Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

STATEMENT OF
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Good morning, Mr. Chairman, Ranking Member Foxx, members of this committee. I am Sabrina Corlette, a Research Professor at Georgetown University's Center on Health Insurance Reforms (CHIR). I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA). The views I express today are my own and do not reflect those of Georgetown University.

I thank you for the opportunity to testify, and for the leadership of this Committee in addressing the need for affordable job-based coverage, particularly for those with pre-existing conditions. In my testimony I will discuss many of the challenges that people with pre-existing conditions faced in obtaining affordable, adequate insurance before the ACA was enacted, how the ACA was designed to address those challenges, and how current threats to the ACA could have disproportionately harmful effects on individuals and workers with health care needs.

The ACA Corrected Many Problems in a Dysfunctional Insurance Market

The Affordable Care Act was enacted in part to correct serious deficiencies in health insurance markets that left millions uninsured and millions more with inadequate coverage that failed to protect them from serious financial harm if and when they got sick. In order to assess the impact the ACA has had, it is important to understand the problems that Congress was seeking to solve when it enacted the law in 2010.

Prior to implementation of the Affordable Care Act's market reforms, approximately 48 million Americans lacked health insurance.[1] Those without health insurance have a lower life expectancy than those with coverage. Before the ACA was enacted, an estimated 22,000 people per year died prematurely because they lacked insurance.[2] This is likely because the uninsured are more than six times as likely as the insured to delay or forego needed care due to costs. For example, uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.[3]

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.[4] Additionally, prior to the ACA, the high and rising uninsured rate led to high and rising uncompensated care costs for providers, in 2009 estimated at $1000 worth of services per

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[1] DeNavas-Walt C, Proctor BD, Smith J. *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, U.S. Census Bureau, Sept. 2013. Available at https://www.census.gov/prod/2013pubs/p60-245.pdf.

[2] Dorn S. *Uninsured and Dying Because of It,* The Urban Institute, Jan. 2008. Available at https://www.urban.org/sites/default/files/publication/31386/411588-Uninsured-and-Dying-Because-of-It.PDF.

[3] *Lives on the Line: The Deadly Consequences of Delaying Health Reform,* Families USA, Feb. 2010. Available at http://familiesusa.org/sites/default/files/product_documents/delaying-reform.pdf.

[4] Cunningham, P. and Sommers, A. *Medical Bill Problems Steady for U.S. Families 2007-2010,* Center for Studying Health System Change, Dec. 2011. Available at http://www.hschange.org/CONTENT/1268/?words=tracking%20report%2028.

uninsured person.[5] Providers ultimately pass those costs onto insured consumers and taxpayers.

Prior to the ACA, for most workers with job-based coverage, leaving their job – to care for a loved one, start their own business, or pursue other work that better fit their skills and talents – meant leaving the guarantee of subsidized health insurance coverage sponsored by the employer for the uncertainty of the individual health insurance marketplace. Economists call this "job lock." Until 2014, the individual health insurance market was an inhospitable place, particularly for anyone in less than perfect health. That's a lot of us - an estimated 133 million Americans have at least one pre-existing condition.[6]

Additionally, although most large employer plans were relatively comprehensive and affordable before the ACA, some plans offered only skimpy coverage or had other barriers to accessing care, leaving individuals—particularly those with costly, chronic health conditions—with big bills and uncovered medical care. For that reason, in addition to reforms for the individual and small-employer insurance markets, the ACA extended several meaningful protections to employees of large businesses.

Problems with Access

Prior to the ACA, in most states, applicants for health insurance could be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors.[7] For many, coverage was often simply not available at any price. One of the many ways insurers maximized revenue was through aggressive underwriting practices resulting in a denial of coverage to individuals posing a potential health risk.[8] A Georgetown University study found that even people with minor health care conditions, such as hay fever, could be turned down for coverage.[9]

A U.S. Government Accountability (GAO) study in 2011 found that average insurer denial rates were 19 percent, but they varied dramatically market-to-market and insurer-to-insurer. For

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[5] Hu, L. et al. *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing,* National Bureau of Economic Research, Feb. 2018. Available at http://www.nber.org/papers/w22170.

