welfare/certificate-need-laws.*

barriers. Peoples in countries with a single-payer system typically experience shortages and bureaucratic rationing. Access to a waiting list is not access to care. In Canada, where private health insurance is effectively outlawed, health care is "free," yet patients pay for it in other ways.[38] For example, Canadians receive fewer cancer screenings than Americans do[39] and have higher mortality rates for certain cancers.[40] The median wait time in Canada for an MRI scan is more than two months—to be treated by a specialist, more than five months.[41] And while Americans enjoy access to 89 percent of new drugs,[42] Canadians have access to only 44 percent—Greeks and Spaniards, a mere 14 percent—because their governments deem most new drugs "too expensive."[43] In these systems, people end up paying for their "free" care by being forced to endure needless suffering, lost income, and preventable death. Realistically, a national single-payer program like that proposed by Senator Sanders ("Medicare for All") would mean significantly higher taxes for American families and significantly less access to needed therapies. In fact, the Congressional Budget Office estimates it would increase federal spending by more than $32 trillion over the first ten years.[44] Unlike the false promise of "Medicare for All," consumer-driven reforms like these would make health care in our state even better and more affordable for all.

Conclusion

Our system needs reforms. But overall it is a good system. Americans enjoy superior quality and access, and something like universal coverage, and most are satisfied with their current coverage and not looking for a radical overhaul. Instead of further expanding government health insurance programs, Congress should enact a personal option for health care that enables us to fix what's broken in our system while preserving what works. A personal option will give the American people the choice and control they want, with the quality they deserve, at prices they can afford, from the medical professionals they trust. We stand ready to help you achieve this exciting vision.

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Statement of Michael G. Bindner

Chairman Grassley and Ranking Member Wyden, thank you for the opportunity to submit our comments. With a new Administration in the White House, the context for reform has changed. Whether what the witnesses will tell you has changed will be determined at the hearing. I am quite sure that none will provide exactly the same options as below.

What we all agree on is that the system is fragmented. Unless Congress abolishes the Veterans Health Administration (Tricare), the Federal Employees Health Benefit Plan and the Postal Service plan, it will stay that way. Even Medicare for All will not stand alone, given the political realities. Unless coverage is extended to undocumented workers, there will be leakages in the system. I will focus on future options and leave further description of the gory details to the invited witnesses.

Adding coverage of undocumented workers fills the major gap in coverage which produces cost shifting. Higher co-pays under the Affordable Care Act Silver Plan also cause bills to be unpaid. Families who cannot afford higher options (largely because subsidies are inadequate) cannot afford medical bills at all. The ending of mandates widened the gaps in the system.

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[38] *https://www.encounterbooks.com/features/sally-c-pipes-on-the-false-promise-of-single-payer-healthcare/.*
[39] *https://www.thecentersquare.com/opinion/op-ed-health-care-a-personal-option-vs-the-public-option/article_c11a65e6-0a4f-11eb-b268-5f4c8d38b20f.html.*
[40] *https://www.cdc.gov/cancer/dcpc/research/index.htm.*
[41] *https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2019.*
[42] *https://www.nationalreview.com/2020/08/canadian-single-payer-health-care-system-slow-inefficient/.*
[43] *https://galen.org/2019/examination-of-international-drug-pricing-policies-in-selected-countries-shows-prevalent-government-control-over-pricing-and-restrictions-on-access/.*
[44] *https://economics21.org/medicare-for-all-winners-and-losers.*

State contributions to Medicaid, plus the supposed drain of pension costs for their employees, are a continuing source of concern.

The former can be remedied by splitting Medicaid into two pots, one for the elderly and disabled and one for the unemployed and the working poor. The first pot can then be transferred to CMMS as Medicare Part E. As detailed in the first attachment, Medicare for All essentially turns all of Medicare into what is now Medicaid. Part E would be a good step in that direction.

As an aside, the push to advance fund pension costs for State governments and USPS is not driven by necessity. It is driven by the financial sector's desire to sell retirement funds to employees, thus earning higher commissions than the current system. The fact that one part of the financial sector insists on full funding while another sells the likely result of this myth has given us the current retirement income crisis most people face.

The majority of workers have incomes too low to save much, regardless of how easy (or automatic) enrollment is made. Until the minimum wage is increased, the refundable child tax credit is passed (and doubled again—and even again), there is no room for consideration of subsidies for increased saving.

The second way to relieve state budgets can be accomplished in one of two ways. Option A is to enroll the unemployed and those in ESL, remedial and higher educational, rehabilitative and job programs into the health plan of the service provider and then raise the reimbursement amounts for any programs delivered through the private sector to include these costs. ESL training would be available regardless of immigration status.

Option B is the Public Option rejected when the Affordable Care Act was debated. Those who opposed it left Congress anyway—which should be a lesson to "moderate" Senators. The President has proposed trying to pass it again. Along with Medicare Part E, this is the best option for now for an increased federal role.

As described in the first attachment, for passage to occur we would have to give something to get something. In this case, higher broad based taxes and ending preexisting condition reforms would be that price. Those who are denied coverage would be automatically enrolled in the Public Option, which would be more heavily subsidized than currently proposed. The Public Option would also include anyone left in Medicaid not transferred to Medicare Part E. Under this plan, all subsidies would be federal and would be much more generous.

The desire for greater profit, which is inherent in our economic system (people get upset when I simply call it Capitalism), will lead employers and insurance companies alike to exclude an ever growing share of the workforce until the Public Option has become what is essentially Medicare for All.

Pay it now, or pay it later. Either way, there will be a transition as the finances are worked out.

This need not take long if health-care reform is combined with tax reform. Payroll tax funding is a non-starter. Transferring costs to higher income taxpayers ala the Affordable Care Act is not viable either. The combination of the two is essentially some form of value added tax.

Our tax reform plan provides a menu of such taxes, including a straight up goods and services tax, an asset value-added tax (which is a transaction-based form of the ACA tax structure, dividend, interest and capital gains taxes) and a subtraction VAT. These are described more fully in the second attachment.

The residual income surtax proposed would be dedicated to paying down the National Debt. This should be a major selling point for those who pay higher income taxes (but not high enough) and who also own the vast majority of the debt held in mutual funds and directly held bonds. The music must stop eventually, probably sooner than later. Starting now is best.

A goods and services tax means everyone pays, including wealthier retirees attempting to dodge taxation through tax free savings accounts, life insurance policies—which can be borrowed from or used to transfer intergenerational wealth, trusts and, for those who are new to wealth, borrowing from their financial assets.

A GST, or Invoice VAT, is broad based and border adjustable. It is good for workers and would be part of any comprehensive tax reform that includes taking most households—indeed, almost all households—off the income tax rolls.

An asset VAT will raise money, but the pool of money raised will decrease given the proposed zero rating for ESOP sales, as well as the loss in trading volume such a tax would bring on. Higher income surtaxes would also decrease the money available for speculation by higher income receivers (I will not call them earners—their high compensation often results in cutting everyone else's pay).

Subtraction VAT funding would be used to the extent that private insurance survives. As is currently the case, there would be a tax exclusion—or even a credit—for providing health insurance to employees. As described below, employee-owned firms could provide direct services rather than third party care. As this sector expands, the need for mandated insurance would simply end (as would outside financing for employee borrowing).

The last option, although similar to the current funding system for "first world" employees, would also be the eventual long term solution to funding gaps.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment One—Hearing on Pathways to Universal Health Coverage, June 12, 2019

There are three methods to get to single-payer: a public option, Medicare for All and single-payer with an option for cooperative employers.

The first to set up a **public option** and end protections for pre-existing conditions and mandates. The public option would then cover all families who are rejected for either pre-existing conditions or the inability to pay. In essence, this is an expansion of Medicaid to everyone with a pre-existing condition. As such, it would be funded through increased taxation, which will be addressed below. A variation is the expansion of the Uniformed Public Health Service to treat such individuals and their families.

The public option is inherently unstable over the long term. The profit motive will ultimately make the exclusion pool grow until private insurance would no longer be justified, leading-again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick. This eventually becomes Medicare for All, but with easier passage and sudden adoption as private health plans are either banned or become bankrupt. Single-payer would then be what occurs when

The second option is Medicare for All, which I described in an attachment to June 18th and 19th's comments and previously in hearings held May 8, 2019 (Finance) and May 8, 2018 (Ways and Means). Medicare for All is essentially Medicaid for All without the smell of welfare and with providers reimbursed at Medicare levels, with the difference funded by tax revenue.

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs saying, "don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund), Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management. Much of this is now managed care, as is Medicare Advantage (Part C).

Medicaid lingers in the background and the foreground. It covers the disabled in their first two years (and probably while they are seeking disability and unable to work). It covers non-workers and the working poor (who are too poor for Obamacare) and it covers seniors and the disabled who are confined to a long-term care facility and who have run out their assets. It also has the long-term portion which should be federalized, but for the poor, it takes the form of an HMO, but with no premiums and zero copays.

Obamacare has premiums with income-based supports (one of those facts the Republicans hate) and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a

standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan.

Either Medicare for All or a real single payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value-added tax (so it would not appear on receipts nor would it be zero rated at the border, since there would be no evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All and leave it alone.

The third option is an **exclusion for employers,** especially employee-owned and cooperative firms, who provide medical care directly to their employees without third party insurance, with the employer making HMO-like arrangements with local hospitals and medical practices for inpatient and specialist care.

Employer-based taxes, such as a subtraction VAT or payroll tax, will provide an incentive to avoid these taxes by providing such care. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid or Medicare for All. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates.

This proposal is probably the most promising way to arrest health-care costs from their current upward spiral—as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. The employee-ownership must ultimately expand to most of the economy as an alternative to capitalism, which is also unstable as income concentration becomes obvious to all.

The key to any single-payer option is securing a funding stream. While payroll taxes are the standard suggestion, there are problems with progressivity if such taxes are capped and because profit remains untaxed, which requires the difference be subsidized through higher income taxes. For this reason, funding should come through some form of value-added tax. Our revised tax reform plan can be found in Attachment Two.

Attachment Two—Tax Reform, Center for Fiscal Equity, March 5, 2021

Individual payroll taxes. These are optional taxes for Old-Age and Survivors Insurance after age 60 for widows or 62 for retirees. We say optional because the collection of these taxes occurs if an income sensitive retirement income is deemed necessary for program acceptance. Higher incomes for most seniors would result if an employer contribution funded by the Subtraction VAT described below were credited on an equal dollar basis to all workers. If employee taxes are retained, the ceiling should be lowered to $85,000 to reduce benefits paid to wealthier individuals and a $16,000 floor should be established so that Earned Income Tax Credits are no longer needed. Subsidies for single workers should be abandoned in favor of radically higher minimum wages.

