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PATIENT RELIEF FROM COLLAPSING HEALTH MARKETS

THURSDAY, FEBRUARY 2, 2016

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Present: Representatives Burgess, Guthrie, Shimkus, Murphy, Blackburn, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Barton, Upton, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Eshoo, DeGette, McNerney, Tonko, and Pallone (ex officio).

Staff present: Mike Bloomquist, Deputy Staff Director; Adam Buckalew, Professional Staff, Health; Karen Christian, General

Counsel; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Paul Edattel, Chief Counsel, Health; Blair Ellis, Digital Coordinator/Press Secretary; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff, Health; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Director of Communications; Peter Kielty, Deputy General Counsel; Katie McKeough, Press Assistant; Carly McWilliams, Professional Staff Member, Health; James Paluskiewicz, Professional Staff, Health; Kristin Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Luke Wallwork, Staff Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Jessica Martinez, Minority Outreach and Member Services Coordinator; Dan Miller, Minority Staff Assistant; Samantha Satchell, Minority Policy Analyst; Matt Schumacher, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Arielle Woronoff, Minority Health Counsel.

Mr. Burgess. I want to thank our guests for being with us this morning. I thank everyone for their indulgence. The Subcommittee on Health will now come to order. I will recognize

myself for 5 minutes.

We are all here to help Americans, all Americans, insured, uninsured and functionally uninsured. We want people to get access to quality affordable health care. Our system is plagued with problems that impose the highest burden on individuals and consumers who have fewer choices, sometimes burdensome mandates, costs that continue to spike and -- Americans who remain uninsured.

Leading up to the 2016 elections, promises were made to voters that the health care system would get back on track. We laid out a step-by-step plan to prioritize access to quality affordable health care not just insurance. The new administration has taken steps to reduce the regulatory burden and this hearing marks another step in that journey to stabilize and rebuild our health care system.

I will be the first to admit we do not agree on everything, but members of this subcommittee, both sides of the dais, have a strong track record of advancing bipartisan legislation. I am confident we can continue to advance bills through an open and through an inclusive process to protect and empower patients.

In today's hearing we will consider policies that bolster the health markets and reassure Americans that help is on the way. To start, we all agree that individuals should have the comfort of knowing that they will not be denied a health plan from an insurer based upon their health status.

Chairman Walden has offered a bill that will maintain safeguards for patients with preexisting conditions following the repeal of the Affordable Care Act. In addition, Representative Brooks is working on a bill that will go beyond protections for preexisting conditions by creating incentives for continuous coverage.

Currently, individuals moving from one job to another are protected from rate increases by existing law. Extending these protections to the individual market is a simple but important reform that will encourage Americans to enroll in coverage and to stay enrolled. Rather than forcing people to buy insurance that fails to meet their needs, this policy will reward people for making responsible decisions.

Young, healthy adults have faced the highest rate hikes in premiums to account for the higher costs of covering older, less healthy individuals. Today we will discuss legislation offered by Representative Bucshon to modify age rating restrictions and bring younger, healthier individuals into the insurance market.

Regulations have allowed individuals to keep coverage for a full 3 months without paying premiums. Dozens of statutory and regulatory instances allow individuals to enroll in a plan through a special enrollment period. To stabilize the market, Representative Flores and Representative Blackburn have offered legislation intended to end manipulation of health insurance rules.

I look forward to hearing from our witnesses on the merits of setting the grace period to 30 days for nonpayment of premiums and requiring verification of eligibility for those special enrollment periods. I think it is important to note that all of these bills, all of these bills would allow states the flexibility to modify the requirements. After all, states understand what their residents need better than Washington.

Good policy that will stand the test of time requires hard work. It requires compromise. It requires the scrutiny of the American people. As we learned as with the Affordable Care Act, policy hastily built by folks behind closed doors results in devastating consequences. We are committed to large-scale reform. Real people are struggling as we speak and we are not waiting to take action.

These bills are an important example of the work we are doing right now, right now to advance member-driven solutions that will improve health care for Americans. I am hopeful, hopeful that we can work together to reform our health system for the benefit of the American people.

And I would now like to yield the remainder of my time to Dr. Larry Bucshon of Indiana.

[The statement of Mr. Burgess follows:]

**********COMMITTEE INSERT 1**********

Mr. Bucshon. Thank you, Mr. Chairman. Currently the Affordable Care Act requires that the most generous plan costs no more than three times the least generous plan according to age. As a consequence, younger healthier individuals have been priced out of the health insurance market, destabilizing risk pools and driving premiums higher for everyone.

H.R. 708, the State Age Rating Flexibility Act of 2017 would set this ratio at 5:1 or also allow states to set their own age rating based on their unique patient population. For example, Indiana had no age rating prior to the ACA. This solution encourages more actuarially sound plans to enter the marketplace, providing more affordable options for younger, healthier individuals and bringing them back into the insurance market to more adequately balance the risk pools and drive down the premiums for almost everyone. I yield back.

[The statement of Mr. Bucshon follows:]

**********COMMITTEE INSERT 2**********

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman and the chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for the purpose of an opening statement, please.

Mr. Green. Thank you, Mr. Chairman. Before I start, we have a member of our Energy and Commerce Committee but not a member of the subcommittee. I would like to ask to waive on Jerry McNerney who will be here shortly and I just wanted to give notice that --

Mr. Burgess. Is the gentleman making a unanimous consent request?

Mr. Green. Yes.

Mr. Burgess. Without objection, so ordered.

Mr. Green. Okay, and Congressman Paul Tonko also, unanimous consent.

Mr. Burgess. Again, without objection, so ordered.

Mr. Green. Thank you, Mr. Chairman. Thanks to the Affordable Care Act, 20 million previously uninsured Americans now have health coverage. For the first time ever, less than nine percent of Americans are uninsured with the uninsured rate currently at 8.6 percent. Since the enactment of the ACA, for roughly 150,000 million Americans who have coverage through their employer, premium growth remains much lower than in the past and everyone benefits from consumer protections and provisions that improve and expand coverage. Unfortunately, my

colleagues want to undo the progress we have made. There should be no repeal of health care reform without an immediate adequate replacement that achieves the same historical gains in coverage, ensures people with preexisting conditions aren't blocked or priced out of the market, and that health plans cover a basic set of benefits and consumer protections.

Repealing the Affordable Care Act in whole or in part without an adequate replacement in place would cause chaos and is downright irresponsible. It has been 7 years and despite claims to have a better way, the bills we are considering today will only further sabotage the existing system and offer only unfinished, inadequate proposals that as written would leave Americans worse off and put insurance companies back in charge.

It is truly fitting that today is Groundhog Day, except unlike Bill Murray it is not a comedy. For 7 years we have asked Republicans to work with us to strengthen the ACA and make health care more affordable and accessible and for 7 years they told us they would not. This is real and not an abstract intellectual debate and the discussion draft my colleagues have put forward today is just indefensible. Thirty million people would stand to lose their health insurance if the ACA is repealed. The emergency room should not be the point of entry for our health care system. It is bad for patients, budgets and the health care system as a whole. Repeal and replace is a slogan not a meaningful policy and would likely put us on a path to catastrophe.

The gravity of the situation is hard to overstate. There are real people with real concerns who deserve more than a half written bill and inadequate talking points. Proceeding with repeal with half-baked ideas for replacement is offensive and confusing and alarming. My colleagues across the aisle control the Congress and the White House. Millions of people are relying on them and looking to them for what they are going to do to protect them. We are well past talking points and the American people deserve answers. As always, I stand to work with my colleagues, with anyone, to amend and improve the Affordable Care Act. And thank you, Mr. Chairman. I yield the remaining balance of time to Congresswoman Schakowsky.

Ms. Schakowsky. Thank you. It has been reported that some of our Republican colleagues have recently voiced important and specific concerns about repealing the ACA. And for example, Congressman Tom McClintock of California, quote, said we better be sure that we are prepared to live with the market we have created that is going to be called Trumpcare. Republicans will own that lock, stock and barrel. And then Congressman Tom McArthur of New Jersey said, quote, we are telling those people that we are not going -- oh, that we are not going to pull the rug out from under them, and if we do this too fast we are in fact going to pull the rug out from under them.

Mr. Cassidy pointed out that their plan to tax employer sponsored insurance will increase taxes on the middle class and

these serious concerns and unanswered questions show that Republicans are finally starting to realize what Democrats have known all along that their plan to sabotage the ACA will leave millions of Americans without coverage, will reduce the quality of insurance and will raise costs for everyone.

And regardless of the rhetoric that we may here today, we know that this half written, half-baked bill put forth by Chairman Walden will allow insurance companies to charge people with preexisting conditions whatever they want and charge them whatever they want for their coverage. That is what the bill actually does.

Now that Republicans have started to recognize the consequences of their plan to take away coverage from 30 million Americans, I hope that they will finally actually work with us to make health care more affordable and more accessible. We are ready to sit down. We have been ready for 7, 8 years to do exactly that. Let's do it.

I do agree with the chairman of the subcommittee that we all agree that we want to provide quality, affordable health care. Those Republicans who have misgivings are right to have that. So let's sit down and do it together instead of these continual proposals that will hurt all of our constituents. And I yield back to the gentleman from Texas.

[The statement of Ms. Schakowsky follows:]

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Mr. Burgess. The gentle chair thanks the gentlelady. The gentlelady yields back. The chair would like to recount the number of times it was rebuffed by the Obama administration on those very points, but I will reserve that until later. The chair now recognizes the chairman of the full committee, Mr. Walden, 5 minutes for questions, please, for opening statement, please.

The Chairman. Yes, thank you. Thank you, Mr. Chairman, I appreciate it and I appreciate the concerns of my colleagues. I would note from the record there have been multiple pieces of legislation since Obamacare was enacted that have received Democrat and Republican votes and actually signed by the President to repeal problems in Obamacare. Those became law.

So to argue that nothing has ever been done to try and straighten it out is false. I think Democrats combined cast 4,775 votes to repeal, to reform, to change Obamacare, so check the facts. We are here today, we know on our side we are going to repeal Obamacare. It is not working. It has left a lot of wreckage around. We are here to clean it up. And in fact we are wide open to hearing from our colleagues on policy. That is what we are about.

We know Obamacare has, what it has done to the health care system. It is why we are hard at work crafting reconciliation language to repeal it, and today we begin the important work of laying the foundation to rebuild America's health care markets as we dismantle Obamacare. We have to save this individual health

care insurance market. It is collapsing. And if you want to walk away and just let it collapse, a pox on your side. That is not what I am about. I have always been a problem solver.

You will hear us in a minute talk about bipartisan legislation, go after those who try and corner certain markets, drive up costs -- things like EpiPen. I am happy to work with you, but it has to be something that can move this forward and take care of people. There is no shortage of evidence that patients and families are hurting under the overwhelming weight of Obamacare. Patients in 21 states have seen average premium increases of 25 percent or more this year. People in seven states will experience premium increases of 50 percent or more. That is not sustainable. In 2016 there were 225 counties across America that had just one insurance choice in the market, just one on the exchange. This year that number has climbed to a 1,022, 1,022 counties with just one insurer. That is a third of the entire number of counties in the country, a third. Five entire states now, patients there have just one choice.

And if you focus on what those plans are saying, they are evaluating right now whether they can even stay in these markets in the outlying years because of what is coming in existing law passed in a partisan manner by Democrats. Over five of the original 23 insurance co-ops remain in business, five of 23. They tried it, it didn't work. Two of those failed co-ops are sadly in my own state of Oregon and we are pretty progressive about

trying new things and a lot of it has worked. These did not.

We have the responsibility to prevent a real train wreck for millions of Americans. Not only can we solve this problem but we must solve this problem. It is time to end the partisan rhetoric and actually come to the table and solve these problems and I commend my colleagues on both sides of the aisle who are willing to do that.

The proposals before us today close enrollment gaps, protect taxpayers and give patients cost relief. The first three bills should come as no surprise. They were introduced last Congress and were the topic of two hearings in this subcommittee. The other proposal is equally important to all of us. We will ensure patients with preexisting conditions will always have access to coverage and care, period.

To take this a step further, we have included a placeholder as all of you have sort of referenced in your testimony, and I appreciate your testimony. Everybody has a different view of this. We want to get it right. That is why there is placeholder language. Our Better Way agenda envisions a new patient protection in the individual market for helping patients keep health coverage. HIPAA, Medicare Part B, Medicare Part D can serve as guidance for the Congress as we consider how best to achieve the goals of protecting America's sickest patients and maintaining market stability. We can do both without Obamacare's unpopular individual mandate where all these carve-outs have

occurred. We have got the best minds focused on helping us including our witnesses today. We are going to get this right. We are going to take the time to get this right. That is why you see a placeholder language in the draft. And my colleague Susan Brooks is championing these efforts and I would actually like to yield her a few minutes for remarks at this time, and then I will conclude with one other announcement.

[The statement of Mr. Walden follows:]

**********COMMITTEE INSERT 4**********

Mrs. Brooks. Thank you, Mr. Chairman. Yes, I agree. We all agree we have to save the individual market, yet we all know current law requires individuals to buy government dictated insurance. Instead, we propose giving people freedom from this mandate, it is only fair. Continuous coverage isn't a new idea. It has been discussed by reputable public policy organizations like the economic and political freedom center at Hoover Institution, free enterprise-focused American Enterprise Institute and others.

We don't pretend that this is the only solution, but we are confident that continuous coverage provides promise. That is why it is part of our Better Way Plan, a fairness agenda for helping patients get relief. And today this placeholder provides the clearest signal yet that we are working with patients and health care groups to draft language that balances important health status protections with necessary risk mitigation tools.

I look forward to the panelists' expert feedback today on the value of how this idea might help patients get and keep health coverage and with that I yield back.

[The statement of Mrs. Brooks follows:]

**********COMMITTEE INSERT 5**********

The Chairman. Mr. Chairman, if I could just conclude. While I know our focus today is on insurance reforms, we are also working in other areas of health care to bring relief to patients. Next week we will take up legislation sponsored by Representatives Bilirakis and Schrader, bipartisan bill that would incentivize generic drug development and increased competition in the market.