[6] Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, Issue Brief, Jan. 2017. Available at https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[7] Corlette S, Volk J, Lucia K. *Real Stories, Real Reforms.* Robert Wood Johnson Foundation, Sept. 2013. Available at https://georgetown.app.box.com/file/124506387872.

[8] U.S. Government Printing Office, Senate Hearing 113-663. *A New, Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules*, U.S. Senate Health, Education, Labor & Pension Committee, Apr. 11, 2013. Available at https://www.gpo.gov/fdsys/pkg/CHRG-113shrg95186/html/CHRG-113shrg95186.htm.

[9] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?* Georgetown University and Kaiser Family Foundation, Jun. 2001. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumers-in-less-than-perfect-health-executive-summary-june-2001.pdf.

example, across six insurers in one state, denial rates ranged from 6 percent to 40 percent.[10] These underwriting practices were banned by the ACA in 2014.

Additionally, it was not uncommon for insurers to rescind coverage after they had accepted an applicant. If an enrollee had any health care claims within their first year of coverage, the insurer would investigate that person's health history. If they found evidence that their condition was a pre-existing one and not fully disclosed during the initial underwriting process, even if unintentional, the company would deny the relevant claims and rescind or cancel the coverage.[11] The ACA has prohibited this practice except in clear cases of fraud by the policyholder.

Problems with Affordability

Prior to the Affordable Care Act, individual insurance was often unaffordable. Unlike those with employer sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance had to pay the full cost of their premium. According to one national survey prior to the ACA, 31 percent of individual market respondents spent 10 percent or more of their income on premium costs.[12] And, although those leaving job-based coverage were guaranteed access to an individual policy so long as they maintained continuous coverage, federal rules did not limit how much insurers could charge in premiums based on their age, gender, or health status.

As a result, the cost of premiums caused many individuals to forego coverage completely. A national survey found that nearly three-quarters (73 percent) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high. The coverage was least affordable for those individuals who needed it the most – people with pre-existing conditions.

Prior to the ACA, older and less healthy individuals had to pay more for coverage because health insurers would segment their enrollees into different groups and charge them different prices based on their health or other risk factors. In practice, this meant that people would be charged more because of a pre-existing condition (even if they had been symptom-free for years), because of their age, gender (insurers assume women use more health care services than men), family size, geographic location, the work they do, and even their lifestyle.[13] A

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[10] U.S. Government Accountability Office. *Private Health Insurance: Data on Application and Coverage Denials*, Mar. 2011. Available at https://www.gao.gov/assets/320/316699.pdf.

[11] Girion L. *Health Insurer Tied Bonuses to Dropping Sick Policyholders*, Los Angeles Times, Nov. 9, 2007. Available at http://articles.latimes.com/2007/nov/09/business/fi-insure9.

[12] Collins SR, Robertson R, Garber T, Doty MM. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act*, The Commonwealth Fund, Apr. 2013. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

[13] Buntin MB, Marquis MS, Yegian JM. *The Role Of The Individual Health Insurance Market And Prospects For Change*, Health Affairs, Nov./Dec. 2004. Available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.6.79.

Georgetown University study of insurers' rating practices before the Affordable Care Act found rate variation of more than nine-fold for the same policy based on age and health status.[14]

Under the Affordable Care Act, using health status and gender to set premium rates is prohibited. In addition, the Affordable Care Act provides low- and moderate-income people between 100 and 400 percent of the federal poverty line with subsidies to help defray their premium costs. In 2018, the average monthly premium tax credit was $550, resulting in an average monthly premium for consumers receiving a premium tax credit of $89.[15]

Problems with Coverage Adequacy

Prior to the Affordable Care Act, coverage in the individual market was often inadequate to meet people's health care needs. In addition to paying more in premiums, people in the individual market also spent a larger share of their income on cost-sharing than those with employer-sponsored coverage. A primary reason people buying individual insurance coverage had high out-of-pocket costs was that many individual plans – over half according to one study – did not meet minimum standards for coverage.[16] Coverage in the individual market was inadequate for a number of reasons, including:

