STATEMENT OF

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HEARING
"THE HISTORY AND CURRENT REALITY OF THE U.S. HEALTH CARE SYSTEM"

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Good morning Mr. Chairman, Ranking Member McCaskill, Members of the Committee. I am Sabrina Corlette, a Senior Research Fellow and Project Director at Georgetown University's Center on Health Insurance Reforms (CHIR). CHIR has a team of faculty and staff devoted to studying private health insurance and insurance markets. We are based at Georgetown University's McCourt School of Public Policy. Please note that I am here in my individual capacity and that my views do not necessarily represent the views of Georgetown University.

I want to thank this Committee for holding this timely and important hearing. We have had over the last several months – over the last several years in fact – an extended and rancorous debate about the future of health care reform. I appreciate this Committee's willingness to engage in a thoughtful, bipartisan effort to understand the root causes of some of the challenges facing our health care system. It is only with that understanding that policymakers can effectively tackle the necessary solutions.

Know Your History: Understanding Health System Challenges Requires Understanding How We Got Here

Both critics and proponents of the Affordable Care Act (ACA) can reasonably ask why it was structured the way it was, with an array of insurance reforms, an individual responsibility requirement (known as the individual mandate), and income-related subsidies for the purchase of private insurance alongside Medicaid expansion for low-income families. Part of the reason it is a complicated law is because it did not sweep away our existing system; rather, the ACA was designed to fill gaps in a patchwork quilt system of coverage that has evolved over a century and more.

How did we arrive at the patchwork quilt health care system we have today? By the middle of the last century, the United States was the only country in the developed world without some sort of system to provide health care for all its citizens. Instead, we have developed an array of disparate programs to provide coverage to specific, politically favored groups of people.

In the early decades of the 20th century, there wasn't much "insurance" as we'd understand it today. Most people paid their doctors in cash or in kind. But health care was also much more primitive – it was not the technology-driven, extraordinarily expensive enterprise it is today.

Over time, however, new treatments, drugs, and technologies advanced the practice of medicine, saving lives but also increasing the costs of medical care. As people were less able to afford the rising cost of care, it created a financing problem for hospitals and other providers. Some of the more entrepreneurial hospital providers decided to create the first plans for groups of employees to buy insurance for hospital expenses. These plans evolved into the "Blue Cross" system, founded in 1929. "Blue Shield" plans to help finance physician care followed a decade later, in 1939.

The Rise of an Employer-based System of Coverage

Before the advent of the Blue Cross/Blue Shield plans, traditional commercial insurers had not been in health insurance business because of their concerns about adverse selection. In general, the only people willing to pay for such insurance were those with high health care costs. Also, the administrative costs of selling insurance directly to individuals was very high.

But the Blue Cross plans demonstrated that if you could target the coverage to employer groups, you could make health insurance a viable business enterprise. Targeting large employer groups meant creating a naturally balanced risk pool – an individual's coverage was tied to their employment, not their need for health care services. It also came with lower marketing costs. Even so, our current system of employer-sponsored coverage didn't really take off until around World War II.

During the war, the government imposed wage and price controls, which led employers to offer generous health benefits in lieu of wages. Additionally, the post-war era was a golden age for labor unions, and millions of workers gained insurance through collective bargaining agreements.

Then, a key federal policy caused employer-based insurance to expand exponentially. In 1953, the Internal Revenue Service (IRS) ruled that a contribution to a group health insurance policy was not taxable (even though a contribution to an individual health insurance policy was deemed taxable). The Eisenhower administration then adopted a blanket exclusion for all employer contributions to an employee health plan. At the time, there was no Congressional Budget Office, meaning that policymakers had no estimates of how much the IRS rule would cost. We now know that it is one of the most expensive federal policies ever adopted. Today, with approximately 150 million Americans covered through their employer, that subsidy costs the federal government about $250 billion per year in lost income and payroll taxes.

The Rise of Risk Segmentation in Commercial Insurance

As employer-sponsored coverage expanded, other important insurance market changes were also taking place. The early Blue Cross Blue Shield plans were non-profit organizations and in general offered coverage at a "community rate," meaning that all employer groups paid the same price, regardless of the age or health status of their employees.

But soon, for-profit commercial insurers entered the market and realized they could make more money if they cherry picked: They would offer certain employers a lower rate if they had younger, healthier workers. This is called "experience rating." Blue Cross Blue Shield was left with sicker employee groups and ultimately adopted their competitors' rating practices in order to survive.