And for those in the industry who think it is okay to corner a market and drive up prices and rip off consumers, know that your days are numbered. President Trump made it clear in the White House meeting I attended with him and Vice President Pence, he wants competition that will bring lower drug prices and that is precisely what this measure will help accomplish.

Patients are tired of waiting for relief. We are going to move forward in a bipartisan way to give them help. It is an important first step. It needs to happen now. Specifically, the bill would require FDA to prioritize and expedite the review of generic applications for drug products that are currently in shortage or where there are few manufacturers on the market.

We all remember recent situations where bad actors jacked up the price of older, off-patent drugs because there was no competition. We want to make sure that does not happen again. This bill would also increase transparency around the current generic backlog at FDA, and while progress has been made there are still an unacceptably high number of generic drug applications sitting at the Food and Drug Administration that if and when

approved could bring additional lower cost alternatives to patients.

Whether it is examples like Daraprim or EpiPen, patients need solutions. I believe this bipartisan bill gives us a new tool to fight back on their behalf. I thank you for the indulgence of the committee and I yield back the balance of my time.

Mr. Burgess. The chair thanks the gentleman. The chair recognizes the gentleman from New Jersey, Mr. Pallone, 5 minutes for an opening statement, please.

Mr. Pallone. Thank you, Mr. Chairman. I am trying not to blow up here today because I like Chairman Walden, he is a nice guy. I like the gentlewoman from Indiana, she is a lovely woman. But I just, the statements that are coming out from the two of you about what you think you are doing versus what is really happening here are very disturbing to me.

No one has a problem with making improvements to the ACA, but you are not seeking to make improvements. You are seeking to repeal it without saying how you are going to replace it. And, you know, you can do a little, you know, if you really wanted to make some changes and do some things without repealing it, you know, we would be fine to work together, but there is no suggestion of that. And the idea that this is collapsing of its own weight is simply not true. The reason that the ACA is going to have problems here is because you and the President are purposely, in my opinion, making it collapse because of the policies that you

are espousing. You know, the best example of that was when the White House last week announced that they weren't going to anymore promotion. They were going to pull the ads, so that people wouldn't even be able to sign up or wouldn't even know what they were signing up for.

So, you know, don't suggest to me that somehow this is going to collapse because of the bill, because of the ACA. It is going to collapse because of purposeful Republican policies. And, you know, the gentleman from Indiana mentioned the individual mandate. You know that without the individual mandate that the younger and healthier people are not going to sign up, and then the insurance pool becomes broken and then the insurance companies pull out and gradually the ACA collapses, again if you eliminate the individual mandate.

So I just have to say, you know, Republicans have been rooting for the demise of the Affordable Care Act for 7 years, actively trying to sabotage the law. They have done this under the guise of having a better way, but today it is clear that this was never the case. Now that the time has come for them to actually show the public this better way they are in complete disarray and today it is clear that Republicans have no plan to replace the ACA. Every day their timeline changes and all they have successfully done so far is create chaos and uncertainty among patients and insurance companies. Chaos here with the ACA, chaos with immigration, chaos with foreign policy, the list goes on from this

badly motivated person, in my opinion, who is in the White House.

The bills we are discussing today are supposedly the first pieces of the Republican's elusive plan, so essentially after a 7-year smear campaign on the ACA they intend to move forward three bills from last Congress that help insurance companies instead of people.

And another bill, the only so-called replacement, is literally half written. You know, I had to laugh -- again I love you, Dr. Burgess, but I had to laugh when you said that the ACA was hastily built upon. I mean the chairman's bill literally runs off the page. I mean I took it this morning and I started to read it and then I got to Title II Continuous Coverage, it says incentive placeholder. Talk about hastily built, what is this half built? I mean I just, I don't even know where to begin.

I am going to stop because I have to give some time to Congressman Kennedy and then if there is also time to Representative Castor, so I will yield to the gentleman from Massachusetts initially.

[The statement of Mr. Pallone follows:]

**********COMMITTEE INSERT 6**********

Mr. Kennedy. Thank you, and I thank the ranking member. I want to thank Chairman Burgess and Ranking Member Green for their leadership as we confront one of the most contentious debates this body will address in the coming year. All of us in the subcommittee can agree that there is room for improvement in our health care system from premium deductibles that should be lower, insurance options in rural and underserved areas that must be increased.

But there are also areas where the law is working well. In Massachusetts we have a 2.8 percent unemployment rate and a 2.8 percent uninsured rate. On this side of the dais we are happy to have the debate about fixing the Affordable Care Act, but repealing the ACA without a replacement, and the four half measures today before us are not a replacement, will only exacerbate those problems. More than that it will erode the very minor progress that we have made to reform our mental health care system in this very room last year with 21st Century Cures.

For the roughly 43 million Americans suffering from mental illness, parity laws that currently guarantee coverage will crumble. For the 30 percent of patients with a mental health issue that is covered by the Medicaid expansion treatment will no longer be within reach. For constituents in all of our districts, red or blue, rural and urban, preventive screenings for behavioral health that can save lives will be unaffordable and inaccessible. Simply put, no matter where you live if you

have coverage or you are uninsured, you are on an uncertain path that will lead to seismic, tragic shifts in our behavioral health care system. Today is an opportunity for all of our colleagues to commit to changing course. I yield back.

[The statement of Mr. Kennedy follows:]

**********COMMITTEE INSERT 7**********

Mr. Pallone. Mr. Chairman, Mr. Walden had like an extra minute and a half and I would like Ms. Castor to have a minute if possible. I would ask unanimous consent.

Mr. Burgess. Are you asking an unanimous consent request? So ordered.

Ms. Castor. Well, thank you very much. Members, the fear across America is widespread about the Republican plan to withdraw this lifeline that is the Affordable Care Act. I wanted to tell you about a woman who approached me recently back in Tampa. 60 year old Kathy Palmer is a single parent with a student in high school, she is doing everything right. She is working part-time at a small company. She is working towards her bachelor's degree in accounting. She is paying her fair share in taxes.

She took personal responsibility because her company is so small and doesn't provide health insurance, she took personal responsibility and went shopping out on healthcare.gov, and in our very robust market, far from collapsing in the Tampa Bay area where we have 61 plans to choose from, she chose a plan and she has been paying her premiums.

And thank goodness for that because in December she wound up in the hospital with what she thought was a heart attack. When she got out of the hospital that bill for all the care she received was $70,000. Without the Affordable Care Act she would be bankrupt. Her future and probably her child's future would have been very bleak.

So I ask my Republican colleagues to listen to our constituents all across this country. Before you go and do the damage of repealing the Affordable Care Act understand what it will mean for the families that we represent and their economic futures. I yield back.

[The statement of Ms. Castor follows:]

**********COMMITTEE INSERT 8**********

Mr. Burgess. Does the gentleman from New Jersey yield back?

Mr. Pallone. Yes, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. We now conclude with member opening statements. The chair would remind members that pursuant to committee rules, all members opening statements will be made part of the record. We want to thank our witnesses for being here today, for taking time to testify before the subcommittee. Each witness will have the opportunity to give an opening statement followed by questions from our members.

We are pleased today to welcome Dr. Doug Holtz-Eakin, no stranger to this committee room, president of the American Action Forum; Mr. J.P. Wieske, deputy commissioner for insurance for the State of Wisconsin; and Dr. Leonard Lichtenfeld, deputy chief medical officer for the American Cancer Society.

We appreciate each of you being here today. We will begin our panel with Dr. Holtz-Eakin, and you are recognized 5 minutes for the purpose of an opening statement.

Mr. Kennedy. Mr. Chairman, just before we begin the statements I would like to raise a parliamentary inquiry.

Mr. Burgess. The gentleman from Massachusetts, what purpose does the gentleman from Massachusetts seek recognition?

Mr. Kennedy. Mr. Chairman, I ask a parliamentary inquiry to try to understand from you, sir, given some of the hearing --

Mr. Burgess. The gentleman will state his parliamentary

inquiry.

Mr. Kennedy. I would like assurance, Mr. Chairman, given what we have learned in the past several days about coordination between various House staffers and the Administration and transition team and the signing of nondisclosure agreements.

Mr. Burgess. The gentleman --

Mr. Kennedy. Would like to understand if such agreements --

Mr. Burgess. The gentleman has actually not stated a parliamentary inquiry, but I do want to accommodate your request. We are here of course to take testimony on bills before the committee. I think that can proceed, and I will defer to the chairman of the full committee for a discussion with you on your parliamentary inquiry.

The gentleman, Dr. Holtz-Eakin, is recognized for 5 minutes for an opening statement, please.

Mr. Kennedy. So Mr. Chairman, when -- I appreciate your deference to the full committee chairman as to what is going to happen next. What, just so I understand given as you did indicate the challenge of hastily built --

Mr. Burgess. The gentleman did not state a parliamentary inquiry.

Mr. Kennedy. And so my question about --

Mr. Pallone. He didn't finish his sentence.

Mr. Kennedy. -- the existence of nondisclosure agreements

is unanswered, so it is unanswered.

Mr. Burgess. The gentleman, Mr. Holtz-Eakin, is recognized 5 minutes for the purpose of summarizing your opening statement.

Mr. Griffith. Mr. Chairman. Mr. Chairman, parliamentary inquiry.

Mr. Burgess. For what purpose does the gentleman from Virginia seek recognition?

Mr. Griffith. Mr. Chairman, I inquire that if a member asks a question that is not a parliamentary inquiry is it not improper for the chairman to answer?

Mr. Burgess. Yes.

Mr. Griffith. So then you would actually be out of order if you attempted to answer Mr. Kennedy's question; am I not correct?

Mr. Burgess. Yes.

Mr. Griffith. I yield.

Mr. Pallone. Mr. Chairman.

Mr. Burgess. For what purpose does the gentleman from New Jersey seek --

Mr. Pallone. I just, I am not sure I understood what you were saying. You are saying you are going to get back to us about -- I understand you are saying it is not a parliamentary inquiry, but did you say you are going to get back to Mr. Kennedy and respond to his question or that Chairman Walden would; is that what you said?

Mr. Burgess. Well, the parliamentary inquiry was not about the proceeding with today's hearing on taking testimony from witnesses on the bill in front of us. I do respect the gentleman from Massachusetts a great deal as he knows, and I do want to see his question answered for him and I will seek the proper forum with the chairman of the full committee for him to do so.

Mr. Pallone. So you will get back to us to respond to his question.

Mr. Burgess. We will seek the appropriate forum.

The gentleman, Dr. Holtz-Eakin is recognized.

Mr. Butterfield. Mr. Chairman. Mr. Chairman.

Mr. Burgess. For what purpose does the gentleman from North Carolina seek recognition?

Mr. Butterfield. I have a unanimous consent request.

Mr. Burgess. The gentleman will state his unanimous consent request.

Mr. Butterfield. I would ask unanimous consent that the gentleman from Massachusetts be allowed to restate his parliamentary inquiry because I did not hear it. He was interrupted in the middle of the sentence.

Mr. Griffith. I object.

Mr. Burgess. Objection is heard.

The chair yields 5 minutes to Dr. Holtz-Eakin for the purpose of summarizing your opening statement.

STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION FORUM; J. P. WIESKE, DEPUTY COMMISSIONER, WISCONSIN OFFICE OF THE COMMISSIONER OF INSURANCE; AND, J. LEONARD LICHTENFELD, M.D., DEPUTY CHIEF MEDICAL OFFICER, AMERICAN CANCER SOCIETY

STATEMENT OF DOUGLAS HOLTZ-EAKIN

Mr. Holtz-Eakin. Thank you, Mr. Chairman, Ranking Member Green and members of the committee. I appreciate the chance to be here today.

Mr. Burgess. Is your microphone on? I can't hear you.

Mr. Holtz-Eakin. Microphone is on.

Mr. Burgess. Okay.

Mr. Holtz-Eakin. Okay. Mr. Chairman, Ranking Member Green, members of the committee, I appreciate the chance to be here today to discuss these proposals to stabilize the ACA individual market. I am going to make three simple points. Point number one is that doing nothing is not an option. Under current law the trend in the individual market is quite bad in terms of premiums rising, insurers exiting and coverage ultimately declining.

Second is that the proposals under consideration, reforms to grace periods, special enrollment periods, the age rating bands and continuous coverage provisions are all sensible policy that I would hope would garner bipartisan support. And then third that if indeed these measures were enacted there would still be much

work left to do; that that would not be enough to stabilize them. Let me elaborate on each and then I look forward to your questions.

Under current law the exchanges are headed in the wrong direction. In 2017, the benchmark Silver Plans rose at an average rate of 27 percent coming on the heels of ten percent rises in 2016, so the insurance is becoming increasingly expensive. As was noted by Mr. Walden, in five states and in one-third of U.S. counties there is only one insurer that is a choice for those participating in this market.

Seventeen of 23 co-ops have failed and the insurance that is out there is not really equivalent to affordable care. Eighty-four percent of participants require taxpayer assistance to purchase these policies and when they do they face family deductibles that are about average $7,400 in the Silver Plans, average $12,300 in the Bronze Plans, which means in many cases they are never getting to the point where the insurance is paying anything even after they have purchased it. My expectation is that if current law were unchanged and things were left on autopilot we would see exchange enrollments decline, decline substantially perhaps as low as eight million or so by 2020.

Clearly something needs to be done. In each case these measures would tend to improve the risk pools, lower the premiums and thus attract people in and stabilize the markets in that fashion. Grace periods in the Affordable Care Act are 90 days. In all but two states, grace periods off the exchanges would be

30 or 31 days.

So the playing field is not level in the individual market between off-exchange and on-exchange products. These long grace periods raise the prospect of an individual paying for 9 months and actually consuming a full year's worth of health care coverage. That leads to obvious problems for insurers and the costs have to be shifted.

In some cases they will be shifted to the taxpayer and in some cases they will be shifted to other customers in the form of higher premiums and thus exacerbating the upward pressure on premiums. And in some cases insurers will be obligated to pay only 1 month of those costs and 2 months will be shifted to providers who will no longer want to participate in providing care to the people who need it in these markets. Moving the grace periods to match those off the exchange would be a very sensible way to take those pressures off.