- ***Pre-existing condition exclusions***: in many states, insurers in both the individual and employer group markets were permitted to permanently or for a period of time exclude from covered benefits treatments for any health problem that a consumer disclosed on their application. This practice was banned under the Affordable Care Act.
- ***Benefit exclusions***: Insurers in the individual market often sold policies that did not cover basic benefits such as maternity care, prescription drugs, mental health, and substance use treatment services. For example, 20 percent of adults with individual insurance lacked coverage for prescription medicines before the Affordable Care Act.[17] The Affordable Care Act requires insurers in the individual and small employer markets to cover a minimum set of essential health benefits that includes maternity services, prescription drugs, and mental health and substance use treatment. The ACA also requires plans, including employer plans, to cover recommended preventive services without consumer cost-sharing.
- ***High out-of-pocket costs***: Prior to the Affordable Care Act, individual insurance policies often came with high deductibles – $10,000 or more was not uncommon – and high

[14] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?*
[15] Kaiser Family Foundation. *Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC)*, Open Enrollment 2018. Available at https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[16] Gabel JR et al. *More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014*, Health Affairs, Jun. 2012. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1082.
[17] Doty MM, Collins SR, Nicholson JL, Rustgi SG. *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*

cost-sharing.[18] In fact, deductibles were often three times what they were in employer-sponsored plans. As a result, many individual insurance plans were extremely low-value. The ACA requires plans to cover, at minimum, 60 percent of an average enrollee's covered health care costs. The law also helps protect consumers in both individual and employer plans from catastrophic medical costs by capping their annual out-of-pocket spending (for 2019, the annual cap is $7900 per individual).

- ***Lifetime or annual dollar limits on coverage***: Prior to enactment of the ACA, an estimated 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. An estimated 18 million people were in plans with annual dollar limits on their benefits. For people with serious high cost medical conditions, such as hemophilia, serious cancers, or end-stage renal disease, this can literally be a life or death issue. The ACA ushered in bans on lifetime and annual dollar limits for both individual and employer group plans.

The ACA: Expanding Coverage, Protecting People with Health Care Needs

One of Congress' goals for the ACA was to extend affordable, adequate health insurance coverage to more people and to protect people with pre-existing conditions from common insurance industry practices, described above. Congress tried to achieve these goals through a three-pronged strategy:

- Insurance reforms for the individual and employer group markets to help people with health care needs;
- 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). The Affordable Care Act also created state-based insurance marketplaces where people can apply for the subsidies and shop for plans.

To a significant degree, the ACA has achieved its goals. It has expanded access to insurance coverage, improved health outcomes, and improved families' financial security. Under the ACA, the percentage of people uninsured declined from 14.5 percent in 2013 to 9.1 percent in 2017. An estimated 20 million people gained insurance coverage because of the ACA, although some recent survey data suggest those gains are now being reversed.[19,20]

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[18] McDevitt R et al. *Group Insurance: A Better Deal For Most People Than Individual Plans*, Health Affairs, Jan. 2010. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0060.

[19] Cohen RA, Zammitti EP, Martinez ME. *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017*, Centers for Disease Control and Prevention, National Center for Health Statistics, May 2018. Available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

[20] Gallup News, U.S. Uninsured Rate Rises to Four-Year High, January 23, 2019. Available at https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx.

The goal of expanding coverage is ultimately to improve people's health outcomes and their financial security in the event of an unexpected illness or injury. Although the law is only a few years old, data are beginning to emerge that suggest it is having a significant positive impact.

Since enactment of the ACA, the percentage 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.[21] Further, more people are reporting that they have a primary care doctor or have had a check-up in the last 12 months.[22]

Research also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the health 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.[23] A Harvard study found that expanded coverage under the ACA was linked to major improvements in the diagnosis and treatment of chronic diseases such as hypertension, diabetes, and high cholesterol.[24]

In addition to improving access to care, health insurance also provides financial security, particularly in the event of a large, unanticipated medical expense. Survey data show that the number of families who say they are having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families.[25]

The ACA has also helped reduce 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.[26]

Unfortunately, much of the progress under the ACA is at risk due to litigation that threatens to overturn the law, as well as recent federal policy decisions designed to roll back key provisions of the law and bypass consumer protections. Ultimately, some of these decisions are likely to

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[21] McCarthy, J. *U.S. Women More Likely Than Men to Put Off Medical Treatment,* Gallup, Dec. 2017. Available at http://news.gallup.com/poll/223277/women-likely-men-put-off-medical-treatment.aspx.