Similarly, before the ACA, insurers found they could make money in the individual market if they engaged in health status "underwriting," or the practice of deterring the enrollment of individuals considered to pose a health risk. These tactics included outright denials of coverage,

pre-existing condition benefit exclusions, and premium surcharges based on factors such as health status, age, and gender.

Medicare and Medicaid

Just as employer coverage became widespread, many policymakers in the middle of the last century recognized that an employer-based market alone wouldn't deliver health coverage to certain vulnerable groups, such as the poor, elderly and disabled. Although many in the progressive community at the time pushed for government-sponsored, universal coverage, ultimately Congress enacted in 1965 a "three layer cake" of reforms: Medicare Part A for hospital bills, Part B for physicians, and Medicaid for welfare recipients (Medicaid was later de-linked from welfare under the 1996 "Personal Responsibility and Work Opportunity Reconciliation Act").

Incremental Reforms: More Gap-filling

For many decades after passage of Medicare and Medicaid, efforts to enact comprehensive reform had little traction. Perhaps surprisingly, it was President Nixon who was the first president to send a legislative plan for near-universal coverage to Congress. The plan included a mandate that employers provide coverage and required a comprehensive benefit package.

While President Nixon's health reform effort ultimately failed, Congress did enact a major law affecting health insurance that few people at the time recognized as a health law: ERISA (the Employee Retirement Income Security Act of 1974). While focused on pension reform, ERISA preempts state insurance laws that would regulate employee benefit plans, including health plans.

Later incremental reforms that attempted to fill gaps in our coverage system include COBRA (1986), which allowed workers to buy into their employer's plan up to 36 months after being laid off, EMTALA (1986), which required hospital emergency departments to stabilize emergency patients even if they had no insurance, and limited expansions of Medicaid eligibility to include the disabled, people with end-stage renal disease (ESRD), and qualifying Medicare beneficiaries.

In the 1990s a more sweeping effort to provide universal coverage sponsored by President Clinton failed. In the aftermath, Congress enacted HIPAA in 1996, which, in addition to providing for the privacy and security of personal health information also modestly improved the "portability" of health coverage by requiring insurers to "guarantee issue" an individual policy to a person leaving employer group coverage. In 1997, Congress enacted the Children's Health Insurance Program (CHIP), a joint federal-state program to extend health insurance coverage to eligible children. Another reform, enacted in 2003, created a prescription drug benefit for Medicare beneficiaries, known as "Medicare Part D."

The Affordable Care Act – Improving Access to Affordable, Comprehensive Coverage

In spite of efforts to fill gaps in our coverage system over the years, on the eve of enactment of the ACA, 45 million Americans were uninsured; over 80 million reported having to go without coverage for at least one month during the prior 12-month period. Those without insurance coverage have lower life expectancy than those with coverage. Before the ACA was enacted, an estimated 26,000 people per year died prematurely because they lacked insurance. This is likely because the uninsured are more than six times as likely as the privately insured to delay or forego needed care due to cost. Uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.

Being uninsured also results in financial insecurity. In 2010, when the ACA was enacted, sixty percent of the uninsured reported having problems with medical bills or medical debt.

Prior to the ACA, the high and rising uninsured rate also led to high and rising uncompensated care costs for providers, in 2009 estimated at $1000 worth of services per uninsured person. Providers ultimately pass those costs onto insured consumers and taxpayers, amounting to almost $700 per family per year.

In attempting to expand coverage to the uninsured, the ACA focused largely on the failures of a dysfunctional individual market, which was inaccessible to those with pre-existing conditions and unaffordable to millions of working families who lacked job-based coverage. The ACA included relatively modest reforms to the employer group market, largely because the approximately 150 million people in that market are generally satisfied with their coverage. In fact, employer-sponsored health coverage was, and remains, one of the top most-valued benefits among employees.

The ACA tried to address the individual market's three main problems:

- *Access*. Prior to the ACA, on average 19 percent of individual market insurance applicants were denied due to their health risk.
- *Affordability*. On the eve of the ACA's passage, the average cost of family coverage was $12,700 – a price out of reach for most families trying to buy coverage on their own. Yet people buying in the individual market lacked any employer or other subsidy to pay their premium (although most of the uninsured work), their premium contributions were fully taxed, and applicants often faced premium surcharges due to their health status, gender, and age.
- *Adequacy*. Prior to the ACA, roughly half of individual market enrollees were in plans that covered no more than 60 percent of their medical costs. Insurers commonly imposed pre-existing condition coverage exclusions, meaning that any care required to treat a previously existing health condition would not be covered. Further, as many as 20 percent of individual policies didn't cover pharmacy or mental health benefits and only 12 percent of policies covered maternity services. These policies also often didn't limit the policyholder's annual out-of-pocket costs, and came with annual and/or lifetime limits on benefits.