For the special enrollment periods the ACA has 30 conditions in which individuals can enroll. By comparison, Medicare has seven and HIPAA provides for three. These special enrollment periods are a way for high cost patients, and all the evidence which is in my testimony suggests they are higher cost than the other enrollees, to enter into the market. Again insurers have to jack up premiums in anticipation of this and the result is that a large number, perhaps as many as a third of the participants in the individual market, have entered using this mechanism.

Tightening them up would be a sensible way to stabilize the market and take pressure off premiums.

The age ratings are 3:1. This relatively raises the cost of insurance for the young and healthy that is a group that has under-enrolled in the ACA exchanges. Getting them in is a key part of stabilizing it. Moving to 5:1 would match the data that is the ratio in costs and be a sensible thing for the committee to consider.

And then lastly is the proposal for continuous coverage. Here I think it is simply the case that the individual mandate is not working as envisioned. There are about six and half million people in 2015 who simply paid the penalty. There are another 12.7 who are simply exempt. The continuous coverage provision would be a way to encourage the young to enter the market at the age of 26, buy coverage, remain covered, and because they remain covered they can never be medically underwritten and charged a special premium because of a preexisting condition. It is a way to stabilize the pools and to ensure that they do not continue to deteriorate. So I thank the committee for the chance to be hear today. I think these are sensible ideas which would be good steps towards stabilizing the individual markets, and I look forward to answering your questions.

[The statement of Douglas Holtz-Eakin follows:]

**********INSERT 9**********

Mr. Burgess. The chair thanks the gentleman. Mr. Wieske, you are recognized 5 minutes to summarize your opening statement, please.

STATEMENT OF J. P. WIESKE

Mr. Wieske. Thank you, Chairman, and thank you, Ranking Member. I appreciate the time and the effort in discussing this important issue. As you know, as a regulator in the state of Wisconsin we have been on the front lines of having to deal with the issues surrounding the implementation of Obamacare. It has been frustrating to hear consistently that the folks don't seem to understand that states have an important role here and that states do have existing laws in place that have protected their consumers.

I would like to just kind of flash back before the ACA and talk a little bit about the Wisconsin insurance market before the ACA, what happened with the ACA, and what we hope to see in the future. In short, prior to the ACA Wisconsin had an excellent uninsured rating and we continue to do so in Wisconsin. We could rate consistently in the top six for the least number of uninsured. We still rank in the top six for the number of uninsured in the last report.

Wisconsin covered its folks who were vulnerable and were not eligible for the private market through a high risk pool. And I know there has been a lot of talk about high risk pools across the country. Wisconsin's high risk pool works, worked while it existed. In fact, I got a call 2 weeks ago from a legislator who had constituents asking him to reinstate the Wisconsin high risk

pool because the coverage they had under Obamacare was inferior to what they had under the high risk pool.

They had numerous plan options. The coverage was obviously expensive. There is no question about that. Although if you see the numbers in my testimony with the federal subsidy those rates went down considerably. And I think one of the most important features that Wisconsinites had in that high risk pool was they could go to any doctor in the state. There is not a single plan in our exchange where you can go to any doctor in the state and get coverage without having really significant deductibles and having out-of-network costs.

It was funded on assessments on the insurers as well as mandatory discounts for the providers, and the coverage, consumers had huge number of options inside that plan. And typically, I think what is interesting about the high risk pools is that they stayed on those high risk pools for about 3 to 4 years and once they were there they moved into other group coverage later, so it was a great gap coverage.

I will also note that we had relatively low premiums in Wisconsin compared to, and you can see in my testimony that the rates went up considerably. They went up much more on the young folks than they went up on the older folks because of the age band and that has caused an abandonment by and large of the market, individual market, by a lot of the folks in the younger age bands unless they have medical conditions. It has been very

expensive for coverage. The fortunate thing in Wisconsin is we haven't seen the high increases. We had 16 percent increases this last year. We still have 15 insurers in the state doing business. We still have a co-op doing business and that is in part because we recognize that our job as a regulator is to minimize the consumer disruption. However, I think one of the big issues going forward is if we don't look at the transition coverage and if we don't make changes going forward we are expecting to see the small group market start to implode and that is going to put folks, more folks in the individual market which is unaffordable And that will impact taxes. That will impact everything across the board.

So we have serious concerns about not reforming the individual market impacting the small group market, not repealing Obamacare and ending up killing the small group market as well, which is on its way. About 80 percent of folks in the small group market are still in transition plans, so that is important to understand.

Going forward I think it is important to understand that states have a number of laws on the books. We have preexisting condition laws in Wisconsin. We have mental health parity laws. We had the coverage to age 27, in fact, not 26 in the state prior to Obamacare passing. We did a number of consumer protections and we take consumer protections seriously in the state and we do a lot of work and we deal with consumers directly, and we deal with insurers directly and we have discussions with insurers

directly. We have done this for years. We have been regulating the health insurance market since the 1940s.

And I will stop and indicate that we are ready to be here and help and be part of the solution as state regulators and that not all of these solutions need to be federally centric. Thank you.

[The statement of J. P. Wieske follows:]

**********INSERT 10**********

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. Dr. Lichtenfeld, you are recognized 5 minutes to summarize your opening statement, please.

STATEMENT OF J. LEONARD LICHTENFELD, M.D.

Dr. Lichtenfeld. Thank you, Mr. Chairman and Ranking Member Green and members of the subcommittee. My name is Len Lichtenfeld. I am Deputy Chief Medical Officer for the American Cancer Society and I appreciate having the opportunity to be with you today.

I am also pleased to be here on behalf of the nearly two million patients and people who will be diagnosed with cancer this year and the over 15 million cancer survivors that are living today as a result of successful treatment. These Americans who are your constituents, for them access to comprehensive, affordable health insurance coverage truly is a matter of life and death.

Mr. Chairman, we appreciate your stated support for retaining two very important patient protections enacted as part of the ACA, the pre-ex provision that bans discrimination against people based on their health condition; and secondly, guaranteed issue of coverage. And we look forward to working with you on the language in the legislation to make sure these provisions work to do just that. Providing patient access to coverage is obviously meaningful, but only insofar as the coverage itself is affordable and provides enough benefits to be meaningful for someone with cancer. And that is certainly the lens through which we view these particular pieces of proposed legislation.

Prior to 2010 the insurance coverage was defined as just

about anything marketed and sold by the industry and often contained exclusions, and hidden clauses resulted in denial of claims for all sorts of medically needed services. Current law requires that insurance provide major health coverage. When people buy insurance, especially when they are required to do so either by mandate or continuous coverage requirements, it is important to remember that insurance must cover a defined set of benefits to cover those individuals when they do become ill.

My written statement goes into greater detail, but in the limited time I have with you today I want to focus on why cancer patients need access to health insurance and how we can improve the system to address their needs. Research shows that individuals who lack health insurance coverage are less likely to get screened for cancer, more likely to have their cancer diagnosed at a later stage when the chance of survival diminishes and the treatments are certainly much more complicated. I know from my days as a practicing oncologist that it is very difficult to tell someone they have cancer; it is even more difficult to guide them through what is hopefully successful treatment. What is worse than that is being told by a patient they can't afford the treatment because they lack health insurance coverage or because their health insurance doesn't provide coverage for the oncology and cancer related services necessary for their journey.

Individuals with cancer including cancer survivors know how important it is to maintain health coverage. And unfortunately,

before the patient protections provided under the ACA many were unable to obtain health insurance coverage because of the cancer diagnosis constituting a preexisting condition and others faced lifetime or annual limits on their coverage while others were still only able to purchase a health insurance coverage with limited benefits that provide inadequate reimbursement when they needed it most. Individuals with cancer want and need continuous access to comprehensive health insurance coverage. Unfortunately, the realities of life sometimes interfere with this goal. We have made great strides in cancer treatments over the years, but unfortunately many treatments still result in unimaginable fatigue and other symptoms that can be very debilitating such that the individual is unable to work.

Research suggests that between 40 and 65 percent of cancer patients stop working while receiving cancer treatment with absence from work that ranges from 45 days to 6 months depending on the treatment, and sometimes these folks lose their jobs and their affordable employer-sponsored coverage. Imagine a diagnosis with cancer and undergoing treatments that make work impossible, repeated absences result in a loss of your livelihood, you have no income, yet you had a terrible disease and you need to get coverage for that illness. Cancer treatments have left you physically unable to even look for a new job. This is not only a hypothetical it is very real, and everyone in this room knows patients with cancer who have gone through such experience.

So as you contemplate changes to the health care market, we urge you to give great consideration to how the various policies under consideration intersect and how an individual with cancer would be impacted. We are not saying the current market is perfect, more needs to be done to ensure affordability, but affordability cannot be judged on premium alone. We need to also consider out-of-pocket costs and the value of the benefits provided. Catastrophic plans will have lower premiums, but few cancer patients will be able to afford the deductibles, co-pays and other out-of-pocket costs associated with oncology treatment.

In closing, I appreciate the opportunity to share our views from the American Cancer Society on how the health care system needs to ensure that individuals with cancer have access to the products and services necessary for their treatment, and I am glad to answer any questions from the committee. Thank you very much.

[The statement of Dr. Lichtenfeld follows:]

**********INSERT 11**********

Mr. Burgess. And the chair thanks the gentleman. The chair thanks all of our witnesses for being here today and for your testimony. We will move into the question portion of the hearing. The chair does note that he was delayed in arriving at the hearing, so in compensation for that I am going to defer my questions to the end and recognize the gentleman from Texas, Mr. Barton, for questions.

Mr. Barton. It is rare that I am speechless, Mr. Chairman, but I am tempted to defer also because I had to go to a private meeting and missed -- I was going to read my briefing book. I guess I am -- but if you are recognizing me I am going to try to go through it.

I am tempted, but since you are Diet Coke man and not a Diet Dr. Pepper man I am a little skeptical.

I do want to, first of all, commend the chairman for holding the hearing and commend our witnesses. I am going to ask a general question about the overall effectiveness or necessity of maintaining some sort of a health exchange option as we move away from the Affordable Care Act. Could each of you gentlemen comment on whether as we move to replace the Affordable Care Act we should give states the option to have something similar to a health exchange and also if we should have a national exchange in addition to that.

Mr. Holtz-Eakin. I certainly think there is good reason to give the states such an option. I have always thought that the

most important thing would be to have healthy competition in the individual market. Exchanges can provide the consumer information necessary to make that competition work better, and the place where I have reservations is only when the exchange becomes a means for excessive regulation.

But the exchange, per se, is a marketplace where consumers can get information and purchase policies that they like. It is a very valuable concept.

Mr. Barton. Okay.

Mr. Wieske. I think the concept of the exchange, it is good way to deliver subsidies but it is a three percent cost on top of the insurance. That is roughly what they are charging back the insurers for coverage to the exchange, and this is a website. I am not so sure three percent is the, I mean that may reflect the actual cost, so I think there is a value proposition there. I think prior to the ACA there were a number of websites that provided coverage as well.

And again, depending on what the purpose of the exchange is I think he is right that it has become a means to add to the regulatory burden on insurers and consumers, so I am not so sure of the value in part because of the cost, but I don't think, you know, I think there is, there may some reason for it.

Dr. Lichtenfeld. Mr. Barton, I appreciate your question. But speaking on behalf of the American Cancer Society our major concern is that consumers have the opportunity to get affordable

coverage that is going to meet their needs at their time of need, and the mechanism by which the committee decides going forward to achieve that must provide the information that people need to make the decision in a reasonable way.

There obviously are folks here who are involved in the insurance community much more directly than I am or that we are, but it is a matter of information, affordability and access and that adequate coverages are available and that the consumer be aware of those options as they go forward with their insurance.

Mr. Burgess. Mr., is it Wieske or Wieske?

Mr. Wieske. Wieske, yes, sir.

Mr. Burgess. Wieske, not wise guy, just Wieske. Your state has a high risk pool, and another thing that we want to try to do as we move away from the ACA is guarantee that people with preexisting conditions get adequate access to insurance. Mr. -- the full committee chairman has put out kind of a placeholder bill dealing with high risk pools. How would you envision based on your state's experience that working absent all the bells and whistles and mandates that we have currently under the ACA?

Mr. Wieske. So sure, you know, I think the first thing is, is a high risk pool isn't necessarily the solution for every state. I don't want to speak for other states. I will say that in the state of Wisconsin while we had a high risk pool it was highly effective. It is still politically popular amongst both Republicans, Democrats and especially amongst some subscribers

of the high risk pool. And they miss the coverage. It was a well thought out coverage. It was a well thought out program.

So I think, you know, I think the key issue is always how you deal with the funding. And that has been one of the bugaboos, I think, in a number of states is when there is insufficient funding for a high risk pool. You know, there was one state, California had a waiting list for their high risk pool. Florida closed their high risk pool in the early 1990s and it remained closed for a number of years. Other states had relatively low dollar caps.

So there are issues in design, so the important piece is design. The other important piece is understanding how the funding works and having a stable funding source. I think it has been consistent that the insurance industry is required through the individual small group and large group market to contribute to the cost of the high risk pool to make sure that it is affordable for consumers. I think as well having good medical discounts that attach to it are also important, but funding is sort of the key piece in making sure that it is maintained over time.

Mr. Barton. You think it can be workable.

Mr. Wieske. I think it worked incredibly well in Wisconsin and it provided great coverage and a lot of options for consumers, yes.

Mr. Barton. My time has expired. Thank you, Mr. Chairman, for your --

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes for questions, please.

Mr. Green. Thank you, Mr. Chairman. Last Congress our committee passed several important pieces of legislation on health care, a number of them fixing the SGR, extending FQHCs, and 21st Century Cures is probably the biggest one. Speaker Ryan once described the 21st Century Cures as the most important legislation to be passed in the 114th Congress.

During the process of passing the Cures many members of our committee heard stories from patients and advocates across the country who were battling tough diseases and hoping for new treatments. Passing the Cures which contained new funding for research on diseases such as cancer we gave so many of them hope that one day they would get that treatment to be needed. Nationwide, the ACA is that delivery. It doesn't do us any good to invest in medical research if we don't have a physician or a facility -- and I am from the Houston area, we are fortunate to have MD Anderson. Although up until the Affordable Care Act, MD Anderson being a state institution did not take a significant number of indigent persons even though they were Texans, and, but now they have something even if it is Medicaid. And of course Texas didn't expand Medicaid expansion so we need to have this delivery system.