[22] Karpman, M. et al. *Time for a Checkup: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Plan Satisfaction among Parents and Children between 2013 and 2015,* Urban Institute, Jan. 2016. Available at http://hrms.urban.org/briefs/changes_coverage_access_affordability_parents_children.pdf.

[23] Van Der Wees, PJ, et al. *Improvements In Health Status After Massachusetts Health Care Reform,* National Center for Biotechnology Information, Dec. 2013. Available at https://www.ncbi.nlm.nih.gov/pubmed/24320165.

[24] Hogan DR et al. *Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions*, Health Affairs, Sept. 2015. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.1435.

[25] Karpman, M and Long, S. *9.4 Million Fewer Families Are Having Problems Paying Medical Bills,* Urban Institute, May 2015. Available at http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having-Problems-Paying-Medical-Bills.pdf.

[26] Schubel, J and Broaddus, M. *Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains*, May 2018. Available at https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

result in consumers in the individual market facing higher premiums and fewer plan choices, while putting protections for workers with job-based coverage at risk.

Health System Upheaval and Workers Put at Risk: Consequences of Overturning and Undermining the ACA

Texas v. Azar: ACA "Repeal" without "Replace"

The attorney general of Texas leads a coalition of states seeking to have the ACA enjoined, arguing that the individual mandate is unconstitutional, and the rest of the law is non-severable from the mandate provision. A district court judge has agreed with that view, although he has stayed enjoining the law while his decision is being appealed.[27] Granting Texas' request to enjoin the ACA amounts to an effort to repeal the law without any clear public policy to replace it. Congress explicitly rejected repealing the ACA without a replacement in 2017. This is because uprooting a complex law that has been in place for almost 10 years, touches almost every facet of our health care system, and includes many provisions with widespread bipartisan support (such as allowing young adults to stay on their parents' plans until age 26, closing the Medicare drug benefit "donut hole," and expanding Medicaid) will inevitably result in dramatic negative consequences:

First, an estimated 32 million people will lose their insurance coverage.[28] Second, those remaining in the individual market would see their premiums roughly double.[29]

Third, even a partial repeal of the provisions of the ACA would primarily harm working middle class Americans. The majority of people losing coverage – as many as 82 percent – would be in working families.[30] Fourth, repealing the ACA will have significant negative consequences for public health and safety. For example, researchers from Harvard and New York University found that repealing the ACA would result in 1.25 million Americans with serious mental conditions losing coverage. They further estimate that 2.8 million Americans with a substance use disorder, including roughly 222,000 with an opioid-related disorder, would lose coverage.[31]

Fifth, repealing the ACA will drive insurance companies out of the market. The CBO estimated that legislation repealing the ACA would leave an estimated three-fourths of the nation's

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[27] *Texas v. Azar…* https://affordablecareactlitigation.files.wordpress.com/2018/12/Texas-v.-US-partial-summary-judgment-decision.pdf

[28] Congressional Budget Office. *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017*, Jul. 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

[29] *Id*.

[30] Blumberg L, Buettgens M, Holahan J. *Implications of Partial Repeal of the ACA Through Reconciliation*, Urban Institute, Dec. 2016. Available at https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.

[31] Frank RG, Glied SA. *Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses*, The Hill, Jan. 2017. Available at http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders.

population in areas where no insurers are willing to offer nongroup coverage by 2026.[32] These estimates align with my own research at Georgetown, in which colleagues and I conducted interviews with 13 health insurance company executives participating in the individual markets in 28 states. In those interviews, executives told us they would "seriously consider" a market withdrawal if the ACA were repealed.[33]

Sixth, an increase in the uninsured will impose significant financial harm on hospitals and other health care providers. For example, repealing the ACA without a replacement was estimated to cost the nation's public hospitals $54.2 billion in uncompensated care charges between 2018 and 2026.[34]

Seventh, repeal of the ACA would lead to significant negative economic consequences. For example, repealing just the Medicaid expansion and Affordable Care Act tax credits would result in an estimated loss of 2.6 million jobs across the country.[35]

Eighth, and importantly for this committee, overturning the ACA would also harm the estimated 156 million Americans with job-based insurance who will lose critical protections, including:[36]

Preventive Services Without Cost-Sharing

The ACA requires all new health plans, including those sponsored by employers, to cover recommended preventive services without cost-sharing, bringing new benefits to 71 million Americans.[37] That means individuals can get the screenings, immunizations, and annual check-ups that can catch illness early or prevent it altogether without worrying about meeting a costly

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[32] Congressional Budget Office. *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017*, Jul. 2017.