Wage Surtaxes. Individual income taxes on salaries, which exclude business taxes, above an individual standard deduction of $85,000 per year, will range from 6.5% to 26%. This tax will fund net interest on the debt (which will no longer be rolled over into new borrowing), redemption of the Social Security Trust Fund, strategic, sea and non-continental U.S. military deployments, veterans' health benefits as the result of battlefield injuries, including mental health and addiction and eventual debt reduction. Transferring OASDI employer funding from existing payroll taxes would increase the rate but would allow it to decline over time. So would peace.

Asset Value-Added Tax (A–VAT). A replacement for capital gains taxes, dividend taxes, and the estate tax. It will apply to asset sales, dividend distributions, exercised options, rental income, inherited and gifted assets and the profits from short sales. Tax payments for option exercises and inherited assets will be reset, with prior tax payments for that asset eliminated so that the seller gets no benefit from them. In this perspective, it is the owner's increase in value that is taxed. As with any sale of liquid or real assets, sales to a qualified broad-based Employee Stock

Ownership Plan will be tax-free. These taxes will fund the same spending items as income or S–VAT surtaxes.

This tax will end Tax Gap issues owed by high-income individuals. A 26% rate is between the GOP 24% rate (including ACA–SM and Pease surtaxes) and the Democratic 28% rate. It's time to quit playing football with tax rates to attract side bets. A single rate also stops gaming forms of ownership. Lower rates are not as regressive as they seem. Only the wealthy have capital gains in any significant amount. The de facto rate for everyone else is zero.

Subtraction Value-Added Tax (S–VAT). These are employer paid Net Business Receipts Taxes. S–VAT is a vehicle for tax benefits, including

- Health insurance or direct care, including veterans' health care for non-battlefield injuries and long-term care.
- Employer-paid educational costs in lieu of taxes are provided as either employee-directed contributions to the public or private unionized school of their choice or direct tuition payments for employee children or for workers (including ESL and remedial skills). Wages will be paid to students to meet opportunity costs.
- Most importantly, a refundable child tax credit at median income levels (with inflation adjustments) distributed with pay.

Subsistence-level benefits force the poor into servile labor. Wages and benefits must be high enough to provide justice and human dignity. This allows the ending of state administered subsidy programs and discourages abortions, and as such enactment must be scored as a must pass in voting rankings by pro-life organizations (and feminist organizations as well). To assure child subsidies are distributed, S–VAT will not be border adjustable.

The S–VAT is also used for personal accounts in Social Security, provided that these accounts are insured through an insurance fund for all such accounts, that accounts go toward employee ownership rather than for a subsidy for the investment industry. Both employers and employees must consent to a shift to these accounts, which will occur if corporate democracy in existing ESOPs is given a thorough test. So far it has not. S–VAT funded retirement accounts will be equal-dollar credited for every worker. They also have the advantage of drawing on both payroll and profit, making it less regressive.

A multi-tier S–VAT could replace income surtaxes in the same range. Some will use corporations to avoid these taxes, but that corporation would then pay all invoice and subtraction VAT payments (which would distribute tax benefits. Distributions from such corporations will be considered salary, not dividends.

Invoice Value-Added Tax (I–VAT). Border adjustable taxes will appear on purchase invoices. The rate varies according to what is being financed. If Medicare for All does not contain offsets for employers who fund their own medical personnel or for personal retirement accounts, both of which would otherwise be funded by an S–VAT, then they would be funded by the I–VAT to take advantage of border adjustability. I–VAT also forces everyone, from the working poor to the beneficiaries of inherited wealth, to pay taxes and share in the cost of government. Enactment of both the A–VAT and I–VAT ends the need for capital gains and inheritance taxes (apart from any initial payout). This tax would take care of the low-income Tax Gap.

I–VAT will fund domestic discretionary spending, equal dollar employer OASI contributions, and non-nuclear, non-deployed military spending, possibly on a regional basis. Regional I–VAT would both require a constitutional amendment to change the requirement that all excises be national and to discourage unnecessary spending, especially when allocated for electoral reasons rather than program needs. The latter could also be funded by the asset VAT (decreasing the rate by from 19.5% to 13%).

As part of enactment, gross wages will be reduced to take into account the shift to S–VAT and I–VAT, however net income will be increased by the same percentage as the I–VAT. Adoption of S–VAT and I–VAT will replace pass-through and proprietary business and corporate income taxes.

Carbon Added Tax (CAT). A Carbon tax with receipt visibility, which allows comparison shopping based on carbon content, even if it means a more expensive item with lower carbon is purchased. C–VAT would also replace fuel taxes. It will fund transportation costs, including mass transit, and research into alternative fuels (including fusion). This tax would not be border adjustable unless it is in other nations, however in this case the imposition of this tax at the border will be noted, with the U.S. tax applied to the overseas base..

Tax Reform Summary

This plan can be summarized as a list of specific actions:

1. Increase the standard deduction to workers making salaried income of $425,001 and over, shifting business filing to a separate tax on employers and eliminating all credits and deductions—starting at 6.5%, going up to 26%, in $85,000 brackets.

2. Shift special rate taxes on capital income and gains from the income tax to an asset VAT. Expand the exclusion for sales to an ESOP to cooperatives and include sales of common and preferred stock. Mark option exercise and the first sale after inheritance, gift or donation to market.

3. End personal filing for incomes under $425,000.

4. Employers distribute the child tax credit with wages as an offset to their quarterly tax filing (ending annual filings).

5. Employers collect and pay lower tier income taxes, starting at $85,000 at 6.5%, with an increase to 13% for all salary payments over $170,000 going up 6.5% for every $85,000 up to $340,000.

6. Shift payment of HI, DI, SM (ACA) payroll taxes to consumers or employers, remove caps on employer payroll taxes and credit them to workers on an equal dollar basis.

7. Employer paid taxes could as easily be called a subtraction VAT, abolishing corporate income taxes. These should not be zero rated at the border.

8. Expand current state/federal intergovernmental subtraction VAT to a full GST with limited exclusions (food would be taxed) and add a federal portion, which would also be collected by the States. Make these taxes zero rated at the border. Rate should be 19.5% and replace employer OASI contributions. Credit workers on an equal dollar basis.

9. Change employee OASI from 5% to 6.5% from $18,000 to $85,000 income. This change is necessitated by decreased gross pay.

Video Link Statement to the committee sent separately: *https://www.youtube.com/watch?v=IQmc0Mey9_Q*.

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October 19, 2021

Senator Ron Wyden
Chairman

Senator Mike Crapo
Ranking Member

U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Dear Senator Wyden, Senator Crapo, and distinguished members of the Senate Committee on Finance,

Consumers for Affordable Health Care (CAHC) is designated by Maine's Attorney General and the Bureau of Insurance as Maine's Health Insurance Consumer Assistance Program. We operate a statewide toll-free confidential HelpLine staffed by trained experts who provide assistance to Mainers in understanding their health coverage options and enrolling in and applying for private Marketplace and public health insurance coverage.

Consumer Assistance Program staff provide training to and work closely with other organizations involved in getting the word out about coverage options, including Maine hospitals, community health centers, community action programs and social service organizations. We also work closely with organizations serving communities that experience racial and ethnic disparities in accessing the health coverage and

care they need, including for example, Maine Access Immigrant Network, Wabanaki Public Health, and New Mainers Public Health Initiative. The outreach, education and enrollment work we are engaged in is, in part, where we often hear about Mainers who are benefiting from health coverage programs, in particular, the Affordable Care Act (ACA) and the increase in subsidies created by the American Rescue Plan Act (ARPA), as well as Medicaid expansion.

As the committee and other congressional policymakers discuss the nation's budget reconciliation, we thought it would be helpful for you to hear about Mainers who are benefiting from the initiatives described above. People who have more affordable options because of the ACA and ARPA. Monthly premium rates have decreased for tens of thousands of Mainers and we have talked with many people over the past several months who have looked into and enrolled in Marketplace coverage as a result.[1] Here are examples of Maine people who have found affordable plans and are now able to access the health care and prescription medicine they need:

- **Pete R. who lives in Penobscot County.** Pete has diabetes and is not offered coverage through his work at an auto repair shop. His gross income is about $31,000 annually. He was uninsured until recently when he learned about increased monthly subsidies and enrolled in an affordable Marketplace plan. He is now able to get the health care and medications he needs to treat his diabetes at a cost he can afford.
- **Debra B. who lives Franklin County.** Debra became uninsured when she lost her job after the explosion at the Jay Paper Mill in 2020. She could not afford her $350/month premium, but now, because of the ARPA increase in subsidies and the extended Marketplace open enrollment, she has coverage and is able to access the health care she needs until she can find another job with health insurance.
- **Alfred H. is a lobsterman who lives in Washington County.** He was uninsured until recently and sometimes skipped the treatment or medication he needs to manage his chronic conditions because of the cost. His wife has coverage through work, but her employer does not offer family coverage. Now that the American Rescue Plan Act increased monthly subsidies, Alfred has coverage he can afford and is able to better manage his diabetes and heart condition.
- **Julie G. lives in western Cumberland County.** She previously worked at a community health center, helping people enroll in Marketplace coverage, until she found she needed help herself after becoming disabled. Thanks to American Rescue Plan Act and the increase in subsidies, she and her husband can enroll in a plan they can afford.
- **Mohamud H. lives in Cumberland County.** He works every day to help address the needs of refugee and asylee new Mainers. Once a new Mainer himself, Mohamud now has affordable health coverage through the Marketplace. The coverage enables him to remain healthy as he works to ensure equal access to programs and services other New Mainers from Africa and the Middle East need as they live, raise families and work in Maine.
- **Tom A. lives in Oxford County.** Tom was laid off from his job at a small business due to COVID. He was receiving Unemployment Insurance when he signed up for a Marketplace plan this past March. After struggling to pay his monthly premium of over $318 a month, he was able to access the increased subsidies under ARPA to lower his premium down to $2.36/month.
- **Maia S. lives in Kennebec County.** Maia was on her mother's coverage until her mom changed jobs and was no longer offered family coverage. Maia was not offered coverage through her work as a mental health rehabilitation technician and is now enrolled in MaineCare (Medicaid in Maine), through expansion. The coverage is helping her access the mental health and other health care she needs as she attends classes at the University of Maine at Augusta.

These are just a few of the people in Maine who are able to access the affordable comprehensive health coverage they need through the Marketplace and the Affordable Care Act's expanded Medicaid.

If we have learned anything from the pandemic, it is how important it is for people to have access to affordable health coverage and care. The high cost of coverage un-

[1] CMS, 2021 Final Marketplace Special Enrollment Period Report, *https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.*

dermines the ability to access health care and control the pandemic to the best possible extent.

The ability of Mainers to purchase affordable coverage is also important to health-care providers in Maine, including our community health centers, mental health clinics and hospitals, especially in rural areas where health-care providers struggle to retain staff and keep their doors open.

We urge you to support a budget reconciliation that extends and makes permanent health coverage affordability provisions that Mainers and other Americans are relying on and that will improve access to the health care and medicine they need.