And we can do things bipartisan, you know, I am hoping that

is what we can do to fix the ACA because there has never been a law passed by Congress that doesn't need to be looked at over a period of years. And by the way I served 20 years in the state legislature in Texas and we wrestled with our high risk pool. The problem is, is that we didn't fund it and if you only have high risk people they can't afford the insurance.

How does Wisconsin, Mr. Wieske, fund your high risk pools? Is it premium? I thought I saw in your remarks it was premium taxes.

Mr. Wieske. So there are number of funding mechanisms, so it was divided out equally. There was no actual state dollars that went into it. However, it was divided out between a 40/30/30 share, so 40 percent was the cost for consumers, 30 percent was the cost for insurers, and 30 percent was the cost for the medical providers. They were required to have that level of contribution remain consistently over time which was true-upped every year in order to maintain the affordability. There was enough money there that it was private sourcing that actually provided the subsidy for folks under $34,000 of family income, so there was subsidies for folks under $34,000 of income as well.

Mr. Green. Well, again and other states have tried that. I, like I said, worked as a state legislator doing work across state lines to see what we could do, but -- and I have a district in Houston. It is very urban. Up until the Affordable Care Act 44 percent of my constituents who worked did not get insurance

through their employer.

And so that is why the ACA is so important to an urban area and there are places all over the country. I would be interested sometime just to talk with you how Milwaukee, a very urban area, compares with most of the rest of Wisconsin, but, you know, that is my concern that not every state is like Wisconsin.

Dr. Lichtenfeld, thank you for being here. This bill requires insurers to cover preexisting conditions like cancer, but the bill doesn't say that insurers can't charge more for that cancer patient. That is one of the major issues, you know, the requirement that people have insurance so the insurance companies can spread that risk. Insurance is about spreading the risk, and if you only have cancer patients in the insurance plan nobody will be able to afford it. So that is why -- and if they have to, you know, once you are diagnosed and you will have to spend it, tell me, is that one of the problems the American Cancer, your client has problems with?

Dr. Lichtenfeld. I am part of the American Cancer Society and honored to be so. Of course it is a concern. You know, nobody goes out and says I want cancer or that I know I am going to get cancer, and that is what insurance is about, making sure that the benefits are adequate, that the cost is affordable and as I mentioned not only the premium cost but also the ancillary costs that inevitably come along. Making sure that patients and consumers have access to care is what this is all about.

We are not here to in a sense solve all the problems in our testimony today. We are here today on behalf of cancer patients throughout this nation and consumers to try to make sure that those principles are adhered to. That some of the fundamental protections in terms of affordability, limits on out-of-pocket expenses --

Mr. Green. Before I run out of time, you don't see this proposed legislation is serving cancer patients?

Dr. Lichtenfeld. What we believe is that this is a work in progress and we want to participate in that progress and help reach solutions in a manner that is acceptable for the people we serve.

Mr. Green. Thank you. Thank you, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair now recognizes the gentleman from Kentucky, the vice chairman of the Health Subcommittee, 5 minutes for questions, please.

Mr. Guthrie. Thank you, Mr. Chairman. I have a chart. I would like to start by walking through a chart if we can have that posted.

Now the chart we see here uses CBO data on where folks get their health insurance coverage in 2016. As you can see, roughly half of the country received coverage through their employer. That is 155 million people. Fifty seven million patients are enrolled in Medicare, another 57 million are Medicaid beneficiaries that were eligible before the Affordable Care Act.

When it comes to the Affordable Care Act there are 11 million recipients who were made Medicaid eligible by law, and a little under 11 million folks on exchange programs and roughly one million enrolled through basic health programs. What this chart illustrates is that we are talking about seven percent of the population all at the potential disruption of where 93 percent of people across the country receive their health coverage. Even more, the IRS said about eight million folks paid the mandate penalty and another 12 million claimed an exemption from the penalty.

So of the 27 million uninsured Americans, 20 million chose to either to pay the individual mandate tax or claim an exemption. Look, we are going to hear a lot of numbers today and remember these. Seven percent of the country can be directly associate their coverage through the Affordable Care Act and all but seven million uninsured Americans paid the penalty or claimed an exemption.

So instead about talking numbers let's talk about people behind the numbers. So Dr. Holtz-Eakin, can you tell me the national average of premium increases for on-exchange patients this year?

Mr. Holtz-Eakin. For the benchmark Silver Plan it is 27 percent.

Mr. Guthrie. And Commissioner Wieske, what is the number for your home state of Wisconsin?

Mr. Wieske. It was roughly 16 percent.

Mr. Guthrie. Let's talk about ways to drive these costs down. Dr. Holtz-Eakin, as you point out in these reforms noticed today, taken individually or separately are good policy and should receive bipartisan support. If our immediate task is to stop the leaks before replacing the pipes, is this a good place to start with the bills before us today?

Mr. Holtz-Eakin. I believe so. Yes, these are sensible reforms that will get part of the way.

Mr. Guthrie. Thank you, and I agree with your written conclusion this will not fix everything but these are necessary changes. One of those longer term changes we strongly considered is continuous coverage. Would you please briefly describe the value of this incentive model and how it is aimed at patients keeping health care instead of simply getting coverage?

Mr. Holtz-Eakin. So the basic concept is to deal with preexisting conditions in two ways. The first is for existing folks you go to a high risk pool model like has been discussed. But for a young person, the minute they come off their parents' policy at age 26 they are young and cheap and if they buy a policy and keep coverage in any form throughout their life, regardless of whatever condition they develop, they cannot be medically underwritten and their premium cannot be raised based on their health condition.

As a result, there is a huge incentive to get the young people

in the pool and have insurance, because they are keeping the insurance over a lifetime insurers have a very different view of them than now. Now they are a 1-year snapshot, they should do everything they can to avoid costs. If you are looking at them over a lifetime you want to do the prevention, you want to do the wellness, you want to take care of them in very different ways. So this continuous coverage solves the problem of preexisting conditions by getting them in the pool to begin with and provides a better foundation for a different kind of medical model.

Mr. Guthrie. Okay, thank you. And Mr. Wieske, you answered some of these in your testimony but I will just give you a couple minutes, a minute and a half here to kind of drill down on some of the things that you said and just point it out again. Can you compare the market, what the market looked like in your state before and after the passage of the ACA?

Mr. Wieske. Yes, I think roughly, I mean we actually did not see any gain in coverage if you look at the numbers, if you count our exchange folks, the current exchange folks, and then you look at the high risk pool and you look at the market before. And so roughly we saw no gain in coverage as a result of Obamacare, at least the numbers don't bear that out.

And it is important to note that the methodology to calculate the uninsured changed in 2013 so it is an apple to oranges comparison to a certain degree. But our market was much more affordable pre-ACA, there was access to coverage.

Mr. Guthrie. What were the difference in options before and after?

Mr. Wieske. Well, we had roughly 25 carriers operating in the individual market in Wisconsin and along with the high risk pool and now we have about 15 in the exchange, but if you look at any particular region we have roughly five at the most, closer to three. There is only one region where we have one, and I think three counties where we have two.

So there are fewer choices in our individual market. It is more costly and the plans are obviously centered, they are sort of government designed plans rather than having a lot of different options for --

Mr. Guthrie. But not an increase in coverage?

Mr. Wieske. Pardon me?

Mr. Guthrie. You have fewer options, more costly and not an increase in coverage?

Mr. Wieske. Correct.

Mr. Guthrie. Thank you. I am out of time. I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from New Jersey, 5 minutes for questions, please.

Mr. Pallone. Thank you, Mr. Chairman. The gentleman from Kentucky put up that chart and, you know, acting as if when you repeal the ACA the only thing you are impacting is people who bought individual policies on the marketplace. But the subject,

certainly the Walden bill, the chairman's bill today is talking about standards. He is talking about, you know, preexisting conditions. That affects over a hundred million people.

There is no reference in this half-baked bill we would assume because it doesn't put it back in that the essential benefit package is impacted, which is going to be my question to Mr. Lichtenfeld. So, you know, I don't understand how you are putting up that chart and acting as if what we are talking about here today is just the people in the marketplace. This affects everyone. The ACA guaranteed an essential benefit package. You start cutting back on that and offering skeletal or catastrophic plans, that is going to affect everybody on that chart including those who have, the majority that have employer-sponsored plans and the same thing with preexisting conditions.

So, you know, I want everyone to understand. When you start talking about standards and repealing this bill, anti-discriminatory practices, essential benefits, this isn't just the people in the marketplace.

Now Mr. Lichtenfeld, my concern about the Walden draft is it would not limit in any way what insurers can charge for insurance. Before the ACA under HIPAA some people were guaranteed access to non-group policies for which they could not be turned down nor have preexisting conditions excluded, but there was no limit on what they could be charged. And left with this only remaining option for discriminating based on health status,

insurers charged very high rates for coverage effectively blocking access for a lot of cancer patients sometimes 2000 percent of standard rates.

So roughly what percent of cancer patients do you think could afford to pay such highly surcharged premiums, and in your experience what happens to people who are diagnosed with cancer who can't afford health insurance? How is their access to treatment affected?

Dr. Lichtenfeld. What we know at the American Cancer Society is that we did a considerable amount of research in the early 2000s to help support our views, shall we say, on the necessity of insurance. And what we found from that research, which we can certainly provide to the committee, is that patients were diagnosed at a later stage and did poorly compared to those who had insurance.

So we do think that the legislation, the current policy has enabled patients in order to get access to care. Certainly there are issues. We recognize that there are imperfections that have to be worked on. One of our concerns with regard to the essential health benefits is the reality that we need to make sure that whatever we do here, whatever the committee in its wisdom decides, that we have adequate coverage to make sure that patients who have cancer can get the care they need without the limitations that might otherwise occur. And clearly affordability is a major issue. Most patients, it is no secret the majority of patients

who would be impacted by this discussion today are people who are age 50 and older. And those folks would have, if they end up in a situation where there is a high premium and they couldn't afford it they would be put back in a situation where they would have difficulty getting the care they need for the illness that they have.

So in response to your question, these are certainly concerns that we have and hopefully we will be able to work with the committee moving forward to address those issues.

Mr. Pallone. Well, thank you, Doctor. You see, my concern is that when the GOP talk about replacement, what they really want is competition downward, skeletal, skimpy plans, you know, plans that -- you know, before the ACA you could buy a plan that didn't cover prescription drugs or even hospitalization. And, you know, now we have these essential benefits, but Mr. Walden's draft assumes to repeal the entire ACA including essential health benefits. Sixty two percent of plans before we put the ACA in place lacked maternity coverage, I mean there was all kinds of exclusions.

And, you know, just give me -- I mean if the ACA benefit standards were to be repealed how would cancer patients be affected? I mean they might -- limited doctor visits, much higher deductibles. I have only got a few seconds, but if you will just comment. I know you kind of mentioned it.

Dr. Lichtenfeld. Mr. Pallone, I have lived through that

experience as a physician and I am aware of what happened in the past and we at the American Cancer Society would be very concerned if we went back to that. We hope that there are solutions within the committee that will avoid that and provide -- speaking with my colleague to my right, certainly some states have been excellent. Unfortunately others have not and we had huge problems in the past that we do not want to revisit. Cancer patients really need to know that they have insurance that works. Thank you.

Mr. Pallone. Thank you, sir.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for your questions, please.

Mr. Murphy. Thank you, Mr. Chairman. Dr. Lichtenfeld, thanks for your statement on the importance of maintaining preexisting conditions. We all agree with that. Those protections are important and guaranteeing issue is part of Chairman Walden's bill too. We agree that these rating protections are important as well and really look forward to working with in your patient community and the broader chronic condition patient community.

Can you talk about how Medicare Part D could serve as a role model, as a model for how we do this, how we approach this?

Dr. Lichtenfeld. Well, as you are aware, Mr. Murphy, sometimes in some respects Medicare Part D works and in some places

there have been some difficulties with how it has been applied. I am not sure that that is necessarily the model. I am not sure that there is any single model. I think that this is obviously a work in progress to be discussed and we look forward to participating in those discussions.

At the end of the day we need to make certain that cancer patients can afford with regard to Part D, can afford their medications whether given in the doctor's office, whether they are bought over the counter or at a pharmacy. Those are critical. And it is also important to make sure that that coverage is uniform across the country. That is what we think is --

Mr. Murphy. Dr. Holtz-Eakin, can you comment quickly on that too, just in a few seconds comment quickly on that question too about how Part D can serve as a role model on that?

Mr. Holtz-Eakin. I think the Part D program has been enormously successful because it is built on very strong competitive pressures and on the ability to have very flexible plan design. And so we have seen that in the prescription drug plans competing with one another and offering products that seniors very much approve of.

Mr. Murphy. Thank you. Mr. Wieske, did Wisconsin -- let me talk about the high risk pool. So does Wisconsin collect data on patients who are in these high risk pools by medical condition, so cancer, certain chronic illnesses and infections, mental health?

Mr. Wieske. We did. I served on the board of the high risk pool. They had extensive information obviously on all the patients. It was -- and some of them were there for an extended period of time, others were not. They had an intensive care management. So it was a very high risk, number of high risk conditions.

Mr. Murphy. I am wondering how deep you could dive into that data. So Kaiser tells us about in terms of the number of people who remain in the high risk pool about 45 percent are in their second year. Many have acute conditions and get better.

And whether it is a chronic condition like cancer or, you know, the short term ones, maternity, and other complications like mental health, did you do a deeper dive when multiple illnesses occurred to see who were those people who were the big over utilizers by behaviors or high utilizers by medical conditions, so we can help analyze what are the differences there?

Mr. Wieske. Yes. In short, yes. There weren't a lot of incentives. There were deductibles that attached. I think the lowest was $1,000 deductible. So there were specific efforts made to deal with high utilizers that were utilizing inappropriately in contacts from the administrator. But most of the folks on the high risk pool were there about 3 to 4 years. They had specific medical conditions. Presumably they were covered or had group coverage at the end of their --

Mr. Murphy. So here is an issue in where I think both sides

of the aisle can agree that when you have a high deductible which is meant to discourage people from overutilizing the system that may work in some cases to keep people from running to the emergency room for every problem. On the other hand it hurts people from going to get medical care when they need it early on, which Dr. Lichtenfeld was describing the person for early stage cancer.