[33] Corlette S, Lucia K, Giovannelli J, Palanker D. Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices, Georgetown University and Robert Wood Johnson Foundation, Jan. 2017. Available at https://georgetown.app.box.com/file/127781433019.

[34] America's Essential Hospitals. *ACA Replacement Must Protect Vulnerable People, Communities*, Feb. 2017. Available at https://essentialhospitals.org/wp-content/uploads/2017/02/UCC-policy-brief-February-2017-FINAL.pdf.

[35] Ku L, Steinmetz E, Brantley E, Bruen B. *Repealing Federal Health Reform: Economic and Employment Consequences for States*, The Commonwealth Fund, Jan. 2017. Available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/jan/ku-aca-repeal-job-loss/1924_ku_repealing_federal_hlt_reform_ib.pdf.

[36] Rae M., Claxton G., Levitt L., McDermott D., *Long-Term Trends in Employer-Based Coverage*, Kaiser Family Foundation, January 30, 2019. Available at https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/.

[37] U.S. Department of Health & Human Services, *Assistant Secretary for Planning and Evaluation, Seventy-one Million Additional Americans are Receiving Preventive Services Coverage without Cost-sharing Under the Affordable Care Act*, March 18, 2013. Available at https://aspe.hhs.gov/pdf-report/seventy-one-million-additional-americans-are-receiving-preventive-services-coverage-without-cost-sharing-under-affordable-care-act.

deductible or co-payment. Women employees can also access affordable contraception, making available a wider variety of contraceptive choices and increasing use of long-term contraceptive methods.

Pre-Existing Condition Exclusions

Under the ACA, employers cannot impose a waiting period for coverage of a pre-existing condition. Prior to the ACA, individuals who became eligible for an employer plan—for example, once hired for a new job—might have to wait up to 12 months for the plan to cover pre-existing health conditions. You could "buy down" that waiting period with months of coverage under another plan, so long as it was the right kind of plan and you didn't go without coverage for 63 days or more. But if you lost your job, couldn't afford COBRA, went a few months without coverage and then were lucky enough to get another job with benefits, you might find the care you needed wasn't covered under your plan for an entire year.

Dependent Coverage to Age 26

The ACA requires all health plans, including those sponsored by large employers, to cover dependents up to age 26. Prior to the ACA, one of the fastest growing groups of uninsured was young adults – not because they turned down coverage offered to them, but because they were less likely to have access to employer-based plans or other coverage. The result has been a dramatic increase in the number of insured young adults, particularly among those with employer-sponsored coverage.

Annual Out-Of-Pocket Limit

The ACA requires all new health plans, including those sponsored by employers, to cap the amount individuals can be expected to pay out-of-pocket each year. Prior to the ACA, even those with the security of coverage on the job couldn't count on protection from crippling out-of-pocket costs.

Prohibition On Annual and Lifetime Limits

The ACA prohibits employer plans from having an annual or lifetime dollar limit on benefits. Prior to the ACA, employer plans often included a cap on benefits; when employees hit the cap, the coverage cut off. For individuals who needed costly care, like a baby born prematurely or those with hemophilia or multiple sclerosis, that often meant a desperate scramble to find new coverage options as one after another benefit limit was reached.