Sincerely,

Ann L. Woloson
Executive Director

Cc: Senator Debbie Stabenow
Senator Chuck Grassley
Senator Maria Cantwell
Senator John Cornyn
Senator John Thune
Senator Robert Menendez
Senator Thomas R. Carper
Senator Richard Burr
Senator Patrick J. Toomey
Senator Benjamin L. Cardin
Senator Rob Portman
Senator Sherrod Brown
Senator Michael F. Bennet
Senator Bob Casey
Senator Tim Scott
Senator Bill Cassidy
Senator James Lankford
Senator Steve Daines
Senator Todd Young
Senator Ben Sasse
Senator John Barrasso
Senator Mark R. Warner
Senator Sheldon Whitehouse
Senator Maggie Hassan
Senator Catherine Cortez Masto
Senator Elizabeth Warren
Senator Angus King
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November 2, 2021

Chairman Wyden, Ranking Member Crapo, and Members of the Senate Committee on Finance, thank you for the opportunity to submit this statement for the record.

The First Focus Campaign for Children is a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions. Our organization is committed to ensuring that all our nation's children have equal opportunity to reach their full potential.

The Status of Children's Health:

The number of U.S. children without health insurance rose in 2020 for the fourth year in a row as the coronavirus pandemic tore through the country.

Nearly 4.3 million children—or 5.6% of all U.S. children—did not have health insurance in 2020, according to new data from the U.S. Census Bureau, a 7% rise over 2019.[1]

Children of color were hit hardest, the data suggests, with 9.5% of Hispanic children lacking health insurance. Black children lack health insurance at a rate of 6%, while less than 4% of white children and less than 3% of Asian children lack health insurance.

Children in the South have the highest uninsurance rate, at 7.7%. The rate of children without insurance is more than twice as high in States that have not expanded Medicaid, at 8.5% of children.

The numbers come as pediatric hospitalizations for COVID–19 surge. As of October 28th, over 6.3 million children have tested positive for COVID–19 since the onset of the pandemic, according to the American Academy of Pediatrics, with more than 100,000 cases added in the past week.[2]

There are bills before Congress now that will improve the health and outcomes of children, some detailed below, and additional bills could be introduced to help create an equitable health system for children.

Children's Health Insurance Program (CHIP) Permanency

Enacting legislation to make the popular and successful Children's Health Insurance Program (CHIP) permanent ensures that the children and pregnant people who receive health insurance through CHIP will never again worry about their coverage expiring mid-year or mid-treatment. As you know, CHIP funding expired on September 30, 2017, and CHIP was not fully funded again until January 2018. For months States made contingency plans for CHIP's possible demise, advocates and lawmakers worked to extend funding, and families across the country received disenrollment notices as they faced an uncertain future about their children's health care. Never again should a family feel the fear and worry of whether their child will have health coverage. Enactment of legislation to make CHIP permanent would ensure that the health coverage of children is no longer subjected to arbitrary deadlines and funding cliffs that lead to chaos, distress, and anxiety for families across this country.

For almost 25 years, CHIP has been an essential source of children's coverage, ensuring access to high-quality, affordable, pediatric-appropriate health care for children in working families whose parents earn too much to qualify for Medicaid but too little to purchase private health insurance on their own. CHIP has played a critical role in reducing the number of uninsured children by more than 68 percent, from an uninsurance rate of nearly 15 percent in 1997 to less than five percent in 2016, while improving health outcomes and access to care for children and pregnant women. CHIP, together with Medicaid, plays a particularly important role for children of color: in 2019 more than half of American Indian/Alaska Native, Black, multi-racial, and Hispanic children relied on Medicaid and CHIP as their source of health coverage. Since 2017, uninsurance rates for children have risen a full percentage point to 5.7 percent. Around 726,000 children lost coverage between 2016 and 2019—even before our country began facing a devastating pandemic that has left more than 28 million Americans infected with COVID–19, including more than six million children. As we work to reverse course and get all eligible children covered, making CHIP permanent is critical so families, medical providers, and governors can depend on it to always be there. By making CHIP permanent, the recurrent funding dilemma would be eliminated, allowing States to develop their programs in ways that best serve children and families. Finally, the public health emergency that has devastated our nation for nearly two years should make clear that comprehensive, affordable health coverage that is reliable is essential. Ensuring CHIP's future as the critical part of the health insurance system for children that it is must be a priority. To never again wonder about CHIP's future would allow lawmakers, federal and state health departments, advocates, pediatricians, and other providers to be entirely focused and attentive to the emergencies at hand—ending the COVID–19 pandemic, addressing our nation's shameful maternal and infant mortality crises, and eliminating health disparities and promoting health

[1] Katherine Keisler-Starkey and Lisa N. Bunch, U.S. Census Bureau Current Population Reports, P60–274, Health Insurance Coverage in the United States: 2020, U.S. Government Publishing Office, Washington, DC, September 2021.

[2] Children and COVID–19: State Data Report. American Academy of Pediatrics and the Children's Hospital Association, October 28, 2021, *https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state-level-data-report/*.

equity. Swift passage of legislation to make CHIP permanent will ensure that never again will we divert any attention away from improving child and maternal health outcomes to prepare for contingency planning for the possible temporary expiration or end of CHIP.

Health Coverage for Children in Immigrant Families

All children should have access to health care, regardless of their immigration status. The COVID–19 pandemic has made clear that we are all connected, that children have been impacted by the public health and economic crises, and that every child and family needs support to recover. Congress must eliminate structural barriers in our immigration system and other systems to protect all children's healthy development, including the five-year waiting period for those with legal permanent status to access certain federal programs and determinations of public charge for children.

The Health Equity and Access under the Law for Immigrant Families Act of 2021 or the HEAL for Immigrant Families Act of 2021 (S. 1660) would help improve access to health care for children in immigrant families. Specifically, it would eliminate the requirement for a five-year waiting period for immigrants to enroll in Medicaid and CHIP, restore full-benefit enrollment in Medicaid and CHIP to all eligible, federally authorized immigrants by eliminating the outdated list of "qualified" immigrants, and ensure that all individuals with federally authorized presence, including Deferred Action for Childhood Arrivals (DACA), are eligible for federally funded health-care programs. Additionally, the Lifting Immigrant Families through Benefits Access Restoration (BAR) Act of 2021 (H.R. 5227) would eliminate the five-year bar and other restrictions on immigrants' access to federal means-tested benefit programs—such as Medicaid, SNAP, Temporary Assistance for Needy Families (TANF), and Supplemental Security Income (SSI). These pieces of legislation should be passed and implemented to ensure equal access to health care.

Pass 12-Month Continuous Eligibility for Children in Medicaid and CHIP

Children in low-income families need to be continuously covered under Medicaid or CHIP for a full year. While families may experience some income fluctuation, their income does not change substantially or for the long-term. Keeping children covered leads to improved health status and well-being, promotes health equity, and alleviates the impact of seasonal work, overtime, and variable work hours on low income families. For States, continuous coverage for twelve months reduces administrative costs and labor while helping to promote more efficient health-care spending. When children with chronic conditions have consistent access to medications and their medical home, and when all children can access care when needed without interruptions, health-care costs go down.[3]

Continuous Eligibility from Birth to Age Six

States should be allowed to cover children from birth to age six with continuous coverage on Medicaid or CHIP. As their brains grow and develop and before they are enrolled in regular, full-time school, we need to ensure continuous health coverage for all children. The American Academy of Pediatrics recommends babies get check-ups at birth, three-to-five days after birth, and then at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months.[4] Babies may receive referrals for additional assessment and treatment from specialists and other providers during or between any of these appointments. It is essential parents and medical providers know their child's primary care and any referrals are covered during this significant time in a child's development.

A critical aspect of well-child exams during the first five years includes developmental, behavioral, and psychosocial screenings. If these screenings are missed or interrupted due to lack of coverage, that can delay needed assessments and necessary early interventions. If a child with a delay or suspected delay is not identified in an early well-child check-up they will have to wait until someone identifies this in school.[5] If a child is not identified until school age, they could have significant delays and might have lost many opportunities for early interventions. This could cause undue harm and suffering to the child and family and increase costs later.

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[3] Brooks, Tricia and Allexa Gardner, "Continuous Coverage in Medicaid and CHIP," Georgetown University Health Policy Institute, Center for Children and Families, July 2021, *https://ccf.georgetown.edu/wp-content/uploads/2021/07/Continuous-Coverage-Medicaid-CHIP-final.pdf*.

[4] "Recommendations for Preventive Pediatric Health Care," American Academy of Pediatrics, last updated February 2017, *https://www.aap.org/en-us/documents/periodicity—schedule.pdf*.

[5] "Developmental Monitoring and Screening," Centers for Disease Control and Prevention, last visited 23, February 2018, *https://www.cdc.gov/ncbddd/childdevelopment/screening.html*.

Continuous coverage during the first 5 years of life would help ensure children see medical providers regularly and receive appropriate care and referrals on time. As Congress weighs the provision to require States to maintain coverage for children for twelve months at a time without churning on and off CHIP or Medicaid, we suggest a broader view of coverage for the youngest children with continuous coverage from birth to age 6.

12-Month Coverage for Postpartum Mothers

More than 700 women die each year in this country due to pregnancy or delivery, a rate higher than nearly all other developed countries, and 60% of these deaths are preventable.[6] Our rates of maternal death are rising—the rate in 2019 was significantly higher than in 2018.[7,8] The United States has an infant mortality rate that ranks 33rd out of the 37 Organization for Economic Cooperation and Development member countries.[9] And the statistics are significantly worse for Black women and infants compared to their white peers. In 2019, the maternal mortality rate for Black women was 2.5 times higher than that of white women and 3.5 times higher than that of Hispanic women.[10]

Medicaid coverage is an important piece of reducing maternal mortality rates, and it varies greatly between States. Coverage is higher and uninsured rates are lower for pregnant and postpartum women in States that have expanded Medicaid coverage.[11] Approximately half of all uninsured new mothers reported that losing Medicaid or other coverage after pregnancy was the reason they were uninsured.[12] And the decline in infant mortality rates is 50% greater in Medicaid expansion States than in non-expansion States and includes a significant reduction in racial disparities.[13] Numerous stakeholders have advocated for a 12-month expansion of postpartum Medicaid coverage in recent years, and COVID–19-related legislation passed in 2020 has begun to make progress toward that goal. The Families First Coronavirus Recovery Act included a requirement of continuous coverage for Medicaid enrollees through the end of the public health emergency, including for pregnant women. The American Rescue Plan included a time-limited, five-year state option for postpartum coverage of up to 12 months, well over the 60 days now required. And in the Centers for Medicare and Medicaid Services (CMS) has approved several state waiver requests to extend postpartum coverage to 12 months. We support efforts in Congress to make permanent the extension of Medicaid benefits to 12 months of postpartum care.