The ACA tried to address these problems with 3-prong strategy, or "three-legged stool":

- *Insurance reforms* to help people locked out of the system due to pre-existing conditions;
- *An individual mandate* to encourage healthy people to enroll in the insurance pool and keep premiums stable; and
- *Subsidies* to help people afford the insurance coverage (with Medicaid expansion available for people under 138 percent of the federal poverty line (FPL)). The subsidies included "advance payments of premium tax credits" (APTCs) to reduce premium costs for people between 100-400 percent of FPL and "cost-sharing reduction" (CSR) subsidies to reduce deductibles and other cost-sharing for people between 100-250 percent of FPL.

The ACA also created state-based insurance marketplaces where people can apply for the APTCs and CSR subsidies and shop for plans.

The ACA Today: Dramatic Improvements in Coverage but Modest, Bipartisan Fixes Needed

The ACA has improved the lives of millions by expanding access to insurance coverage, improving health outcomes, and increasing financial security. Specifically, thanks to the ACA, the percentage of people uninsured declined from 14.5 percent in 2013 to 8.9 percent in 2016 – an estimated 20 million people gained coverage because of the ACA.

What does coverage mean for these individuals and families? The reforms were fully implemented in 2014, so it is still early to assess the impact of the ACA. But we are starting to get data showing that the law has succeeded in improving Americans' access to care, health outcomes, and financial security, as well as reduced the burden of uncompensated care for hospitals and other providers.

Since the ACA, the percent of Americans reporting that they didn't see a doctor or fill a prescription because they couldn't afford it has declined by more than one-third. Further, more people are reporting that they have a primary care doctor or had a check-up in the last 12 months.

The research to date also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the reforms in Massachusetts, upon which the ACA was modeled, have found that coverage expansion in that state led to reported improvements in physical and mental health, as well as reductions in mortality. The early data on changes in health outcomes due to the ACA's coverage expansions are consistent with these findings.

Health insurance is not just about improving access to care. It is also provides financial security, particularly in the event of a large, unanticipated health care expense. And make no mistake: health care in this country is expensive. For example, the average cost of a MRI today is $1,119.

An uncomplicated hospital-based labor and delivery costs an average of $10,808, while a C-section will average over $16,000. One course of treatment for colon cancer will cost you roughly between $21,000 and $52,000. Yet almost half of American families report that that they would not be able to afford to pay just $400 in cash for an unanticipated medical event.

Recent research suggests that the ACA is helping to improve the financial security of the newly insured. Survey data show that the number of families who say they're having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families. Other studies have demonstrated that the ACA's Medicaid expansion has led to reductions in the amount of debt sent to collection agencies and improvements in credit scores.

The benefits of coverage expansions do not just affect the newly insured. Thanks to the ACA, we've witnessed a significant reduction in uncompensated care costs borne by providers. For example, hospital-based uncompensated care fell by over 25 percent between 2013 and 2015, and in Medicaid expansion states it has fallen by closer to 50 percent.

Even so, the most ardent supporter of the ACA would likely agree that the law faces challenges, not least of which is the continued policy uncertainty created by congressional efforts to repeal the law, threats by the Trump administration to cut off the CSR reimbursements to insurers, and concerns among insurers that the individual mandate will not be enforced.

Fix it, Don't End It: Common Sense Solutions for Individual Market Stability

While CBO has concluded that the ACA's insurance markets are likely to be stable in most places, if left unchanged, continued policy uncertainty over the law's future could cause more insurers to exit the market or to increase premiums.

A bipartisan consensus on a set of policies that would boost and maintain enrollment in the ACA marketplaces and stabilize insurer participation and premiums is not out of reach. For federal policymakers who want to improve the individual markets and build on the coverage gains launched by the ACA, such common sense policy fixes would include:

- *A clear and long-term commitment to paying the CSR reimbursements.* The Trump administration has threatened to cut off CSR reimbursements, which for 2018 are projected to be roughly $8 billion. If these reimbursements do terminate at the end of this year, CBO has estimated it will result in an average 20 percent increase in 2018 premiums and many insurers have signaled they will need to exit the market if the funds are cut. For insurers to commit to continued participation, they need certainty from Washington that they will be reimbursed for those costs.
- *A reinsurance program or similar premium stabilization fund*. The individual health insurance market is likely always to have a somewhat sicker risk pool than the employer group market, if for no other reason than there are many people unable to work full time because of their health status. One of the primary drivers of premium increases in 2017 was the expiration of the ACA's reinsurance program. When Alaska enacted a

state-based reinsurance program in 2016, proposed premium increases were reduced from 42 percent to just 7 percent.