External Review

The ACA guarantees individuals the right to an independent review of a health plan's decision to deny benefits or payment for services, regardless of whether the employer plan is insured or self-funded. Prior to the ACA, only workers in insured plans had the right to an independent review of a denied claim. But more than 60 percent of workers are in self-funded plans, and

before the ACA, the only option for those workers to hold their plan accountable was to sue, an expensive and lengthy process.[38]

Administrative Actions to Roll Back ACA Result in Higher Prices for Older, Sicker Americans

In 2016, financial data from insurers demonstrate that the ACA markets were beginning to stabilize and insurers were gaining their footing after a rocky start.[39] Indeed, in 2017 the CBO concluded that the ACA's insurance markets would likely be stable in most places if left unchanged.[40] Consistent with this projection, 2017 appears to have been a profitable year for most individual market insurers.[41]

Unfortunately, my own review of insurers premium rate justifications (referred to as actuarial memoranda) for plan years 2018 and 2019 found that recent policy changes are putting the stability of the individual market at risk.[42] Specifically:

The Trump administration's decision in October of 2017 to cut off reimbursement to insurers for low cost-sharing plans (called cost-sharing reduction or CSR plans) resulted in significant premium increases in 2018. Additionally, the uncertainty about that decision, which the President had been threatening for months, was a contributing factor for some insurers to either exit the marketplaces or reduce their service areas.

Additionally, although Congress did not zero out the individual mandate penalty until 2019, many insurers increased premiums for 2018 coverage on the expectation that the Trump administration would not enforce the individual mandate.

Similarly, insurers increased premiums due to the Trump administration's decision to decrease spending on marketplace advertising and consumer assistance, which are critical for educating and enrolling the healthy uninsured. For example, a Cigna filing for 2018 noted that they

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[38] Kaiser Family Foundation, 2018 Employee Benefit Survey, October 3, 2018. Available at https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/.

[39] Banerjee D. *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer*, S&P Global Ratings, Dec. 2016. *See also* Herman B. *How some Blues made the ACA work while others failed*. Modern Healthcare. October 15, 2016. Available at www.modernhealthcare.com/article/20161015/MAGAZINE/310159989.

[40] *H.R. 1628 American Health Care Act of 2017,* Congressional Budget Office, May 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[41] Cox C, Semanskee A, Levitt L. Individual Insurance Market Performance in 2017, Kaiser Family Foundation, May 2018. Available at http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in-2017.

[42] *See* Corlette S. *The Effects of Federal Policy: What Early Premium Rate Filings Can Tell Us About the Future of the Affordable Care Act*, CHIRblog, May 2018. Available at http://chirblog.org/what-early-rate-filings-tell-us-about-future-of-aca/; Corlette S. *We Read Actuarial Memoranda so You Don't Have to: Trends from Early Health Plan Rate Filings*, CHIRblog, Jun. 2017. Available at http://chirblog.org/we-read-actuarial-memoranda-so-you-dont-have-to/; Corlette S. Proposed Premium Rates for 2018: What do Early Insurance Company Filings Tell Us? CHIRblog, May 2017. Available at http://chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings-tell-us/.

expected a smaller and sicker population in their risk pool due to the lower "overall awareness of individual health insurance products."

Going into 2019, insurers predicted that their risk pools would be smaller and sicker due to "potential movement into other markets." These markets include association health plans and short-term health plans, both of which are exempt from many of the Affordable Care Act's consumer protections and are being promoted by the Trump administration as cheaper alternative coverage.

Individuals who are eligible for the ACA's premium tax credits are largely insulated from these premium increases because the tax credit rises, dollar for dollar, with the increase in premiums for silver level health plans. The people who suffer the most from these premium increases are the working middle class: entrepreneurs who run their own businesses, freelancers and consultants, independent contractors, farmers and ranchers, and early retirees who earn too much to qualify for the ACA's premium subsidies.

For people with job-based coverage, the higher prices and uncertainty roiling the individual market inevitably leads to more "job lock," as people stay in jobs that guarantee health benefits, even if their skills and talents are not optimally deployed.

Conclusion

The ACA is by no means perfect, and there remain many people who struggle to find affordable health care coverage. Even the law's most ardent supporters acknowledge that more could be done to encourage states to expand Medicaid, help families who earn too much to qualify for subsidies, reduce excessive deductibles, and improve access for those who are otherwise ineligible for coverage. There are a range of policy options that would strengthen the law's foundation while also building on its remarkable achievements. I applaud this committee for providing a forum for constructive debate on these issues. Thank you, and I look forward to your questions.