Improve ACA Affordability by Eliminating the "Family Glitch"

The ACA offers tax credits to make private, employer-sponsored health insurance more affordable for working families. The law bases eligibility determinations on a comparison of the cost of the insurance and the family's income. However, the Treasury Department's regulations implementing that provision of the ACA base that assessment on the cost of insuring the employee alone, instead of the cost of family coverage. While individual-only employer-sponsored health insurance pre-

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[6] Building U.S. Capacity to Review and Prevent Maternal Deaths. (2018). Report from nine maternal mortality review committees. Available at: *https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf.*

[7] Centers for Disease Control and Prevention, Pregnancy-Related Deaths. Available at: *https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm.*

[8] Hoyert DL. Maternal mortality rates in the United States, 2019. NCHS Health E-Stats. 2021. DOI: *https://doi.org/10.15620/cdc:103855externalicon.*

[9] United Health Foundation. (2020). *America's Health Rankings, Annual Report, https://assets.americashealthrankings.org/app/uploads/annual20-rev-complete.pdf.*

[10] Hoyert DL. Maternal mortality rates in the United States, 2019. NCHS Health E-Stats. 2021. DOI: *https://doi.org/10.15620/cdc:103855externalicon.*

[11] Ranji, Usha, Ivette Gomez, and Alina Salganicoff, "Expanding Postpartum Medicaid Coverage," KFF, March 9, 2021, *https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/*.

[12] Urban Institute. Uninsured New Mothers' Health and Health Care Challenges Highlight the Benefits of Increasing Postpartum Medicaid Coverage. May 28, 2020. Available at: *https://www.urban.org/research/publication/uninsured-new-mothers-health-and-health-care-challenges highlight-benefits-increasing-postpartum-medicaid-coverage.*

[13] Searing, Adam and Donna Cohen Ross, "Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies," Georgetown University Center for Children and Families, May 2019, *https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf.*

miums average around $7,470 a year, annual premiums for family coverage average $21,342—nearly triple.[14]

Over 5 million people fall into the ACA family glitch, and the vast majority (4.4 million people or 85%) are currently enrolled through employer-sponsored health insurance.[15] These families likely spend far more for health insurance coverage than individuals with similar incomes eligible for financial assistance on the ACA Marketplaces and could spend less on premiums if they could enroll in Marketplace plans and qualify for subsidies. One study estimated that those impacted by the family glitch are spending on average 15.8% of their incomes on employer-based coverage.[16]

If not clarified by the Administration or changed through legislation, this interpretation will continue to leave millions of children as well as their non-employee parents ineligible for tax credits or subsidized coverage in the ACA Marketplaces. Over half of those who fall in the ACA family glitch (about 2.8 million people) are children under the age of 18. These are children who do not qualify for the Children's Health Insurance Program (CHIP). About 500,00 people in the family glitch are ages 18-26. The ACA requires employers to offer coverage to dependents up to age 26, but that coverage does not need to meet affordability standards set elsewhere in the ACA.[17]

Permit Families to Buy In to Coverage through Medicaid or the Federal Employees Health Benefits Program (FEHBP)

For families who are self-employed, work part-time, or work for small businesses that may not offer health benefits, these options offer the chance to provide their children with coverage that will meet their needs and be cost-effective. Allowing all families regardless of income and immigration status to buy into coverage through these programs will improve coverage and access to care for families who remain in the coverage gap.

Conclusion

More than ever before children across the country are waiting for Congress to do its part and secure their coverage and help improve their lives. There are bills before Congress now that will advance the health and development of children, and additional bills could be introduced. At the First Focus Campaign for Children, we stand ready to work together to get legislation passed to insure all children with the health coverage that will meet their needs to grow, develop, and thrive.

Thank you for the consideration of our ideas. Please reach out to Bruce Lesley at Brucel@firstfocus.org.

Sincerely,

Bruce Lesley
President

HEALTHCARE LEADERSHIP COUNCIL
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Washington, D.C. 20001
202–452–8700

October 20, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
Washington, DC 20510

Dear Chair Wyden and Ranking Member Crapo:

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[14] "2020 Employer Health Benefits Survey," Kaiser Family Foundation, October 8, 2020, *https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/*.

[15] Cox, Cynthia, Krutika Amin, Gary Claxton, and Daniel McDermott, "The ACA Family Glitch and Affordability of Employer Coverage," Kaiser Family Foundation, April 7, 2021, *https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/*.

[16] Buettgens, Matthew, Lisa Dubay, and Genevieve M. Kenney. "Marketplace subsidies: Changing the 'Family Glitch' reduces family health spending but increases government costs." *Health Affairs* 35.7 (2016): 1167–1175.

[17] *Ibid,* 15.

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing on, "Health Insurance Coverage in America: Current and Future Role of Federal Programs." HLC appreciates the opportunity to share its thoughts with you on several healthcare coverage priorities.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st-century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies—advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Medicare Part D Drug Coverage

Nearly nine of every 10 Medicare beneficiaries enrolled in Part D prescription drug plans say they are satisfied with their medication coverage with large majorities saying that their costs for both generic and name-brand drugs are affordable.[1] In the current Medicare Part D program, beneficiaries are only responsible for 5 percent of drug costs above the catastrophic threshold. However, five percent of a $100,000 drug is burdensome for seniors. Annual out-of-pocket expenses for these patients are significant. Beneficiary spending exceeds more than $3,000 on average, and one in 10 beneficiaries spends at least $5,200 for out-of-pocket prescription drug costs. HLC supports an out-of-pocket cap that provides all seniors with certainty and financial relief. We believe that any changes to the Medicare Part D program should be patient-centered and address beneficiaries' affordability issues.

HLC believes that establishing an out-of-pocket cap is a meaningful way to help seniors afford the lifesaving prescription drugs they need, especially those who are not eligible for supplemental help. The cost associated with an out-of-pocket cap needs to be shared among stakeholders, including, but not limited to health plans, pharmaceutical manufacturers, and the federal government.

Single Payer Healthcare System

HLC believes all Americans should have access to affordable, high-quality healthcare. Congress and the administration should bolster the stability of the health insurance marketplace by encouraging greater competition, and providing all Americans enhanced coverage choice by guaranteeing issuance of health insurance for those with preexisting medical conditions, with no annual, or lifetime coverage limits, but in conjunction with continuous coverage requirements and other critical safeguards to prevent adverse selection.

Specifically, HLC opposes Medicare-for-All approaches, including permutations such as a public option and Medicare and Medicaid buy-in proposals, which could adversely affect care delivery. While HLC supports access to universal health coverage, we believe that should be done by building on what's currently working. More than 90% of Americans had health coverage at some time in 2020.[2] Polling has consistently shown Americans are not seeking a radical overhaul of our healthcare system. Further, there is no compelling evidence they would be better off if it did occur. The most striking aspect of a single payer healthcare system is not what it gives to millions of working families and individuals, but what it takes away. It forces everyone, no matter how much they value their current health coverage, to give that up and enter into a one-size-fits-all system that would require significant tax increases to provide adequate financing.

In addition, it is impossible to overstate the extent to which a government-run public health insurance option or a Medicare buy-in approach could destabilize the health insurance marketplace and generate unexpected adverse consequences for consumers and healthcare providers.

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[1] Nationwide Survey of Seniors Shows High Approval Ratings for Medicare Prescription Drug Coverage; Beneficiaries Say Their Part D Plans Are Affordable, Provide Good Value, *Medicare Today* (July 28, 2021), *https://medicaretoday.org/2021/07/nationwide-survey-of-seniors-shows-high-approval-ratings-for-medicare-prescription-drug-coverage-beneficiaries-say-their-part-d-plans-are-affordable-provide-good-value/*.

[2] U.S. Census Bureau: Health Insurance Coverage in the United States: 2020 Highlights: In 2020, 8.6 percent of people, or 28.0 million, did not have health insurance at any point during the year and the percentage of people with health insurance coverage for all or part of 2020 was 91.4.(September 14, 2021), *https://www.census.gov/library/publications/2021/demo/p60-274.html#:~:text=Highlights,part%20of%202020%20was%2091.4.*

Assuming that a public option or Medicare buy-in are successful in attracting a significant number of enrollees—entirely probable because the government would have the power to establish below-market out-of-pocket costs—private health plans would find it more difficult to remain competitive in the individual coverage marketplace and some would undoubtedly cease participation. In fact, a recent study by FTI Consulting[3] found that, over the next decade, up to two million enrollees in the individual marketplace would lose their private health insurance coverage in the event a public option is enacted.

Should this occur, not only will we see Americans lose choice in their healthcare decision making, but also healthcare providers and participants in employer-based private insurance plans could be harmed if a public option or Medicare buy-in utilizes Medicare reimbursement rates. That would force a destructive level of cost shifting. Thus, HLC strongly urges Congress to oppose these types of proposals.

Healthcare is currently in a period of evolution, transitioning from a fee-for-service system to one that emphasizes value, improved outcomes, elevated population health, and greater cost- efficiency. To halt this progress in order to create a massive new single payer healthcare system would serve the interests of neither taxpayers nor patients. HLC believes that Congress should continue improving and building upon the current healthcare system. These improvements could include:

Expand Private Coverage

- Offer employers and consumers more choices for their coverage, increasing competition in the market (*e.g.,* value-based insurance designs), and removing barriers to innovation.
- Modernize health plans that are linked to health savings accounts (HSAs).
  - Allow all catastrophic and bronze health plans to qualify as HSA-eligible.
  - Allow flexibility for high-deductible health plans (HDHPs) to reimburse certain services, treatments, or medications necessary to treat chronic health conditions before an enrollee has met their deductible, which will allow millions of Americans in HSA-eligible plans to better afford essential services.
- Expand Health Reimbursement Arrangements by allowing them to fund the purchase of short-term renewable health insurance plans, which can be much more affordable than traditional plans.

Health Insurance Exchanges Stabilization

- Provide regulatory relief to allow States to redirect subsidies according to the unique needs of healthcare beneficiaries in their States.
- Continue the current auto-reenrollment process. Auto-reenrollment promotes continuous coverage for enrollees and limits gaps in coverage that impede consumers' access to care. Ending or modifying auto-reenrollment would have serious, negative consequences for consumers, issuers, brokers, and exchanges.
- Continue to defer to States on "silver loading." Silver loading refers to when health insurers load premium increases into the popular silver-level exchange plans to make up for the loss of cost-sharing reduction payments. Removing silver loading would increase the number of uninsured and result in significant consumer premium increases for both those eligible and ineligible for Advanced Premium Tax Credits (APTCs). State regulators are in the best position to identify which rating practices will best protect consumers in their States.
- Fix the "family glitch" in which the cost to add family members to an individual's employer-sponsored health insurance is not considered when determining "affordability."
- Educate stakeholders on how to enroll potential beneficiaries using mass communication technology without violating the Telephone Consumer Protection Act.