- *Higher funding for outreach and enrollment assistance*. Robust support for outreach and education campaigns and one-on-one assistance with eligibility determinations and plan selection are critical not just to keep enrollment stable and growing, but to maintain a healthy risk pool.
- *A fix to the "family glitch"*. Under Obama administration rules, families are denied access to financial assistance on the marketplaces if one family member has access to affordable employer-based self-only coverage, even if the coverage isn't affordable for the family. Reversing this interpretation of the ACA would make coverage more affordable for significant numbers of families and boost enrollment in the marketplaces.
- *Affordability improvements*. The top reason people don't enroll in individual market insurance is that they don't perceive it to be affordable. One way to solve this problem is to improve the generosity of the subsidies to defray consumers' premium and cost-sharing expenses.
- *A level playing field*. The continuation of health plans that do not have to comply with ACA rules, referred to as transitional or "grandmothered" plans, has perpetuated a segmented market and adverse selection against the ACA's marketplaces. This, in turn, has led to higher premiums for people enrolled in ACA-compliant plans. Similarly, federal policy should prevent insurers or other entities, such as health sharing ministries, from marketing "look alike" products that mimic health insurance but do not comply with the ACA's consumer protections. Entities selling these products siphon off healthy enrollees, leaving the ACA's marketplaces with a sicker, more expensive risk pool.
- *A simpler eligibility and enrollment process*. When it takes as much as 90 minutes for a consumer with a relatively uncomplicated financial and health situation to apply for and enroll in coverage, something is wrong. An onerous and complicated process discourages healthy people from signing up and depresses overall enrollment. The federal and state marketplaces need to invest more in the design and user testing of their IT systems to make the sign up process as simple and quick as possible.
- *Smarter, not skimpier, benefit design*. What to do about high deductibles? Every year, as many as 20 percent of marketplace enrollees drop out, in part because of dissatisfaction with high deductibles. What we need are not skimpier benefit designs but smarter designs. For example, policymakers could require high deductible plans to provide some benefits pre-deductible, such as two or three annual primary and urgent care visits and a prescription or two, in addition to preventive services like birth control and pediatric wellness visits. This could, in turn, improve the attrition rate in marketplace plans, as consumers receive more high-value services without having to pay the full cost.
- *A fallback plan*. Under the ACA, private insurers are the sole route through which consumers can obtain premium tax credits and cost-sharing subsidies. But the law doesn't require those insurers to participate. When Congress created the Medicare Part D program, the authors were worried there might be some parts of the country that would lack a willing insurer, so they created a fallback option, to be triggered only if

there weren't at least two plans available. With many parts of the country down to just one insurer participating in the individual market, Congress could take a page from Medicare Part D and create a similar fallback option for the marketplaces.

- *Flexibility to provide regulatory relief*. Congress could also consider giving HHS and states greater flexibility to provide regulatory relief to insurers willing to compete in underserved markets, such as by relaxing network adequacy standards, supporting the use of telemedicine for some services, or offering the ability to recoup losses in future years if an insurer had an unexpectedly bad year.

Are all of the above politically feasible in today's polarized climate? Probably not. Several would require more federal spending. But in the late 1990s, Medicare Advantage faced similar challenges, with many private insurers pulling out of that market. In response to that crisis, Congress did not repeal the program or reduce its funding. Rather, congressional leaders negotiated and passed bipartisan reforms that injected new financing to enhance plan payments. Plenty of people criticized the costs of that policy at the time, but it did result in dramatic enrollment growth and stable insurer participation.

As this Congress considers potential improvements to the ACA, I encourage you to continue the bipartisan, civil discussions that you are engaged in today. The law is by no means perfect, but it has improved the health and financial well-being of millions of American families. Future efforts to amend the ACA must be judged by whether they build upon the ACA's coverage expansions and keep insurance accessible, affordable, and adequate to meet enrollees' health care needs.

Thank you and I look forward to your questions.

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