I am particularly concerned here about such things as the mental health disorders. Generally a person with serious mental illness goes 60 to 80 weeks and adults longer between first symptoms and first treatment. And those complications were for example in Medicaid, five percent of Medicaid patients it is 55 percent of Medicaid spending and virtually all of those have a concurrent mental health problem. Your state has gone above and beyond the numbers in terms of mental health parity.

Mr. Wieske. Right.

Mr. Murphy. Have you looked at that also as an issue in terms of having parity and making sure people are getting concurrent mental health services whether they start with a chronic illness or start with a mental illness that does something to help drive down costs?

Mr. Wieske. Well, I think we have done a number of efforts I think both through the Medicaid program has done a fabulous job of working through that. I think we have new efforts related to the opioid issue which has gotten more attention and certainly in the opioid task force.

There are a number of issues that we get to, but I think you are exactly right that there is this management in reflection of that this is an illness like any other illness and you need to treat it as such is sort of ingrained in Wisconsin.

We have had mandates that attached mental health for decades, so while we have some mental health parity that applies we also have requirements that go back into the 1980s. We have had mental health coverage since the 1980s.

Mr. Murphy. Well, I might take issue with you when you say Medicaid has done a fabulous job on that because we have had a lot of problems this committee has discussed. But I mentioned Wisconsin's data because we have seen from private markets and others that when private companies insure and they make sure their employees are covered with mental health benefits and concurrently looking at the impact, the cross pollenation here of chronic illness and mental illness, cancer is an example of that -- high rate of depression, anxiety, panic -- it drives people back to the emergency room versus if a doctor is working with them, so a lot of serious concerns there.

If you are able to give us more data on that or if you and I could sit down and talk about that, the same with Dr. Holtz-Eakin and Dr. Lichtenfeld, I would love to talk to you. This is an area where I have got to believe both sides of this committee can agree we can work on more effective health care and driving down costs.

I realize I am out of time, Mr. Chairman. Thank you for

indulging me.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions, please.

Ms. Schakowsky. Thank you, Mr. Chairman. My colleagues on the other side of the aisle claim to be concerned with, quote, protecting infant lives, unquote, which is what they called their panel last year that investigated Planned Parenthood and failed to prove any wrongdoing. But we know full well that that panel was created to attack women's health choices and not protect infant lives.

But because it actually comes to protecting infant lives, when it actually comes to protecting infant lives Republicans are happy to put insurance companies back in charge, allow them to reinstate lifetime caps on coverage and medical underwriting. This would directly impact some of the most fragile and vulnerable patients in our country including premature infants, infants with congenital abnormalities and their families.

So I would like to enter into the record an article featured on Slate called Our Insurance Paid $2.5 Million to Keep Our Child Alive.

Mr. Burgess. Would the gentlelady yield? Is that a unanimous consent request?

Ms. Schakowsky. Yes.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 12**********

Ms. Schakowsky. The author explained that her child was born with congenital defects and their family accrued $2.5 million in medical bills by the time that child was 3 years old. This by the way to make our Ranking Member Pallone's point, they had employer-based coverage and the benefit package made sure that they were covered.

And should Republicans have their way and reinstate lifetime caps on insurance coverage this child might already have reached her lifetime limit on coverage at the age of 3 and would be forced to pay all of her future care out-of-pocket if they could possibly afford it. Because of the ACA, more than 27 million children have benefitted from the ban on lifetime caps and overall more than 105 million Americans have benefitted.

Before the ACA, 89 percent of insurance plans included a lifetime limit on benefits. To add insult to injury, under Chairman Walden's bill this child may be subjected to an astronomical premium cost for the rest of her live based on her preexisting condition from birth.

Let me ask you, Dr. Lichtenfeld, what does it mean for premature infants or children born with congenital abnormalities if these conditions are once again permitted to be medically underwritten?

Dr. Lichtenfeld. Well, obviously when speaking about that specific issue those costs can rise rapidly and last for a lifetime, and we are concerned on behalf of cancer patients that

lifetime caps or annual caps or whatever caps might in fact limit the treatment they receive.

When you deal particularly in the cancer world with young people with cancer whether they be children, whether they be young adults, there is a very real issue about the cost of their care over time. And if in fact they become rated within the insurance market going forward as they age that would become obviously a very serious burden.

Ms. Schakowsky. Have you seen that in your practice of young people who actually either have or live in fear of these lifetime caps?

Dr. Lichtenfeld. Before the ACA it was a real problem and people even within organizations that I am familiar with would run up against, you know, and group insurance, would run up against caps and that would be a serious issue particularly patients for example with bone marrow transplants.

When you talk about young people it is definitely, I can speak on information from the bone marrow transplant community, the financial toxicity of that care and the inability to work going forward for many of these young folks is a very real issue. And we do believe that that is something that needs attention as this again as this process moves forward.

Ms. Schakowsky. And so once the ACA passed did you see then an improvement in those situations?

Dr. Lichtenfeld. We do believe there was an improvement.

It certainly removed the major concern that cancer patients have. We talk a lot these days about financial toxicity. We talk about the stress. We talk about mental health issues as was brought up --

Ms. Schakowsky. What is your phrase, financial --

Dr. Lichtenfeld. Financial toxicity.

Ms. Schakowsky. That is what I thought.

Dr. Lichtenfeld. It is a very real issue within the cancer community, the high cost of drugs, the high cost of care, the deductibles, the co-pays, whatever it may be, caps is clearly something that is part of that conversation.

Ms. Schakowsky. Have you seen Chairman Walden's bill and how it would impact children or adults that have cancer?

Dr. Lichtenfeld. Well, you know, to be honest with you again that is, there are things that are in the bill and things that are not in the bill so we still have a ways to go. So rather than supposing what is going to be offered, I would rather defer that until we have more information.

Ms. Schakowsky. Okay, thank you. And I yield back.

Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady. The chair recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for your questions, please.

Mr. Lance. Thank you very much, and good morning to the panel and I apologize for not being here for all of your testimony. We are shuttling back and forth between two subcommittees.

To Mr. Holtz-Eakin, thank you for being here. In your testimony you mentioned that the individual mandate was an ineffective mechanism to encourage the enrollment of young people in the exchanges. In what ways is the continuous coverage concept a more effective tool to engage people to gain and maintain health insurance coverage?

Mr. Holtz-Eakin. It is a natural and economic incentive and health incentive. You know, most of the replacement plans that have been offered that we have looked at would maintain the provision under current law where you can stay on your parents' policy until you are 26.

At that point a young person who recognizes they are cheap to insure so it is easy for them to get insurance, they may develop, may not be medically underwritten so they aren't going to get their premiums jacked up because of their health, that is a real incentive to get in early. That broadens the risk pool and when people do develop conditions you have both the high risks and the low risks in the pool. That is always the goal in insurance.

Mr. Lance. Would others on the panel like to comment on that?

Dr. Lichtenfeld. I would, thank you.

Mr. Lance. Certainly.

Dr. Lichtenfeld. You know, the continuous coverage issue is one that is obviously again under discussion, but our concern at the American Cancer Society is and on behalf of our

constituents, of our patients, is the details of what happens because the risk is very real.

I mean what -- you know, no one again expects to get cancer, and sometimes when it happens it happens very quickly and it absorbs people and they can lose their jobs and then they might lose their insurance and then they enter the market under the proposals and they may be rated at a premium they can't afford.

So how the committee addresses this going forward again is a major concern of ours to get it right, to make sure that the rules are appropriate and that people who get a sudden illness may not be capable of dealing with a continuous coverage provision of 30 days, for example, are able to have some leeway and understanding that meets their needs at their particular time.

Mr. Lance. I certainly agree that we want to get it right. It is just my concern that young people have not been involved to the extent we would like them to be involved. And we want to repair the ACA and I have never favored its repeal without a replacement. I think it needs to be repaired and we are trying to focus on repairing it and that is why we are conducting this hearing along with other hearings.

To the commissioner, given your background as a state insurance commissioner, could you speak to some of the effects you have seen at the state level regarding the 3:1 age band, special enrollment periods and the 90-day grace period?

Mr. Wieske. I think you can see in our testimony that the

impact of cost, the increases have been borne by the young which has made it unaffordable, just caused the risk pool to deteriorate which has caused, you know, sort of a death spiral.

We have seen consistent changes from the insurers in the areas that they are covering. There is a lot of chaos. We had 37,000 folks that lost coverage from their particular insurer in Wisconsin last year which pales in comparison to the 100,000 in Minnesota that lost their coverage last year. So there have been pronounced effects.

You know, the problem with the SEP process is it is confusing for consumers, it doesn't make, you know, the current one it doesn't make any sense. It is harm to insurers. If you use magic words that go into the, with HHS you get your SEP. If you don't use the right magic words even if you deserve it you don't get an SEP. That has been a consistent problem when it is done at the federal level, so there has been problems. We would like to see it go back to the companies to administer.

Mr. Lance. Dr. Holtz-Eakin, would you care to comment on that please?

Mr. Holtz-Eakin. I think all the evidence that we have seen on it and summarized in my written testimony suggests that this is exactly right. It is not just a Wisconsin problem, this is a pervasive problem. It is worse in the risk pool and it has had the insurers unable to price things effectively.

Mr. Lance. And I hope that the American people who are

undoubtedly listening to our deliberations recognize that there has been this type of terrible situation across the country not only in Wisconsin and Minnesota but in other states as well. And the goal of the ACA was a good goal and the question is how to achieve that goal in the most effective and efficient manner recognizing that we want no one to be discriminated against, for example, based upon a preexisting condition. I yield back 5 seconds, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. Before we go to our next question, the chair would ask that members on both sides of the dais who are engaged in conversations be mindful of the fact that I think Mr. Griffith of Virginia is hard of hearing and he is having difficulty in keeping up with the important discussions going on. So the chair would ask that side conversations be taken off the dais or kept to a minimum.

The chair now recognizes the gentleman from North Carolina, Mr. Butterfield, 5 minutes for questions.

Mr. Butterfield. Thank you very much, Mr. Chairman, for yielding time. Let me begin, Mr. Chairman, by just echoing some of the sentiments that were expressed by Ranking Member Pallone at the outset of this hearing. I share those concerns. This topic is very perplexing and very difficult for us to grapple.

We hear different terminology as we have this debate. I hear Mr. Lance talk about repairing the ACA and I hear others talk about repealing the ACA, and so I am still trying to grapple with what

we are talking about today. This appears to be another hearing to discuss Republican plans to change the health care system and reduce people's access to care and to make health care more expensive. That is the way it appears to me.

You are trying to enact these changes that will actually make health care more expensive for low-income individuals and children and families and older Americans. After 7 years of complaining about the ACA and actively trying to disrupt by ripping it apart and causing it to fail, it is disheartening now to see a plan that is half written and incomplete. I expect more. I think the American people expect more.

And I will say what my colleagues have said repeatedly, we are prepared and willing to work with you to improve the Affordable Care Act, make no mistake about it. This is the second day we have been in this room discussing ways to make it harder for people to access health care.

I represent one of the poorest districts in the country in North Carolina where nearly one in four people live in poverty. Every day I hear from constituents about increasing access to health care, not decreasing it. Many of my constituents talk to me about expanding Medicaid and strengthening the ACA not making it harder to access health care.

My constituents overwhelmingly, Mr. Chairman -- maybe I spent too many years in a courtroom, Mr. Chairman. If the committee will come to order.

Mr. Burgess. The gentleman from North Carolina is correct.

Mr. Butterfield. Yes.

Mr. Burgess. The committee does need to be respectful to the people who are speaking. Can I ask the committee to come to order?

Mr. Butterfield. My constituents, Mr. Chairman --

Mr. Burgess. The gentleman continues suspend.

Mr. Butterfield. Thank you. I guess I was spoiled by being in the courtroom, Mr. Chairman.

Mr. Burgess. The gentleman may proceed.

Mr. Butterfield. My constituents, Mr. Chairman, overwhelmingly support our new governor in North Carolina who is doing all that he can to expand Medicaid. In my district the uninsured rate has been cut by one-quarter. More than 35,000 people have insurance as a result of the ACA. Across the country 20 million people have obtained health insurance since 2010. The uninsured rate in our country is at an all-time low. That is a fact.

I could talk for hours about the statistics that show North Carolinians and Americans are better off because of the ACA. Our health care system is better off because of it. It could be in an even better situation if detractors had not consistently fought it at every turn.

Now Republicans want to turn back the clock. They want to put insurance companies back in charge of health care, make it

more difficult to keep your health care plan and make it more expensive for many Americans to pay for health care.

Chairman Burgess, I agree with your comments yesterday that seemed to indicate that this committee has gotten off on the wrong foot. I believe it has. Democrats will not stand idly by while we are forced to consider proposals that will restrict access to health care. Mr. Chairman, I have received a letter from AARP which supports the positions that I have just articulated. I would ask unanimous consent that it be included in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 13**********

Mr. Butterfield. All right, I have 1 minute remaining. Dr. Lichtenfeld, thank you for your testimony in support of many of the improvements to our system made by the ACA. Many of my constituents in eastern North Carolina are from minority groups, racial minority groups.

Can you discuss some of the cancer health disparities experienced by ethnic and African Americans and Hispanic Americans and would some of the potential changes to our health care system discussed today further exacerbate these disparities?

Dr. Lichtenfeld. Well, Mr. Butterfield, thank you for your question. I mean there is no question that ethnicity plays a role in access to care and there is also no question that socioeconomic status plays a role in access to care. Making certain that all individuals have appropriate access to affordable care that meets their needs particularly for cancer patients is so important.

I have lived in a rural area. I have experienced and seen the issue. I am in a state that did not expand Medicaid as have 19 other states have not done so, and what the evidence is showing us is that access to care through insurance by whatever mechanism is important to reduce the burden of cancer.

So we are aware of that. We are hopeful in the committee going forward will address that issue as well.