Medicaid Expansion

HLC shares your goal of achieving greater healthcare affordability so that every American had the opportunity to attain quality coverage. The American Rescue Plan Act has helped strengthen healthcare quality and access during the COVID–19 public health crisis. However, more is needed to close the coverage gap in Medicaid non-expansion States. Adults who fall into the coverage gap have incomes above their state's eligibility for Medicaid but below poverty, the minimum income eligibility for

[3] Assessing the Impact of a Public Option on Market Stability and Consumer Choice, FTI Consulting (November 19, 2019), *https://www.fticonsulting.com/-/media/files/us-files/insights/reports/2019/nov/impact-public-option-market-stability-consumer-choice.pdf?rev=e91f388b1bb543faab36366f95396e4b&hash=3BACC4822BE377790B491D34915B215F.*

tax credits through the Affordable Care Act marketplace. This makes coverage unaffordable for most of these individuals.

Research shows that Medicaid expansion has wide-ranging benefits, including reducing overall mortality, as well as cardiovascular disease and liver disease. It has decreased racial disparities in coverage rates, affordability of care, and in some States, health outcomes including maternal mortality. Some 60 percent of people in the gap in 2019 were people of color, reflecting longstanding racial and ethnic disparities in healthcare access that coverage expansions would do much to address. Closing the coverage gap, by allowing individuals in non-expansion States access to the health insurance exchanges or other means, and providing more Americans with quality, affordable, healthcare coverage is vitally important to reducing both the uninsured rate and health inequities across the United States.

Thank you again for your efforts to improve healthcare coverage in America. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449–3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

HR POLICY ASSOCIATION AND AMERICAN HEALTH POLICY INSTITUTE
1001 19th Street North, Suite 1002
Arlington, VA 22209

HR Policy Association represents the chief human resource officers of more than 390 of the largest employers in the United States. Collectively, their companies provide health-care coverage to over 21 million employees and dependents in the United States. The American Health Policy Institute, which was created by the Association, serves to examine the challenges employers face in providing health care to their employees and recommends policy solutions to promote the provision of affordable, high-quality, employer-based health care.

Employer-sponsored health coverage is a critical pillar of the American healthcare system with significant strengths public programs cannot provide. For example, employers can act more quickly than public programs to adopt new technologies and plan offerings that improve the quality of care and help control costs. Employers can also tailor their health benefits to the unique needs of their employee populations and can therefore provide more efficient and effective care.

HR Policy Association members believe all Americans should have access to affordable choices for high-quality health care and reforms should focus on improving access while reducing unnecessary costs. When considering health-care reforms to address coverage issues, Congress should follow the following principles:

- **Preserve employer-sponsored health coverage:** Reforms should strengthen employer-sponsored health coverage so that companies are encouraged to continue to provide coverage to their employees. Employers are in a unique position to advocate for their employees to receive value-based care and services and to encourage employees to engage in their care and health.
- **Foster innovation:** Employers and the health care supply chain should have the flexibility to design and implement health care benefit solutions, payment models, and information exchange to ensure best health outcomes through evidence-based treatments and reduced waste. Federal policies should leverage and encourage this innovation by reducing unnecessary and costly mandates and restrictions.
- **Increase transparency:** Reforms should enable employees to be prudent consumers of health care by fostering patient and employer access to appropriate health-care value, price and quality data while protecting individual privacy and security. Common data definition and standards are required to allow consistent evaluation of value across the health-care ecosystem.
- **Drive quality improvement:** All stakeholders—employers, providers, insurers, intermediaries, individuals, and government should work towards a common set of quality measures to improve the health of consumers and ensure Americans receive appropriate, high-quality care.

Employers have a great stake in the development and implementation of health-care policies. We urge Congress to devote its attention and resources toward addressing systematic cost drivers and wasteful spending. We stand ready to work with the 117th Congress in a bipartisan manner to strengthen and preserve our nation's private-sector employment-based health system.

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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 employees [1] 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 world "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 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,

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[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.

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 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. Since the passage of the American Rescue Plan Act, premium tax credits have been 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. NAHU supports expanding

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[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.

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

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October 25, 2021

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Wyden and Crapo:

On behalf of the National Retail Federation (NRF), I write to thank you for holding your recent hearing on "Health Insurance Coverage in America: Current and Future Role of Federal Programs." NRF strongly supports employment-based coverage and urges this Committee to guard against disrupting this vital base of coverage.

NRF is the world's largest retail trade association, representing discount and department stores, home goods and specialty stores, Main Street merchants, grocers, wholesalers, chain restaurants and internet retailers from the United States and more than 45 countries. Retail is the nation's largest private-sector employer, supporting one in four U.S. jobs—52 million working Americans. Contributing $3.9 trillion to annual GDP, retail is a daily barometer for the nation's economy.

More than 181 million Americans get their health coverage today through employers. Employer-sponsored insurance provides employers and other stakeholders with incentives and opportunities to innovate, strengthen and protect the system from threats. This is the single largest source of coverage in America today.

The nationally uniform framework established by the Employee Retirement Income Security Act (ERISA) is the backbone of the employer-based health-care system because it allows employers to maintain common benefit plans, which provide employees comprehensive, affordable plan options. Preserving employers' ability to offer and maintain uniform and affordable benefit plans across the country is key to preserving the employer-sponsored benefits system.

Policymakers should avoid policies that weaken the pillars that support employer-sponsored insurance. Policy proposals that threaten ERISA's uniformity or seek to change the tax treatment of coverage will decrease innovation and increase costs for employees. These proposals threaten the very basis of coverage for most working Americans.

Public programs like Medicare, Medicaid and the exchanges serve a vital and irreplaceable role in our health-care system. Some proposals to expand Medicare, Medicaid, or increase Affordable Care Act subsidization could disrupt employer-sponsored insurance by cannibalizing employees from employer-sponsored group coverage. For example, an employee-optional early buy-in to Medicare or subsidized enrollment in the individual market could saddle the employer plan's risk pool with less healthy employees who prefer the richer coverage available in the employer plan. The natural risk balance in employer plans between younger, older, healthier

or less healthy employees helps to keep coverage more affordable for all employees and covered dependents in the group.

The employer-based health-care system would also be harmed by the enactment of civil monetary penalties for mental health parity violations. Addressing the current mental health crisis will require significant efforts in partnership between employers, providers, government, patient groups and other stakeholders. The imposition of new civil monetary penalties would only poison these efforts.

Thank you for the opportunity to share these thoughts on the importance of the employer-based health-care system. We respectfully request this letter be included in the record of the hearing. We look forward to working with you to enhance access to health care for all Americans.

Sincerely,

David French
Senior Vice President, Government Relations

NATIONAL TAXPAYERS UNION

October 19, 2021

The Honorable Ron Wyden
Chair
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chair Wyden, Ranking Member Crapo, and Members of the Senate Finance Committee:

On behalf of National Taxpayers Union (NTU), the nation's oldest taxpayer advocacy organization, I wish to submit a statement for the record for the Committee's October 20 hearing, "Health Insurance Coverage in America: Current and Future Role of Federal Programs."[1] NTU strongly believes that lawmakers should narrow their focus and work towards closing health coverage gaps in a manner that favors the lower costs and increased efficiency of private health coverage over federal health programs. Unfortunately, some of the recent proposals from lawmakers that would greatly expand Medicare coverage or enhance Affordable Care Act (ACA) premium subsidies for six-figure households would increase the taxpayer's burden for subsidizing health coverage in the U.S. without meaningfully reducing coverage gaps.

NTU's Stake in Health Coverage Policy

Given the nation's taxpayers heavily subsidize both private and public health coverage, NTU has an important stake in the present and future direction of federal subsidies for health coverage. Some context may help frame our viewpoints and policy recommendations.

According to a Congressional Budget Office (CBO) study released in 2020, federal support for health insurance—for individuals under 65 **alone** (*i.e.,* not including the cost of Medicare coverage for individuals 65 and older)—was projected to total $921 billion in fiscal year (FY) 2021.[2] Nearly half of that support (47 percent, or $433 billion) went to Medicaid and the Children's Health Insurance Program (CHIP), programs designed to primarily support low-income and disabled individuals. Just under a third of FY 2021 taxpayer support for health coverage (32.9 percent, or $303 billion) went to the tax exclusion employers and employees receive for employer-sponsored health insurance. The remaining 20 percent or so of federal support went to ACA marketplace subsidies (in most cases, premium tax credits (PTCs)) or Medicare coverage for individuals under 65.

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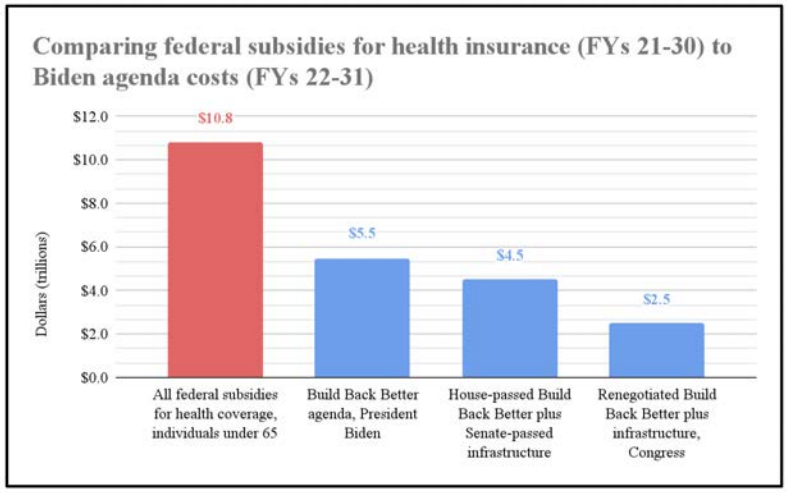
[1] Senate Committee on Finance. "Health Insurance Coverage in America: Current and Future Role of Federal Programs." October 2021. Retrieved from: *https://www.finance.senate.gov/hearings/health-insurance-coverage-in-america-current-and-future-role-of-federal-programs.* (Accessed October 19, 2021.)

[2] Congressional Budget Office (CBO). "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030." September 2020. Retrieved from: *https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf.* (Accessed October 19, 2021.)

Put another way, the federal government currently spends (or foregoes taxation on) nearly $1 trillion supporting the health coverage of individuals under 65. These combined costs are projected to grow nearly 48 percent over the next 10 years—outpacing expected inflation—to $1.36 trillion in FY 2030.[3]

Put yet another way—framing these costs over 10 years, as lawmakers are doing with their reconciliation and infrastructure plans—federal spending and subsidies for health coverage for individuals under 65 will total a staggering **$10.8 trillion** over the decade.[4] This is nearly double the reported cost of President Biden's original Build Back Better agenda of $5.5 trillion.



Lawmakers' approaches to closing health coverage gaps and/or subsidizing health coverage can have substantially larger budget implications for taxpayers than the entire reconciliation package being fiercely negotiated in Congress, making the Committee's hearing an extremely important endeavor.

NTU Principles for Health Coverage Policy

As a taxpayer advocacy organization, NTU urges lawmakers to pursue health coverage policies that adhere to two broad principles: (1) have a **narrow** focus to closing health coverage gaps that prioritizes low-income individuals who do not have access to subsidized care elsewhere, and (2) pursue the lower costs and increased efficiency of private health coverage over federal health programs.

NTU Concerns With ACA and Medicare Expansion Proposals

Unfortunately, several current reconciliation proposals violate both of these principles while committing taxpayers to hundreds of billions of dollars in additional health coverage subsidies over the next decade.

Premium Tax Credit (PTC) Expansion

NTU has warned for years that ACA premium tax credit (PTCs) expansion is ill-suited to reducing coverage gaps in a cost-effective manner, primarily for three reasons: (1) expansion is expensive (a $212 billion deficit impact over 10 years, according to a 2020 estimate from the Congressional Budget Office);[5] (2) targeting generous PTCs to households making six figures or more is a poor use of limited taxpayer dollars; and (3) PTCs are not designed to bend the cost curve for private

[3] *Ibid.*
[4] *Ibid.*
[5] CBO. "Estimated Effect on the Deficit of Rules Committee Print 116–56, the Patient Protection and Affordable Care Enhancement Act." June 24, 2020. Retrieved from: *https://www.cbo.gov/system/files/2020-06/Patient_Protection_and_Affordable_Care_Enhancement_Act_0.pdf.* (Accessed October 19, 2021.)

health coverage, and will only increase in cost as premium hikes outpace wage increases.[6]

We have also demonstrated how, under House Democrats' PTC expansion plan, an upper-middle class family of four that sees their income steadily rise from $125,000 per year to $250,000 per year over a 15-year period, earning $2.7 million over that time (or about $180,000 per year on average), could receive nearly $60,000 in PTCs under the reconciliation expansion plan.[7] This would be an extraordinary misallocation of taxpayer dollars, supporting the premium costs of an affluent household that likely does not need taxpayer-funded assistance. While a substantial portion of PTC dollars may still go to low-income families in the form of refundable credits, we are seeing some early evidence that a concerning proportion of PTC recipients under the temporary, American Rescue Plan expansion of PTCs are making above 400 percent of the federal poverty level (FPL)—over seven percent (or 150,000) of 2.1 million *HealthCare.gov* enrollees from February through August 2021.[8]

We would add that several design features of the PTC expansion increase taxpayer subsidies of health coverage but may not meaningfully reduce health coverage gaps, including but not limited to: (1) increasing the value of PTCs for *existing* beneficiaries by reducing the proportion of income that households are expected to contribute to insurance premiums, including for individuals making above 400 percent of the FPL, (2) allowing individuals to access PTCs regardless of income level, (3) allowing individuals who received *any* unemployment benefits in a year to access PTCs as if they made only 150 percent of the FPL, and (4) limiting recapture of excess PTCs regardless of income. Given the Joint Committee on Taxation (JCT) estimated that these provisions for 2020–2022 alone would have a $45.6 billion budget impact,[9] it is conceivable that lawmakers seeking to make these policies permanent could spend tens of billions of dollars over a decade subsidizing care for individuals who already have or otherwise would have coverage.

Medicare Benefit Expansion

Depending on how lawmakers structure the timing of expanding Medicare to dental, vision, and hearing benefits, and depending on how universal lawmakers make the benefits, the 10-year costs of Medicare benefit expansion may run up to $350 billion.[10] This potentially significant commitment of taxpayer dollars would not provide comprehensive health insurance to a single individual in the country, but instead would provide ancillary benefits to tens of millions of seniors, many of who already have dental, vision, and hearing coverage through Medicare Advantage.

The reconciliation proposal would provide universal dental, vision, and hearing coverage under Medicare Part B, but over 90 percent of Medicare Advantage enrollees are in plans that offer some access to dental, vision, and hearing coverage.[11] What's more, of *all* Medicare beneficiaries (in traditional Medicare and Medicare Advantage) the median cost in 2018 for hearing care was $60, for dental care was $244, and for vision care was $130.[12] While we would not dispute that dental, vision, and hearing care is health care, and while we would not dispute the plain evidence that some seniors are in need of dental, vision, or hearing care and struggle to afford

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[6] Lautz, Andrew. "What's the Deal With Premium Tax Credits?" National Taxpayers Union, September 23, 2021. Retrieved from: *https://www.ntu.org/publications/detail/whats-the-deal-with-premium-tax-credits.*

[7] *Ibid.*

[8] Department of Health and Human Services. "2021 Final Marketplace Special Enrollment Period Report." September 2021. Retrieved from: *https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.* (Accessed October 19, 2021.)

[9] Joint Committee on Taxation. "Estimated Revenue Effects of H.R. 1319, The 'American Rescue Plan Act of 2021,' as Amended by the Senate, Scheduled for Consideration by the House of Representatives." March 9, 2021. Retrieved from: *https://www.jct.gov/publications/2021/jcx-14-21/.* (Accessed October 19, 2021.)

[10] CBO. "H.R. 3, The Elijah E. Cummings Lower Drug Costs Now Act." December 10, 2019. Retrieved from: *https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf#page=10.* (Accessed October 19, 2021.)

[11] Freed, Meredith; Cubanski, Juliette; Sroczynski, Nolan; Ochieng, Nancy; and Neuman, Tricia. "Dental, Hearing, and Vision Costs and Coverage Among Medicare Beneficiaries in Traditional Medicare and Medicare Advantage." Kaiser Family Foundation, September 21, 2021. Retrieved from: *https://www.kff.org/health-costs/issue-brief/dental-hearing-and-vision-costs-and-coverage-among-medicare-beneficiaries-in-traditional-medicare-and-medicare-advantage/.* (Accessed October 19, 2021.)

[12] *Ibid.*

it, the reconciliation proposal misfires in providing a universal, taxpayer-funded benefit to millions of beneficiaries who already have coverage for such services.

Together, the ACA and Medicare expansion proposals envisioned by House Democrats could cost $553 billion, according to a recent CBO estimate.[13] While not every dollar therein would go to beneficiaries who have access to coverage and care already, the above evidence suggests that hundreds of billions of dollars at minimum *would not* meaningfully reduce the coverage gap.

Lawmakers Should Focus Coverage Gap Efforts Narrowly

While numerous headlines and reports focus on the fact that nearly 30 million people in the U.S. are uninsured, few reports we have reviewed provide a narrower focus on what proportion of that uninsured population both (a) cannot afford any type of comprehensive health coverage and (b) cannot access any subsidized health coverage under current law and policy.

CBO's 2020 report, "Who Went Without Health Insurance in 2019, and Why?" is instructive.[14]

Of 29.8 million Americans uninsured in 2019, two-thirds (20 million total) were **eligible for subsidized coverage,** either through Medicaid, CHIP, employment-based coverage, or ACA marketplace subsidies.[15]

Of the remaining 9.8 million Americans, who were uninsured in 2019 and could access subsidized coverage, around 40 percent (4 million) were not lawfully present in the U.S. NTU does not weigh in on immigration matters, so we focus our analysis here on the remaining 5.8 million Americans: those who are not covered by Medicaid but would be if their state expanded Medicaid under the ACA (3.2 million) and those who have income that is too high to receive ACA subsidies and also do not have access to employer-sponsored care.

More recent estimates of the Medicaid coverage gap are closer to 2.2 million than 3.2 million,[16] meaning that this is the population lawmakers should be focusing on with new initiatives to close the coverage gap. There is a major difference between attempting to provide coverage to 30 million Americans (one in nine Americans) and 2.2 million Americans (less than one in 100 Americans). And a far narrower problem calls for far narrower solutions.

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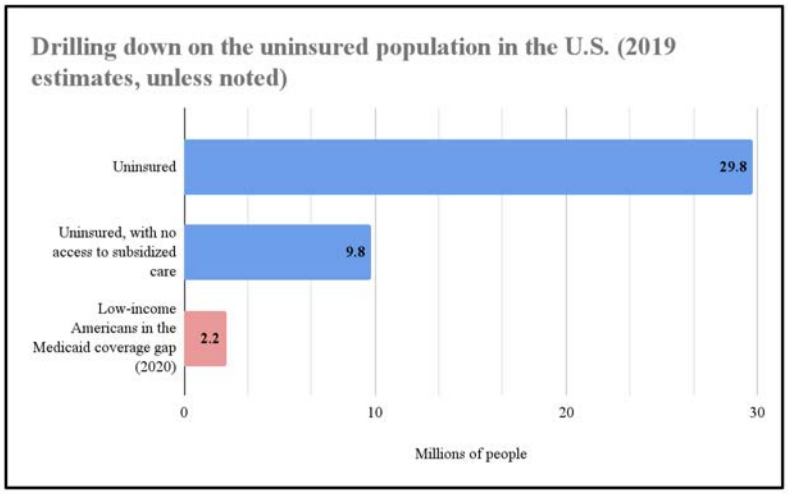
[13] CBO. "Re: Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage of People Under Age 65." October 19, 2021. Retrieved from: *https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Letter_Honorable_Jason_Smith.pdf.* (Accessed October 19, 2021.)

[14] For more, *see:* CBO. "Who Went Without Health Insurance in 2019, and Why?" September 2020. Retrieved from: *https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf.* (Accessed October 19, 2021.)

[15] Statistics in this section are sourced from CBO's report, unless otherwise noted.

[16] Garfield, Rachel; Orgera, Kendal; and Damico, Anthony. "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid." Kaiser Family Foundation, January 21, 2021. Retrieved from: *https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/*. (Accessed October 19, 2021.)



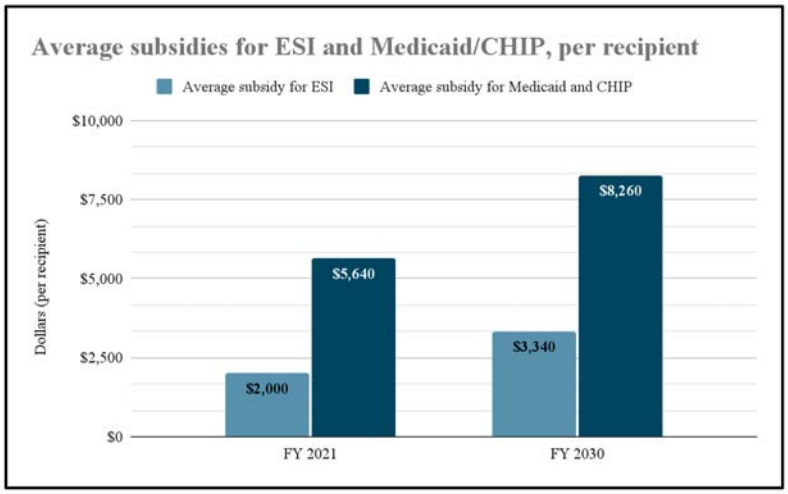
Lawmakers Should Focus on Cost-Effective Private-Sector Solutions to Closing Coverage Gap

Some lawmakers are considering a federal Medicaid expansion proposal that would cost up to $323 billion over a decade to close the 2.2 million-person coverage gap noted above.[17] Unfortunately, substantial research indicates that the subsidy cost per person for public health coverage is much higher than private health coverage, and that public health programs are subject to high improper payment rates that put taxpayer dollars at risk. Policymakers may see fewer taxpayer dollars do more to reduce the coverage gap by helping low-income Americans obtain more cost-effective private health coverage instead.