Mr. Butterfield. Thank you, Doctor, and thank you, Mr. Chairman. I yield back.

Mr. Burgess. The chair thanks the gentleman. The

gentleman yields back. The chair now recognizes the gentleman from Oregon, the chairman of the full committee, Mr. Walden, 5 minutes for your questions, please.

The Chairman. Well, I thank the chairman. And I have been listening to the various comments and the testimony and let me say again, this is a discussion draft. It is not a finalized bill. We are not coming here to cram something through that nobody has had a chance to have input on or read. I thought that is what you wanted. It is what I want. And so there are some opportunities to weigh in. That is what a -- this may be unusual for some, but that is kind of what a legislative process is supposed to look like. And I will tell you what. I read all your testimony and I appreciate it from a lot of levels. I have heard some of the things hurled my way. I don't want lifetime caps. I care pretty deeply about older people and younger people including infants, very personal place.

And I have seen markets that work and markets that don't. I fought on insurance companies when they were denying care and shouldn't. I fought to create high risk pools when in my home state you didn't have the fix on a preexisting condition. I have seen cancer up close. My mother died of ovarian cancer, my sister-in-law, brain cancer. Like many of you, you or people in your families or in your communities deal with this. The notion that somehow because there is a break in the dais we don't care about getting this right is beyond the pale.

So I hope going forward we can have a really constructive discussion here about how to make this bill work, how to make sure regardless of what we or some other Congress does going forward that if you had a preexisting condition you will always have access to care and that there won't be some artificial cap that says through no fault of your own you have a disease that keeps coming at you, but sorry, you are on your own and you are destitute. That is not the choice here. The choice is how do we get it right.

The notion that this individual market is in a wonderful place is a fiction. All you have to do is listen to the experts that are out there and they will tell you this can't survive the way it is today. If Hillary Clinton were in the White House and Democrats controlled everything, I tell you, you would be back because just like we had to deal with other problems over the years, just like the laws that have been passed and voted on by Republicans and Democrats to deal with problems in Obamacare, we are going to repeal this and we are going to come back with a plan that will work for everybody. Now I want to ask the gentleman from Wisconsin, reading your testimony it was pretty evident you had a market that was working, not perfect but working. Tell me what happened when the ACA came down on top of what your state was doing and tell me this too. Is it possible for us here to pass this piece of legislation as appropriately written that will guarantee people have access to care of their preexisting conditions and that there won't be caps on lifetime coverage and

could you still put together a market with those two conditions?

Mr. Wieske. We can in Wisconsin. I feel confident that -- I mean we still have 15 insurers in the marketplace, in the market and selling insurance through the exchange. We have another six or seven that are selling off-exchange. We think that those will step up more to the plate if the rules reflect the actual costs.

We have had a number of significant market exits. We think we can get them to return if the market rules are more reasonable across the country. It is not our rules that are the problem it is the federal rules. They are losing money. We have seen significant, if you talk to our financial folks you have seen significant loss of capital inside the insurers that will never return under this environment and that is why they are leaving the individual market.

The individual market is a residual market as was shown in the slides. It is roughly, you know, seven percent, five percent of any state's market. It is very small and it is leading the losses and that is why they are exiting the market. That is what is causing the issue.

So I think a return to that if it returned to market principles with appropriate consumer protections that the market will return. It will take some time. Kentucky destroyed their market in the 1990s. It eventually came back. And so I think it will come back, yes.

The Chairman. Mr. Holtz-Eakin, do you agree with that

concept?

Mr. Holtz-Eakin. I do agree with that. I think there is a lot of evidence that you can put in place sensible market rules and have vibrant individual markets. We don't right now, but it can be done.

The Chairman. I know I have used up my time, Mr. Chairman, unless the doctor wants to respond. I would be happy to get his additional comments as well.

Dr. Lichtenfeld. Thank you. Thank you, Mr. Chairman, I appreciate that.

Mr. Burgess. Proceed.

Dr. Lichtenfeld. You know, we sit here and we talk in certain words such as market principles, and I understand that. I accept that and that is not the problem. But when market principles get in the way with people having affordable care particularly the older people, then we run into difficulty.

The Chairman. Right.

Dr. Lichtenfeld. So as you said and I said earlier in my testimony or in my comments, this is a work in progress, understood, here to help try to meet a resolution.

The Chairman. We appreciate that.

Dr. Lichtenfeld. That is what we are aiming for so that we don't run into the problem where a principle becomes a barrier that then prevents people from getting access to care.

The Chairman. Right, thank you. Thank you for your

indulgence and your help.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair now recognizes the gentlelady from California, Ms. Matsui, 5 minutes for your questions, please.

Ms. Matsui. Thank you, Mr. Chairman. When we started writing the ACA over 7 years ago, I consulted with a full range of health care leaders in my community in Sacramento. We called together the hospitals, the health plans, the community health centers, the patients, and all those that contribute to our health care systems. Everything was fully constructed because we knew that each policy affected the next and the system as a whole.

We all know that health care is complicated. You can't simply consider these changes in a vacuum. The Republicans have been saying for almost 7 years that they have a better way, but what we have seen today does not protect people. It really does take coverage away.

One of the bills shortens grace periods to 30 days, which means that if someone misses just 1 month's premium payment they can be kicked off of their health plan. For many workers with fluctuating income they may need to forego a payment 1 month in order to put food on the table and then pay it back the next when they receive their paycheck. Now if getting kicked off your plan wasn't bad enough, the second policy kicks, which says, or we assume it will say that you must maintain continuous coverage or else insurance companies will charge whatever they want the

next time you sign up. If they know you are sick they could offer you a plan but only if you paid thousands of dollars a month and what good is that? So now if a person ever misses even a single payment they could be locked out of receiving health coverage for years or even for life.

Now we talk here in statistics and charts and things like that and that is very important. But I think we have to all understand that health care is very personal, to all of us here it is personal. Chairman Walden mentioned how personal it is to him with his mother having ovarian cancer. My mother had ovarian cancer. Many people here have had individuals with lymphoma, blood cancer. It is very personal. And I think to a certain degree we have to understand that there is certain diseases like cancer that may hit you with such a shock at the very beginning and you have to figure out what you are going to be doing next.

So this is really a journey for most people with cancer is that type of disease. So Dr. Lichtenfeld, in your experience, do cancer patients often spend a lot of time with their doctors and care teams to help get them well?

Dr. Lichtenfeld. I am sorry. Can you rephrase the question again? I may have missed it.

Ms. Matsui. Do your patients, cancer patients, often spend a lot of time with their doctors and their care teams to try to figure out what to do next, how to get them well?

Dr. Lichtenfeld. Cancer is a complex disease and there is

no question that the most important objective is to get the patient well and that takes time, it takes effort and it takes teams. There are, as I mentioned earlier there is increased attention to mental health issues with respect to cancer, financial toxicity issues, which are above and beyond the care discussion, and there are now requirements being put into place that expect that type of discussion.

So yes, I mean it is not a simple process. It is complex. It is much more complex as time goes on. The drugs are more complex, the treatment, trying to help people get to the treatment, all of these are issues that have to be addressed as part of the cancer journey.

Ms. Matsui. So during this process do cancer treatments like chemotherapy have side effects that make it hard for patients to accomplish daily tasks?

Dr. Lichtenfeld. There is no question that the treatment is toxic for many situations and the fact that many patients are so impacted. I mean the fatigue issues are well known, the ability to work, whether someone, as I mentioned earlier the substantial number of people are not able to work. Meeting payment requirement is important, but yet perhaps the 30 days is not the right number that we should be talking about.

Ms. Matsui. So cancer patients don't get a pass at all on taking care of the finances.

Dr. Lichtenfeld. No, they don't get a pass. So I think we

have to look through that cancer lens to understand the implications of what we do, and understanding it through that lens will give us guidance, we believe, in terms of how this should be constructed going forward.

Ms. Matsui. So it is possible that a cancer patient has to deal with so much that even when a loved one is managing their affairs a month's payment can be overlooked?

Dr. Lichtenfeld. It is incredibly complex. We have many life situations that are complex and cancer is certainly one of the most complex that we have to deal with.

Ms. Matsui. So if that patient is kicked off their plan for missing one payment what happens to that patient?

Dr. Lichtenfeld. Well, they end up, whether they could get the care the care would be interrupted, and then when they come back into the system so to speak their premiums under some discussions may be much higher than they would have been otherwise and that may last a lifetime.

Ms. Matsui. Okay. I yield back.

Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady. The chair recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for your questions, please.

Mr. Griffith. Thank you very much, Mr. Chairman. I have heard a lot of folks talk about things and what their constituents are telling them. And while I have constituents who certainly have liked the ACA, a vast majority of my constituents have had

problems similar to Mark from Stuart, Virginia, who writes in part talking about the increased premiums that he has had to pay. He says it has cost my family around $21,000 over the last 3 years.

He goes on to say, I would like nothing more than to see this law repealed as fast as possible and relegated to the trash heap of history. He goes further, please be responsible in what it is replaced with and make sure it consists of common sense measures that will help, not hurt, middle class families.

And I think that is why we are here. We are trying to figure out how we can do things that balance it out which is why, Mr. Wieske, I want to talk to you about the high risk pools that were successful in your state. How many people did you all cover?

Mr. Wieske. Roughly 25,000.

Mr. Griffith. Okay. And what rates were you able to offer these patients? I know you said they were affordable but just give me some idea of what they were.

Mr. Wieske. They varied, so the deductibles varied from $1,000 deductible all the way up to a $7,500 deductible. I believe the rates for the typical, in my testimony I compared it to the rates that what a Silver Plan would be and it was a little bit lower than what the ACA plans are in Wisconsin currently.

Mr. Griffith. Okay.

Mr. Wieske. So roughly about depending on, it varied based on age so between 200 and $500 roughly.

Mr. Griffith. Okay. And I thought it was interesting you

said that 40 percent was paid by the insured, 30 percent by the insurers, 30 percent by the medical folks taking some discounts --

Mr. Wieske. Correct.

Mr. Griffith. -- but then at one point I thought I heard you say there was also some private money?

Mr. Wieske. There were subsidies that were also included as part of those assessments. So consumers who had, or members who had incomes at or below $34,000 received subsidies, at the lowest end was up to a 43 percent subsidy on the premiums.

Mr. Griffith. And the subsidy came from?

Mr. Wieske. It came from the high risk pool.

Mr. Griffith. It came from the high risk pool.

Mr. Wieske. The high risk pool funds, yes.

Mr. Griffith. Okay, so that would have been some state money?

Mr. Wieske. No state money. There was no state money at that time.

Mr. Griffith. Explain that to me. It came from the high risk, was that the insurers?

Mr. Wieske. It was the insurers and the providers, the discounts. So they were able to provide --

Mr. Griffith. So that was part of the 40/30/30 that you were talking about?

Mr. Wieske. Correct, right.

Mr. Griffith. All right. And I think you have already answered it was not a one size fits all? You could make some choices within the high risk pool itself?

Mr. Wieske. Yes, yes.

Mr. Griffith. All right, so we are trying to figure out how to craft which is why, you know, it is interesting. I have heard some criticism that Chairman Walden's bill has a placeholder in it, but we are trying to figure out exactly, you know, what we can do to make this and get all the ideas, Democrat and Republican.

So what in your opinion, if we are going to set up a high risk pool what are the most important factors to consider when states design these high risk pools? When we say to the states if we decide that is where we want to go, what should the states be doing to make their high risk pools work as yours did?

Mr. Wieske. Yes, I think affordability is the key. I think having a good partnership between the providers and the insurers and having a strong board that is interested in governing, a long-term board. It was outside of the -- it was a quasi-governmental entity that ran the high risk pool. I think that was effective. They hired outside experts.

They had, instead of taking the claims in-house they hired an administrator. They had a great administrator who did great work. So I think having a strong structure in place is the most important piece and then having the funding mechanism that is stable.

Mr. Griffith. All right. And, you know, one of the things that I had thought we might have to do, but you all didn't have any state money, do you think we need to at least prime the pump so to speak and have some federal money to help the states get their high risk pools started, or do you think they can take your model and not have any federal money?

Mr. Wieske. I think you see if you look at the federal, so early on the ACA did include funding for high risk pools, and I think if you look at the premiums for that they dropped considerably. There was about a 150-$200 drop depending on the age in premiums. So I think federal funding could certainly help make that coverage much more affordable.

And again I will say that high risk pools are not for every state so there may have to be other options like re-insurance schemes or, you know, maybe some states do want to do guaranteed issue, but we found high risk pools effective.

Mr. Griffith. Okay, I really do appreciate that. You know, this is a tough nut to crack on all those bills that we are considering, not only the ones for today but other bills you see us considering. All three of the witnesses, if you would please let us know.

I mean I am making suggestions to Chairman Walden's team to make some improvements on his bill that I think might need to be in there, but we encourage you to let us know what you see and what you think you can do because we are looking for constructive

criticism. We want to take the time to get this right for the American people, and so as Mark from Stuart said to make that we are helping folks and not hurting middle class families in America. But thank you so much for being here today. I yield back.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for your questions, please.

Ms. Castor. Well, thank you, Mr. Chairman, and thank you to the witnesses for being here. I wanted to make sure that we go back again to the point because we have the chart that was up on the screen and the impression that may have been left that repealing the ACA applies just to the healthcare.gov marketplace.

And I think folks really need to understand that when you repeal the ACA as my Republicans are on track to do that affects all Americans, everyone. Medicare, Medicaid, or the folks, the 20 million Americans who did get coverage under healthcare.gov, the marketplace -- and in Florida that was 1.7 million, larger than the population of some states have enrolled in the marketplace in Florida -- but the employer based insurers where most of our neighbors get their insurance.

There are vital consumer protections that have improved the lives of our neighbors and you simply can't gloss over that or ignore it and people need to really understand what they have gained, and Florida is a great place to look. In Florida we have

8.8 million that have their insurance through their job that means that all of those folks can no longer be discriminated against if they have a preexisting condition like cancer, diabetes, asthma, heart disease -- we estimate that that is about 7 million Floridians.