The average subsidy per recipient of employer-provided coverage (ESI) was $2,000 in FY 2021, according to CBO.[18] Compare this to $5,640 per recipient under Medicaid and CHIP. CBO projects that gap will narrow over the next decade, but Medicaid and CHIP subsidies will still more than double the average subsidy for ESI.

[17] CBO. "Re: Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage of People Under Age 65." October 19, 2021. Retrieved from: *https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Letter_Honorable_Jason_Smith.pdf.* (Accessed October 19, 2021.)

[18] Congressional Budget Office (CBO). "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030." September 2020. Retrieved from: *https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf.* (Accessed October 19, 2021.)



In other words, ESI subsidies are far more cost-effective on a per-recipient basis than Medicaid and CHIP. While the difference may be explained by a number of factors, one worth considering is the extraordinarily high improper payment rate in Medicaid.[19]

According to 2020 data from the Centers for Medicare and Medicaid Services (CMS), Medicaid comprised nearly two-thirds of all CMS improper payments in Medicare and Medicaid in 2020, $86.5 billion out of $134.2 billion.[20] The Medicaid improper payment rate of 21.36 percent was 18.6 times higher than improper payments in Medicare Part D and 3.1 times higher than improper payments in Medicare Advantage, two subsidized health coverage programs that rely primarily on private insurers.

And as health experts like the Galen Institute's Brian Blase have pointed out, access to care (and not just coverage) in Medicaid raises concerns for proponents of the program. As Blase wrote in 2020:

> Coverage is not the same thing as care. A 2019 study by the Medicaid and CHIP Payment and Access Commission, a congressional advisory group, found that one-third of primary care physicians and nearly two-thirds of psychiatrists do not accept Medicaid patients. Doctors cite difficult Medicaid paperwork, administrative burdens, and poor reimbursement rates as reasons they do not accept more patients on the program.[21]

That said, closing the coverage gap is a laudable goal both on public health grounds and fiscal grounds, if the problem and the solutions are properly defined. Estimates for the cost of uncompensated or charity care (the latter a subset of uncompensated care payments) vary, but range from anywhere between $14 billion for nonprofit hospitals' charity care (2017 estimate)[22] to $41.6 billion for all hospitals' uncompen-

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[19] Improper payments are evidence that fraud or misuse of funds *may* exist, but are not completely indicative of fraudulent payments or other misdeeds. As CMS writes: "Improper payments are payments that did not meet statutory, regulatory, administrative, or other legally applicable requirements and may be overpayments or underpayments." For more, *see:* CMS. "2020 Estimated Improper Payment Rates for Centers for Medicare and Medicaid Services (CMS) Programs." November 16, 2020. Retrieved from: *https://www.cms.gov/newsroom/fact-sheets/2020-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs#_ftn1.* (Accessed October 19, 2021.)

[20] *Ibid.*

[21] Blase; Brian; Adolphsen, Sam; and Turner, Grace-Marie. "Why States should not expand Medicaid." Galen Institute, October 6, 2020. Retrieved from: *https://galen.org/assets/Reasons-Not-to-Expand-Medicaid-100620.pdf.* (Accessed October 19, 2021.)

[22] Bai, Ge; Yehia, Farah; and Anderson, Gerard F. "Charity Care Provision by U.S. Nonprofit Hospitals." *JAMA Internal Medicine,* February 17, 2020. Retrieved from: *https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2760774.* (Accessed October 19, 2021.)

sated care (2020).[23] CBO has found that "it is likely that being uninsured results in worse health outcomes, at least for some people."[24] In short, there are societal and taxpayer costs to millions of Americans wanting access to affordable health coverage with no subsidized options available to them.

However, the evidence is clear that the private sector will have more cost-effective solutions to reducing the coverage gap. Two avenues where lawmakers should explore reforms and, possibly, support for low-income Americans are (1) employer-provided care and (2) consumer-directed health savings accounts (HSAs).

As noted above, taxpayer support for employer-sponsored insurance (ESI) is far lower than subsidies for public health coverage. That said, the tax exclusion for ESI is far from perfect. Some evidence demonstrates the exclusion puts upward pressure on health insurance premiums, at the expense of higher wages, and it is worth noting that 37 percent of the tax benefit in 2018 went to households making 600 percent or more of the FPL.[25]

Lawmakers could explore reforms to the ESI exclusion that more narrowly target the benefit at taxpayers who need support and/or incentivize businesses that currently do not offer ESI to low-wage or low-income employees and contractors to do so.

HSAs are another promising and cost-effective route for lawmakers. JCT estimated the costs of HSA tax subsidies for FYs 2020 through 2024 to total $66 billion, an average of $13.2 billion per year.[26] If the average number of Americans contributing to an HSA hovers between 10 million and 12 million people per year,[27] then the tax expenditure cost per person is between just $1,100 and $1,320 per person. NTU has outlined numerous ways that lawmakers can expand both access to HSAs and the list of health expenses HSAs can cover.[28]

Conclusion

In short, NTU appreciates that lawmakers are attempting to reduce health coverage gaps, and we acknowledge that closing health coverage gaps could bring benefits to society and to federal taxpayers. That said, Congress should take care to narrowly define both the uninsured problem that federal policies can fix and the big-picture solutions that lawmakers should pursue to help people that truly need taxpayer-funded assistance. Furthermore, those big-picture solutions should focus on the cost effectiveness of private health coverage, rather than public programs that come with significant cost, access, and improper payment concerns. NTU is pleased to work with Committee members on policies that adhere to these principles. Should you have any questions, I am at your service.

Sincerely,

Andrew Lautz
Director of Federal Policy

CC: Members of the Senate Committee on Finance

PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

The Partnership for Employer-Sponsored Coverage is an advocacy alliance of employment-based organizations and trade associations representing businesses of all sizes and the more than 181 million American workers and their families who rely on employer-sponsored coverage every day. We are committed to working to en-

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[23] American Hospital Association. "Fact Sheet: Uncompensated Hospital Care Cost." January 2021. Retrieved from: *https://www.aha.org/fact-sheets/2020-01-06-fact-sheet-uncompensated-hospital-care-cost.* (Accessed October 19, 2021.)

[24] CBO. "Who Went Without Health Insurance in 2019, and Why?" September 2020. Retrieved from: *https://www.cbo.gov/system/files/2020-09/56504-Health-Insurance.pdf.* (Accessed October 19, 2021.)

[25] Congressional Research Service. "Tax Expenditures: Compendium of Background Material on Individual Provisions." December 2020. Retrieved from: *https://www.govinfo.gov/content/pkg/CPRT-116SPRT42597/pdf/CPRT-116SPRT42597.pdf#page=901.* (Accessed October 19, 2021.)

[26] *Ibid.*

[27] *Ibid.*

[28] Lautz, Andrew. "Ideas to Expand and Promote the Use of Health Savings Accounts: An Alternative to Government-Run Health Insurance." National Taxpayers Union, October 21, 2019. Retrieved from: *https://www.ntu.org/publications/detail/ideas-to-expand-and-promote-the-use-of-health-savings-accounts-an-alternative-to-government-run-health-insurance.*

sure that employer-sponsored coverage is strengthened and remains a viable, affordable option for decades to come. We urge caution in considering expansion of public programs to safeguard employer-sponsored coverage in the years ahead.

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), an employer can tailor coverage to meet their workforce's specific needs across state lines. They pay all health claims and bear the financial risk and utilize third-party administrators (insurance carriers) 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 does 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 well-being 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 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 purposes 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 multi-faceted 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.

While 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 "Medicare for All" 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 or Medicaid through a buy-in effect current program beneficiaries and resources?
- How would a Medicare or 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? Insure a cohort of uninsured? Why not consider a firewall to protect employer health plans?
- 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?
- How would the cost of existing employer coverage be affected by an employee-option model for Medicare buy-in?

The Partnership for Employer-Sponsored Coverage opposes "Medicare for All." Dismantling our nation's private-sector employment-based health system which provides coverage to 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;
- Providing employers with compliance relief from burdensome regulations; and,
- Protecting ERISA.

As a coalition representing business 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 to strengthen and preserve our nation's private sector employment-based health system.

PATIENTS RISING
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Statement of Terry Wilcox, Executive Director

Patients Rising is a national nonprofit organization dedicated to advocating for the rights of patients with chronic and life-threatening illnesses. We work at the community, state, and federal levels to activate patients in support of reforms and legislation aimed at advancing patient access to and affordability of healthcare.

The healthcare system in the United States has become complex, expensive, and impersonal. To many Americans, it seems that any healthcare policy debate has become nothing but a food fight between politicians, providers, insurance companies, pharmacy benefit managers, and the biopharmaceutical industry. What should be driving motivation of this debate—the patient—is being drowned out by special interests on all sides of the issue.

The American healthcare system remains the world's leading market-based system that rewards scientific advancement and medical innovation. But currently, there are too many barriers and entrenched interests working against meaningful change in how healthcare is provided.

Patients Rising, through the **Patient Access and Affordability Project** (PAAP), is working to empower patients, encourage advances in medicine, and disrupt the payment landscape to accommodate innovation not only in medicines that save lives, but also finding innovative ways to pay for them.

During the October 20, 2021, Senate Finance Hearing, *Health Insurance Coverage in America: Current and Future Role of Federal Programs,* the areas where each party agrees to disagree are stark, but the places where change for patients is possible exists. It is our aim to work with Congress to advance patient-centered compromises.

According to the CDC, six in ten Americans live with a chronic disease, and four in ten Americans live with two or more chronic diseases. At the same time, between 25–30 million Americans are living with a rare disease, more than 90% of those diseases have no treatment.

These are the Americans that Congress should prioritize when discussing current and future health insurance coverage issues and reforms.

When pre-existing conditions were no longer a barrier to accessing health insurance, this was a monumental moment for many Americans who had been unable to obtain any insurance because of these conditions. But now, those same patients are fighting for reasonable and fair access. They stand there holding a card, that in many instances denies the rightful access to the treatments and services they need. The deductible is too high, the out-of-pocket costs are skyrocketing, and the access to treatment is often limited.

When a patient is left with a relatively useless insurance card, the pre-existing condition coverage becomes nothing more than a talking point. The system has failed, denying those most vulnerable patients meaningful healthcare.

It is true, 90% of Americans agree with negotiating with Medicare. Those same Americans also want ready access to treatments when they need them. There is no model where price controls would result in maintaining world leading innovation and reliable access. For this reason, we hope this Committee will fully support the following health-care reforms:

1. **Capping Out of Pocket Costs in Medicare Part D:** *Cap Medicare Part D below $3,100.* A $2,000 cap in Medicare Part D would be life changing for the patients who find themselves in the catastrophic coverage phase. It is a small percentage of patients, but those who require this type of coverage often face extreme hardship. We have seen caps anywhere between $2,000–$3,100, but all-in-all this is a bipartisan solution that will help the patients who need it the most. This overall cap coupled with a monthly out of pocket cap referred to as smoothing, would go a long way in providing seniors with fixed incomes and high drug costs some much needed relief.
2. **Insulin:** *All brands of insulin should be available to all patients at a fixed low cost.* Insulin is a life-saving medication to millions of Americans, and no one should be held hostage by the extreme supply chain manipulation of the list price. The pharmaceutical company net price has been decreasing in recent years, despite list prices increases. However, what pharmacy benefit managers are making in kickbacks and fees often pay for the insulin itself several times over. This is an example of a supply chain that is failing patients because of the perverse incentives that exist within it. In this instance—and possibly EpiPen's as well—the pharmaceutical industry needs to sell a product and the patient needs to buy it from the pharmacy counter. Any entity in the middle purporting to save money for the system or patients has failed abysmally at their job.
3. **Benefit Design and Healthcare Finance:** *Price negotiations will leave behind the sickest of patients. Therefore, alternative benefit design policies should prioritize doctor-patient relationships.* When it comes to healthcare finance, there is a lot of discussion about price controls and fines to curb pharmaceutical pricing and lower patients out of pocket costs. There is no guarantee that this negotiation will lower out of pocket costs at the pharmacy counter for anyone. Most patients will not even notice. Negotiation is a false promise to the sickest among us that polls well with many Americans who are **not** sick or unhappy with their healthcare nor drug worried about their drug costs.

Members of the Senate Finance Committee should be leading the way on benefit design policy. Health insurance is a card for coverage. Benefit design is a road to providing actual **care** for the patient. In many instances the coverage (whether it is government provided, employer provided, an off the shelf insurance plan, or something in between) provides insufficient care for those who need it the most. As a nation, we should be addressing these insufficiencies.

Ultimately there are three primary payers: the government, employers, and patients. We recognize and acknowledge when a patient lacks access to coverage that all the burden falls on them. It is for this reason; we must simultaneously address the inequities in coverage. Everyone else in the supply chain is providing a product or service or serving as a middleman for oversight of benefits. Benefit design has become more cumbersome for doctors and patients, leaving many doctors prescribing not what is best for their patients, but what is covered. And sometimes what is best, is not what is covered, and in many instances, it is not even what is the most expensive—but you would never know that from the formulary design.

Benefit decisions are driven by perverse financial incentives in the supply chain, with little regard for the patients themselves. Again, the doctor-patient relationship should be leading the change in benefit design, not the patient-government or the patient-employer relationship.

While medical innovation is unfolding rapidly, our current healthcare finance system is not designed to accommodate it. We must change our healthcare finance system to become more efficient, nimble, and responsive to that innovation.

As America spends twice as much as other industrialized countries on healthcare as a share of our economy. This is due, at least in part, to the perverse incentives created by a dated hodgepodge of federal policy that eliminates efficiency and creates excessive spending throughout the system.

Patients Rising urges the Committee to consider the following solutions:

1. **Establish a healthcare finance and payment model that rewards improvements in long-term care of patients.**
   - Incentivize innovative insurance and finance models that are designed to reward and encourage major breakthroughs in therapies and cures, while keeping the costs to patients low.
   - Make doctors the primary force behind coverage recommendations, and not flawed frameworks with little regard for the doctor or the patient.
   - Ensure that doctors, nurses, and other healthcare providers can make decisions independently to provide optimal patient care.
2. **Promote the market-based healthcare model that encourages patient choice and maintains American leadership in life sciences and medical innovation.**
   - Audit policies and practices that can create perverse incentives and lead to unnecessary treatments like surgeries or other expensive procedures.
   - Establish transparency across the health system to understand the actual drivers of healthcare inflation.
   - Encourage entrepreneurial disruption that leads to the health system competing for patients, which would help lower costs and improve the use of health resources.
   - Patients, not companies like pharmacy chains, should benefit financially from the data collected on individuals.

Chairman Wyden, Ranking Member Crapo, and distinguished members of the Senate Finance Committee, it is our pleasure and privilege to present written testimony on this vital topic on behalf of Patients Rising. We stand ready to serve as a resource and support the work of Congress to protect patients.

STATEMENT SUBMITTED BY LEE STANFIELD

Lies and Distortions at the Senate Finance Hearing 10/20/21

Apparently, it would be more accurate to call the Center for Medicare and Medicaid Innovation the "Center for Medicare and Medicaid Infestation" since it clearly intends to infest Medicare with the all-too-familiar ideology of "Profit Over Patients" (the covert slogan of the for-profit parasites that are already so rampant in U.S. healthcare).

For Representative Sheldon Whitehouse to imply that there are onerous hoops physicians must jump through to be paid a fee for services rendered, completely ignores reality, and reveals who he truly represents . . . the big corporate vultures who generously fund him to rip Medicare apart, so they will have better access to swoop in and greedily scavenge yet another social safety net . . . thus securing even more U.S. taxpayer money for their private coffers.

Whitehouse's claims are even more insulting in light of the fact that the very "Managed Care" models he proposes are notorious for requiring medical professionals to fill out onerous forms and jump through numerous hoops just to get paid for their services. In fact, most physicians prefer to deal with Traditional Medicare (as opposed to Medicare Advantage or any other commercial insurance) precisely because Traditional Medicare has always been so much more dependable and prompt in paying for services rendered than any commercial insurance.

This is still the case, despite the understaffing due to the decades-long yearly cuts to Medicare funding by our corporate-bought Congress, and despite the previous appointment of Medicare saboteur Seema Verma. Now we have Ms. Brooks-LaSure, whose previous career has been confined to the favorite den of the for-profit parasites . . . Medicaid and the ACA! Oh, how I long for someone who would just think outside that infested box!

At 78, I have witnessed an ever-increasing number of stealth attempts to privatize Medicare via the introduction of parasitic middlemen (as in the Advantage plans) and the decades-long funding cuts to the program on the part of the corporate-owned politicians in Congress. Prior to this onslaught, Traditional Medicare was an excellent program that patients and physicians loved!

Because (like the majority of U.S. residents) I still love Medicare, I will not sit by and allow this newest outrage called "Direct Contracting Entity" to be inflicted on Medicare! DCE is nothing more than a thinly veiled attempt to infect Medicare with yet another parasite to weaken it to the point where it can no longer adequately

serve seniors. Once their dastardly goal is achieved, then the same corporate-owned politicians who infected Medicare with these fatal parasites, will loudly claim that government-run Medicare cannot be sustained and must be entirely privatized!

One of the for-profit concepts that has already been proven to be an abject failure is the "Value-Based Payment" program (VBP). It has failed to do either of the two things it was touted to do . . . maintain or increase the quality, or lower the cost of healthcare. Instead, the VBP model is nothing but a tool for incentivizing providers to avoid taking on cases where the beneficiary is likely to be costly to treat (such as those who are seriously, chronically, or terminally ill). Of course, this discriminates strongly against people of color and the poor in general. **And this is the same result that the DCE will generate!**

But if Whitehouse wants to talk about onerous "treadmills" of bureaucratic forms and other hurdles that take time away from actual patient encounters . . . all forms of Managed Care and VBP are "poster children" for that!

In truth, the unspoken underlying goal of the DCE is to destroy Medicare as we know it by transferring financial risk onto providers through up-front speculative lump sum payments, which will incentivize providers to pay more attention to budgeting and cutting costs than to patients' welfare. This is a stealth attack on Medicare! Step by step, it will replace Medicare with an egregious system that values and incentivizes profit over patients!

I say "NO" to this corrupt commercializing of Traditional Medicare! I will be taking this fight to the public to make them aware of this attempt to transform Medicare into a set of virtual "Advantage Plans" (or even worse) . . . plans that will little by little limit beneficiaries' choice of doctors and other providers, increase the need for prior authorizations, incentivize providers to under-treat, "cherry-pick" and "lemon drop" beneficiaries, and to spend less time face to face with patients, while the cost of care continues to increase every year in order to increase the profits of the already ultra-wealthy!

All these privatized models are cash cows for profit-driven health insurance companies at the expense of taxpayers! What you should be considering and discussing is how to (as quickly as possible) get Congress to pass and implement the most efficient, least expensive, highest quality healthcare possible . . . **original Traditional Medicare expanded to cover ALL medical needs (including mental, dental, hearing, vision, and long-term care) for EVERYONE nationwide! And it will SAVE the U.S. hundreds of billions, and the average family several thousands of dollars every year!**

You should be STRENGTHENING Traditional Medicare instead of sabotaging it with the likes of either DCE or VBP!

Lee Stanfield

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Statement of Claire Cohen, M.D.

Countless studies show that the United States healthcare system is too expensive and will continue to be without fundamental change. As you have noted, American healthcare is a greater percentage of the GDP in the US than in any other developed country. And it is growing greatly as the costs of private health insurance is greatly growing. The Congressional Budget Office (CBO) projects that the premium subsidies to private insurance companies over the next 10 years will cost $553.2 billion. CBO also predicts that a single payer system will generate $650 billion dollars in savings per year by 2030. CMS has overpaid the private health insurers $143 billion in the last ten years. MedPAC projects that Medicare Advantage plans cost CMS at least $8 billion more than traditional Fee For Service Medicare in 2020 alone.

A recent report by the Commonwealth Fund revealed that the most cost-efficient and highest quality state Medicaid Programs were the two that have public, non-privatized programs; and that contracting Medicaid health coverage to private insurance companies lowers quality of service and increases cost. The Annals of Internal Medicine report that over one third of all healthcare costs in the United States

are due to insurance company overhead and provider time spent on billing—that is the private health insurance bureaucracy. Studies repeatedly find that the administrative overhead costs for traditional Medicare is 2–3%, as compared to private insurers (including Medicare Advantage and those under the ACA) who have administrative overhead costs of 12% to 15%, translating into a $400 billion annual savings under a single-payer system.

Finally, an article by Christopher Cai published in *PLOS Medicine* on January 15, 2020, looked at 22 studies that compared 10 year projections for the financing of a single-payer healthcare system in the United States with the projected 10-year costs for our current multi-payer mostly privatized system. Regardless of ideology, no study found single payer to be more costly. Twenty of the studies, including one by the right wing Mercatus Center, found at least $2 trillion dollars in savings; while two studies found the costs to be equal with our current system.

What should be the conclusion from all of this wealth of information? If congresspeople and government officials were not blinded by neoliberal ideology and biased by the corruption of big-money interests, the conclusion would be that the United States needs to get private insurance totally out of healthcare and needs to implement a single payer health system. Such a system would bring our healthcare costs, quality and accessibility rapidly in line with those of other developed countries. Such a system would ensure high-quality, low-cost health coverage for everyone living in the United States without all the administrative bureaucracy that we now have. Healthcare is a human right and should be a public good.