Under the Affordable Care Act, under your private policy your kids can stay on your policy until they are 26 years old. Insurance companies cannot cancel your policy if you get sick and they can't impose lifetime limits or caps. All of that will be lost under the ACA Republican appeal plan. These consumer protections have been a godsend to our neighbors.

And let's talk a little bit about cost because I am very, I am sensitive to the fact that the markets are different across the country, but you can't deny that before the ACA health care costs were out of control. And if you look just in my state, the ACA has generated significant savings for Florida families.

And we have got to do more to control the cost. If we can really tackle pharmaceutical costs that would be a great help for families. I don't see any bills on the agenda today that do that but that would be very positive. Florida families with employer coverage saw their premiums grow only 1.3 percent from 2010 to 2015 compared to 8.2 percent over the previous decade before the Affordable Care Act. That means if you look at it in real dollars a savings of about $7,600 per family.

The ACA also requires, and this doesn't get a lot of play

but it is very important. The ACA also requires health insurance companies to spend at least 80 percent of their premium dollars on actual health care, not administrative costs or profits, and if the insurance companies go over that 80 percent they have to -- consumers get a refund. HHS reports that Floridians with employer coverage have received $109 million in refunds since 2012. That really makes a difference for the working families I represent.

So one of the bills that is on the agenda for discussion today is age rating. Boy, have you really hit a nerve back in Florida to ask that our older neighbors, and we are talking about those that are under 65, are going to pay a whole lot more for their insurance coverage.

The thing about the Affordable Care Act, it is this very considered, thoughtful balance. Over time it is going to need rebalancing. Like I said, markets like mine are very competitive even in the individual market with 61 plans to choose from. Not all parts of the country are like that. But if you start tinkering here and asking my older neighbors to pay a whole lot more before they go into Medicare that is not smart. We want them to be as healthy as possible before they go into Medicare because we have our challenges there as well.

So watch out for this age rating, and I go back to the woman that I mentioned during my opening remarks who is 60 years old, working part-time in a small business, taking care of her

youngster in high school, going to school. You ask her to pay five times the going rate instead of what is in the ACA now you probably price her out of this.

So let's be thoughtful in what we do. We have got to turn back this repeal effort though and make more considered and thoughtful policy here in Washington, D.C. I yield back my time.

Mr. Burgess. The chair thanks the gentlelady, the gentlelady yields back, and recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions, please.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it very much and I thank the panel for their testimony as well.

Mr. Holtz-Eakin, I understand you run your, CBO, and you currently run a think tank?

Mr. Holtz-Eakin. That is correct, sir.

Mr. Bilirakis. Your organization recently did a review on the various replacement plans that conservatives had introduced. There is the Better Way by House Republican Conference, the Patient CARE Act, the Improving Health and Health Care Act, Empowering Patients First Act, the American Health Care Reform Act, the 2017 project in the World's Greatest Health Care Plan.

When people say Republicans don't have a plan that is simply not true. There are many plans and competing ideas. However, it would be fair that there are certain common areas that are in most of these plans. Can you talk about the ACA provisions that in your expert opinion would most likely be kept? If you would

elaborate, please.

Mr. Holtz-Eakin. Yes, I mean one of the reasons we wrote the paper is that there is an enormous amount of overlap and so it seems to me to be sensible to expect those to be present in any replacement plan.

So all of them allow children to stay on the parents' policy until age 26 as in current law, all prevent discrimination against those with preexisting conditions and guarantee the issuance of an insurance policy, all of them ban caps on annual or lifetime out-of-pockets for individuals, and then they all have subsidies for individuals, typically age based so the elderly, the older and more likely to be expensive patients get some help.

All of them have some sort of risk pool for those who can't be managed in the normal pool and all have some sort of approach to the continuous coverage idea where the differences quite frankly are in how do you handle the gaps. Handling the gaps, I want to echo what was said, is a really important issue. All of them have some provision to cap the most exposure that an individual would face if somehow they did develop a coverage gap for reasons outside of their control. So there is always common elements in these replace plans.

Mr. Bilirakis. Very good, thank you.

Mr. Wieske, when the ACA was passed there were several promises made about it. The American people were promised it would bend and cost curve through increased competition the health

insurance market. In Florida today 73 percent of the counties have only one health insurer and average premiums increased by 19 percent last year. I fear that what it will look like 2018.

You mentioned that in Wisconsin you have an active insurance market pre-ACA --

Mr. Wieske. Yes.

Mr. Bilirakis. -- and then how was the health market before ACA and now with the ACA? Can you discuss it?

Mr. Wieske. Yes, I think we saw the highly competitive markets were fortunate. We still have a lot of choice in our market, but it is evaporating slowly but surely. And we see carriers consistently move their market around, move their coverage areas around, so there is a lot of instability. They have changed their networks. They have changed their networks around in order to deal with affordability and competition and issues, and the net result for a consumer is consumers don't have as many choices as they had before the ACA. They have fewer choices in coverage.

Mr. Bilirakis. Thank you. Mr. Holtz-Eakin, again just in case members of the minority might not be familiar with our Better Way agenda, can you please detail that the Center for Health and Economy analysis finds the plan broadly what it accomplishes. Again, the impact on premiums would they increase or decrease? What about provider access? Would there be an impact on the federal budget? Can you go ahead and discuss that?

Mr. Holtz-Eakin. The Center for Health and Economy of which I am a board member did an analysis of the Better Way plan. I won't remember all the numbers right, but broadly speaking the insurance market deregulation lowers premiums something in the vicinity of 15 percent or so. Lower premiums improve private coverage in that plan and expand coverage. As a result of both the lower premiums and the subject structure there is less stress on taxpayers and there is budget savings in the Better Way Plan.

And underneath the plans is important I identify what kind of networks and provider access are available, and access has improved. And there is an index of medical productivity, something to think about in terms an index for bending the cost curve, and there is improved medical productivity in the plan.

Mr. Bilirakis. Thank you very much. I yield back, Mr. Chairman, appreciate it.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for your questions, please.

Mr. Schrader. Thank you very much, Mr. Chairman. I appreciate the panel for being here. I just want to put some emphasis on the goal of what we are trying to do here and that is not to just beef up an insurance market, but to provide good health care for Americans. That is really our goal.

The vehicle we currently have is dealing with the insurance market, I get that. But I think when we are talking about you

can't have the plans you want, et cetera, the goal here is to provide the essential benefits that basically provide health care for the scope of the people of this great country. And if everyone just pays in their little bit just like you do in any insurance program everyone benefits at the end of the day.

I think we have to focus on the health care aspects here. I am a little concerned about the tenor of the hearing. I want to make sure we are talking apples to apples as we go forward.

Mr. Holtz-Eakin, you talked about that some of these fixes could help stabilize the markets, so I assume you don't see these as replacement for the ACA but to stabilize the current market structure?

Mr. Holtz-Eakin. Yes, the special enrollment periods, grace periods, those kinds, again these are what I think of as near term Band-Aids to make sure the current deterioration doesn't continue and it works --

Mr. Schrader. I think that is fair. So they are not going to replace the ACA in and of themselves.

Mr. Wieske, you talked a lot about the high risk pools and you have a robust market in Wisconsin. Knock on wood we still do in Oregon, but some states don't, some counties don't depending on the state they are in. I get that. You talked about the federal subsidy driving down the cost of the program if you will making it more affordable for Wisconsinites.

You know, if we get rid of the ACA in its entirety which has

been proposed, and all the revenues, the 800 billion plus some of the other policy changes that make sure this is a deficit reduction, a piece of legislation, you know, what do you think? Don't we need some federal revenues to make whatever system we have going forward affordable for Wisconsinites?

Mr. Wieske. I mean I think federal revenues obviously make it easier, but functionally, I mean I will say our market functioned pretty well. There was guaranteed issue available. Nobody could be turned down in most states, I think all states because of a health condition once they were insured, so that didn't exist and that didn't exist in Wisconsin. People were not dropped off their coverage due to --

Mr. Schrader. So I have to interrupt, I apologize. I don't have a lot of time. Yes, and I think there is different opinions about, you know, who should get, you know, well, apparently some different opinions about who should get covered. I think everyone should have coverage and that means making it affordable and maybe even giving some people more of a break than some people think they deserve, because it all costs us at the end of the day if they don't have health insurance and that is just not productive.

I want to make a statement and I would like everyone to think about this both Democrat and Republican and you certified smart people over there on the dais. I am very worried these young people we are trying to get onto the individual marketplace they

don't exist. I see no evidence that these people are out there no matter what we do -- age bands, difference in premiums.

The reason I say that is, and I would love to be proven wrong but no one has been able to give me the information, insurers, you know, providers, whatever is that a lot of young people are on their parents' plan, age 26. A lot of people have jobs, especially right now. They are working. The people that are on the individual market are, in my state and I think most states, adversely selected. They are 50 to 65 years old. They have got a bunch of medical conditions.

And last but not least, with the Medicaid expansion that has been successful across the country and is part of the ACA -- I think we have to understand that the Medicaid expansion is part of the ACA -- the biggest portion of that population that signed up, they are young. Well, younger than me, under 45 years of age, eh. So that is good.

I am worried that we are chasing a unicorn here, folks. I am worried we are chasing a unicorn. I don't care what plan I have heard from my Republican colleagues or as Democrats. So I think we need to put that into the mix as we think about how do we make sure this individual market is stabilized. It has been a boon for a lot of folks. It has worked very well for a lot of folks. It has some problems and maybe some of these fixes would get to them.

And I would hope that the majority party would look at working

with the minority party on some of these. The age bands don't have to be 5:1. The grace period doesn't have to be 3 months, you know, there is accommodations that we have talked about in previous hearings.

And I think we keep in mind that this is to stabilize the current ACA marketplace while my colleagues, trying to chase maybe a unicorn, maybe we have been chasing it and now it is their turn, but I hope we look at this and the goal again is to provide excellent health care to every single American in the greatest nation on earth. And I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for your questions, please.

Mr. Bucshon. Thank you, Mr. Chairman. Dr. Holtz-Eakin, your written testimony is packed with incredible statistics on age rating bands and I would like to read a few, just some facts. Average health care expenses for a 64 year old are 4.8 times greater than that of a 21 year old, and according to U.S. Census data, the insured rate for those age 19 to 34 is 4.6 percent higher than the uninsured rate for those age 35 to 64.

I raise this because you note that the Administration predicted that the individual market would need about 40 percent in the enrollee population to be made up of young, healthy patients. Today that number is 28 percent. So the 3:1 age band in my view is just not an actuarially sound principle based on

that. Would you agree that modifying the age variation in premiums would help balance risk and help stabilize the marketplace?

Mr. Holtz-Eakin. Yes, it would help. It would allow insurers to offer relatively cheaper policies to the young and relatively inexpensive. It is true that they would be relatively more expensive for the older and sicker. That is a financial reality. But getting those into the pool helps everyone over the long term.

Mr. Bucshon. So at the end of the day do you think one of the biggest problems with what is happening in the exchange marketplace is mostly based on the fact that it is 28 percent young, healthy people versus 40 percent? Would you consider that the major factor or are there other reasons?

Mr. Holtz-Eakin. There are probably some other reasons. I think this sort of grace period or the special enrollment periods or things like that have exacerbated the fundamental problem. But this is a core problem and because of the exits and the rising premiums it is getting worse not better.

And we have discussed a little bit about the design of high risk pools today, my basic theory is we have a high risk pool and it is called the exchange market and it is just getting more and more like one every day.

Mr. Bucshon. Okay. Mr. Wieske, do you have any comments on that?

Mr. Wieske. No, I think that is exactly right. And part of to understand is as you get more of the young folks in that drives the average rate down so that 5:1 may still be a 5:1, but it is not necessarily the same 5:1. It is a lower figure that you are starting with when you multiply it times 5.

Mr. Bucshon. Correct. So the 1 will be a lower starting point.

Mr. Wieske. Correct.

Mr. Bucshon. And I think that is one of the concepts I think that people try to overlook. If you take changing the age rating band and the concept that the 1 will stay in the same place that it is today, you can make the argument yes, costs will be so high for the older, sicker patients that it might price them out of the marketplace.

But my, you know, shifting the idea is to shift the whole marketplace back to a more actuarially sound position.

So it is not just this, but there is some other actuarially unsound principles in the ACA that in my view have predictably resulted in where we are today.

Do you have any other final comments, Dr. Holtz-Eakin, on that? Anything else that is what you consider non-actuarially sound other than the age bands that we might be addressing that we haven't addressed? Do you have any other thoughts?

Mr. Holtz-Eakin. I think the more you delegate the sort of regulatory process and the review process to the state insurance

commissioners, the better you are going to get this because the pools are different state by state, dramatically different.

Mr. Bucshon. Very important concept.

Mr. Holtz-Eakin. And so I think you should recognize that in going forward.

Mr. Bucshon. Okay. Mr. Wieske.

Mr. Wieske. Obviously we agree. And I think, you know, I think the other piece here is that you can take a look at the testimony and you can see the disparate impact that the ACA had on rates when it was implemented. And in my testimony we have numbers that show that the increases were substantially higher on the younger folks than they were on the older folks, so it is a return back to where it was before.

Mr. Bucshon. Dr. Lichtenfeld, I was a cardiac surgeon before I was in Congress, so I am going to ask and this is a serious question. Before the ACA, prior to the ACA, if you were referred a patient, you know, that has cancer for example, say, a GI doctor referred you someone that has a colon cancer and that person did not have medical coverage how did you handle that situation?

Dr. Lichtenfeld. With difficulty, quite frankly.

Mr. Bucshon. Yes. Did the patient get medical care?

Dr. Lichtenfeld. Well, they may have gotten some medical care but they didn't get adequate medical care.

Mr. Bucshon. So if they needed follow-up chemo from their colon cancer for example what, a 5FU or whatever you guys do these

days, did they get that or they didn't get it?

Dr. Lichtenfeld. 5FU is one question, the newer treatments we have today are entirely different, okay.

Mr. Bucshon. Okay, the newer treatments then, yes. Okay.

Dr. Lichtenfeld. And certainly, sir --

Mr. Bucshon. I haven't done GI or colon stuff in 25 years so I am behind.

Mr. Bucshon. I respect the work that you have done. In fact, one time in my life I wanted to be a cardiac surgeon and didn't make it, so --

Mr. Bucshon. You made the right decision.

Dr. Lichtenfeld. But the reality is, you know, we as physicians always want to do what we can to stabilize somebody in their time of need. That is very important.

Mr. Bucshon. Yes.

Dr. Lichtenfeld. Unfortunately cancer is a complex, long-term disease.

Mr. Bucshon. Understood.

Dr. Lichtenfeld. And those folks will fall through the cracks. They did and they are doing less so today.

Mr. Bucshon. Okay, thank you. I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Massachusetts, Mr. Kennedy, 5 minutes for your questions, please.

Mr. Kennedy. Thank you, Mr. Chairman, and I want to thank

the witnesses for their testimony today, touch on a couple of issues.

Mr. Wieske, you had testified and you spoke an awful lot today about the benefits of the Wisconsin's high risk pool, sir. I wanted to make sure we just fleshed that out a little bit. My understanding is that when you talk about the comprehensive coverage that was provided to consumers and that the cost coverage closely mirrored the cost of private coverage in the state, I believe though that the premiums for the Wisconsin high risk pool were set at twice the individual marketplace; isn't that right?

Mr. Wieske. No, that is not correct. They were set based on an actuarial basis, so the --

Mr. Kennedy. So that is information coming from Kaiser Foundation.

Mr. Wieske. -- I am sorry.

Mr. Kennedy. I am sorry. The information coming from the Kaiser Family Foundation indicated that those prices were twice the --

Mr. Wieske. The numbers in my testimony were actually provided through the Legislative Audit Bureau which did an audit of the state high risk pool. I sat on the state high risk pool board. The rates were set based on the actual contribution to costs by each of those that split the 40/30/30 that I talked about.

So that was where it was. It was not set in an artificial 200 percent of the federal -- I don't know where they got that

number unless it came from the federal high risk pool piece which is a separate and they had their own separate rules of how they set their rates.

Mr. Kennedy. So if it is not -- I understand that you are saying they weren't pegged that way. Were the premiums though twice as high as they were for the high risk pool as they were for the individual markets?

Mr. Wieske. Yes. I don't think so, no.

Mr. Kennedy. No, okay. Didn't Wisconsin's high risk pool exclude coverage for 6 months for a preexisting condition that made patients actually eligible for that pool in the first place?

Mr. Wieske. It depended on how you came into the pool. So folks who had continuous coverage it mirrored the preexisting condition piece so that is something that could certainly be fixed. But folks that came from no coverage similar to folks who were facing a grace period who have not signed up for the ACA and can't sign until the open enrollment period and have to wait until then to sign up if they don't have coverage, if they came from no coverage they did have a 6-month waiting period.

Again it would be like an open enrollment period except you get to sign up anytime, but only for coverage of that condition. Now folks who came from other coverage that lost their coverage involuntarily did get preexisting condition credit and did not have a preexisting --

Mr. Kennedy. So if I were, just to make sure I understand

that if I did not have coverage before and came down with cancer I would have to wait 6 months for those cancer treatments to get covered?

Mr. Wieske. Similar to if you did not have --

Mr. Kennedy. Yes.

Mr. Wieske. -- coverage right now you could not buy coverage in the individual market. You have to wait until open enrollment.

Mr. Kennedy. Dr. Lichtenfeld, can you tell me what the impact of having a cancer patient wait 6 months for treatment might be?

Dr. Lichtenfeld. We have actually been through that in the past where in fact some of the commercial plans in the group plans had exclusions of 9 months, so it is a pretty serious issue. And we have also had issues with regard to women who were screened for cancer, mammography for example, who did not get automatic coverage.

So the question was, well, you have screening, you know you may have breast cancer but you can't get the care. So that has been addressed in some respect through the breast and cervical cancer early detection program. So it is a very real issue cancer doesn't wait, and there is acute conditions that really don't wait. So obviously the 6-month exclusionary period which has existed in the past in some places is something to be concerned about.

Mr. Kennedy. So let me shift topics a little bit here, but I would appreciate your medical opinion on this. We have, as I mentioned in my opening comments a while ago now, this committee has dived into a partial examination of the failures of our mental health system across our country and some of the systemic failures with that marketplace.

As you might be aware, the largest provider of mental health, or payer for mental health service in the country is Medicaid. And so the combination of mental health parity and the Medicaid expansion and some of the clauses in the Affordable Care Act themselves were a sea change in terms of access to care, understanding we still have an awfully long way to go.

I was hoping you might be able to comment on what the impacts of either doing away with that Medicaid expansion or issues around preexisting conditions what that would mean for folks suffering from mental illness.

Dr. Lichtenfeld. Mental health issues are serious and as I mentioned earlier they certainly impact patients with cancer and families of patients with cancer. Access to those services is very important. And clearly within the community and now with the opioid addiction epidemic that we have and the stress that that is putting on mental health services, we have to make certain that everyone has adequate access to mental health services just as we have talked about with respect to services for patients diagnosed with cancer.

Mr. Kennedy. Thank you, sir. I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for your questions, please.

Mrs. Brooks. Thank you, Mr. Chairman. I just want to clarify, Dr. Lichtenfeld, under current law, current law, if a patient is diagnosed with cancer they also have to wait, do they not, to get into a market?

Dr. Lichtenfeld. I am going to share with you that I can't respond to that directly. To my, you know, depending on the circumstances -- I am trying as I think through this -- they really are individual. If I may, they are individually specific to that person as to what happens to them, have they been engaged or not, and that is a very real --

Mrs. Brooks. If they had not been engaged.

Dr. Lichtenfeld. If they have not been then that could be problematic.

Mrs. Brooks. Okay, so that -- and Commissioner Wieske, would you -- and I am sorry. How do you say your last name?

Mr. Wieske. Wieske.

Mrs. Brooks. Wieske, I am sorry. Is that your understanding --

Mr. Wieske. Yes.

Mrs. Brooks. -- that under current law if an individual had paid the penalty or had, you know, and was not insured right

now, if they develop cancer they too have to wait for open enrollment?

Mr. Wieske. Healthy or not they have to wait until open enrollment. They cannot enroll until January of the next year unless there is a special enrollment period.

Mrs. Brooks. Okay, thank you. I would like to talk about what we are trying to explore which has to do with continuous coverage and the importance of continuous coverage as a potential tool in incentivizing individuals to stay covered. And so some folks would suggest that this could lead to higher premiums based off of health status or preexisting conditions, but I believe that to be false.

And because we want to prohibit rating based off of health status, we want to prohibit rating based off of preexisting conditions, critically important, but in order to accomplish this fairness goal we have to stabilize the markets, as I understand actuarially sound market stabilizers.

And so, Commissioner Wieske, as chair of the NAIC Health Care Reform how do both the state of Wisconsin and the association view the concept of continuous coverage?

Mr. Wieske. Well, I think it is important. I mean I think a lot of the issues that surround the individual health insurance market are driven by the fact that again it is a residual market and the fact that folks jump in and out from carrier to carrier which has been exacerbated by the ACA.

So I think insurers --

Mrs. Brooks. Can you expand on that please?

Mr. Wieske. Sure. That in the ACA that you have seen people typically jump from one carrier to another obviously based on price, based on their interest.

Mrs. Brooks. And when you say they jump from one carrier to another what is the time period in which they have been doing that?

Mr. Wieske. Every year they look to switch as to what their best options are. That is appropriate shopping. But I think if you can design a system that where their coverage is more continuous, I think that the interest of the insurers change in driving more long-term health and I think that is really where the issue is, is that if you have only got somebody for a year or 2 your investment in their long-term health never pays off. It pays off for the next insurer.

So if you can have a long-term coverage with a single insurer you end up having a system where those further investments pay off for the insurer.

Mrs. Brooks. And do we have some circumstances where people might be insured for 9 months and then drop out?

Mr. Wieske. Yes, definitely we have heard that the -- yes, consistently.

Mrs. Brooks. Dr. Holtz-Eakin, I understand -- what are your thoughts with respect to continuous coverage with respect to a

mechanism for stabilizing the health care markets?

Mr. Holtz-Eakin. As I said before, I think it is a very important concept. Obviously there are details that need to be worked out, but the incentives to get the young into the pool are very powerful. The issue of having a balanced pool gets taken care of organically because the young are always jumping in. Some will become more expensive as they get older; they are all in the pool.

But the fundamental issue has always been how do you get quality care at lower costs, and this gives insurers the correct incentives to look over a lifetime, work with the providers not just for short-term purposes but for the long term and that would be beneficial. We don't have those incentives in the system right now. The closest place for that quite frankly is employers. Self-insured employers often have employees for an average of 7 years. That is a time period over which you can make a big difference.

And I consider it no surprise that that is the place where we have seen the slowest cost growth in the U.S. health system.

Mrs. Brooks. Can you share any actuarial cautions we should consider as we are shaping this process and what are some of the incentives that you believe could be really helpful?

Mr. Holtz-Eakin. I think the most important thing is to separate what the system looks like from how we get there, and today's discussion is largely that sort of stabilizing it so that

you can get something in place. The high risk pools will be at a minimum a very important part of the transition mechanism. Figuring out who goes in and who comes out and gets back into the regular pool, I think, is going to be a really important part of this.

Mrs. Brooks. Thank you. I yield back.

Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady. The chair recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. Eshoo. Thank you, Mr. Chairman, and thank you to the witnesses for being here today. I guess it is an advantage to come early and hear what everyone has had to say and the questions that are asked and the answers that you have proposed.

I want to start out by commenting on Chairman Walden's remarks. He is a good man and I take him at his word in terms of what he believes in. But for each one of us we are legislators. We are legislators. So while we can all talk about what we believe in what is actually written down in legislation which you are here to give testimony on, we came to a hearing where Title II Continuous Coverage Incentive is blank, blank. It is blank. So I can't help but comment on that first.

There are so many things that have been said that I find either curious or really menacing. First of all, the Affordable Care Act in its promise which has been kept so far is that no one can take it away from you. That is not what the American people

experienced before that legislation became law. Now today the only ones that can take it away from you are the Republicans. And that is what repeal is. Repeal is a heavy, heavy word. It is a wrecking ball.

We are sitting in a hearing room that was recently remodeled. The entirety of the Rayburn Building was not taken down. It wasn't destroyed and then rebuilt simply because these daises needed to be adjusted or the room repainted. So when the word repeal is used it is chilling and, you know what, it is chilling to markets. It is chilling to markets. And I don't think that has been taken into consideration by our witnesses today.

Now this whole issue of insurance across state lines and what it is going to do, I can buy an insurance policy across state lines today. Maybe I pick Idaho, I don't know, Arizona, wherever. Terrific. Maybe it is lower cost than what I have now. The only problem is when I get sick I have to travel to that state in order to take advantage of it. And within our 50 states there are many different standards. Some states are low-ball states. They have practically no protections for consumers, so if that is what is opened up that is a disaster in my view.

Now what I want to ask each one of you is do you support national insurance for people in our country, each one of you, yes or no? Quickly, because my time is running out.

Mr. Holtz-Eakin. I don't know what national health insurance is.

Ms. Eshoo. That everyone in this country is able to get health insurance.

Mr. Holtz-Eakin. Everyone has an opportunity to buy a policy, sure.

Mr. Wieske. Everybody should have access to affordable health insurance.

Ms. Eshoo. Just access or be able to get it? I can go to Nieman's. I can have access at Nieman's.

Mr. Wieske. I think access means that they can get it. If it is affordable, access means they can get it.

Ms. Eshoo. Dr. Lichtenfeld.

Dr. Lichtenfeld. Ms. Eshoo, and my personal thoughts are not relevant to my presentation today, I am here on behalf of --

Ms. Eshoo. Well, you are here on behalf of -- say yes or no.

Dr. Lichtenfeld. I am here on behalf of the American Cancer Society and we are just like everything else we will certainly consider proposals if they are made. Our concern today is to make sure that --

Ms. Eshoo. That is it. I am losing my time.

Dr. Lichtenfeld. -- going forward that we --

Ms. Eshoo. Do you support, you all say that you support the very good things that are in the ACA. No discrimination, preexisting conditions, women, up to 26 on their parents' policy, so you would support a mandate in whatever replaces the ACA to

include those because it is a mandate.

Mr. Holtz-Eakin. I didn't say that. I said every replacement we have studied continued those --

Ms. Eshoo. No, I am asking you do you support that? You accept that it is a mandate or is it voluntary? How are these things going to come about if they are not baked in as a mandate for an insurance policy?

Mr. Holtz-Eakin. People are permitted to have their children on their policies up to age 26. They are not mandated to have them until 26.

Ms. Eshoo. But there is a mandate to the insurance industry that those reforms which cover everyone --

Mr. Holtz-Eakin. Yes, it is the current law.

Ms. Eshoo. -- so you accept that?

Mr. Holtz-Eakin. Yes.

Mr. Wieske. We had these reforms in place --

Ms. Eshoo. Do you, Mr. Wieske?

Mr. Wieske. We had these, we performed --

Ms. Eshoo. No, I don't want to hear about that. I just want to know if you --

Mr. Wieske. But Wisconsin believes that it has a good market and it doesn't need a federal mandate to tell us what to do.

Ms. Eshoo. But do you support those being mandated relative to the insurance industry in our country, those reforms?

Mr. Wieske. We would look at it in state law, yes.

Ms. Eshoo. Do you think that beyond your state it should be?

Mr. Wieske. I can't speak for other states.

Ms. Eshoo. Do you want it for your state?

Mr. Wieske. We will work with our legislature and the legislature will figure out what is --

Ms. Eshoo. Well, you know what, this is like nailing Jell-O to a wall because I don't think there is a commitment. I think you talk about these things and that they are good things, but unless these reforms are held onto that were made and have made an enormous difference in people's lives including all the cancer patients in our country then there isn't a commitment to them. And I think that this is part of the basics of what the integrity of what insurance plans need to have in the country. This has revolutionized people's lives.

Mr. Burgess. The chair thanks the gentlelady. The gentlelady's time has expired. The chair recognizes the gentleman from Oklahoma, 5 minutes for questions, please.

Mr. Mullin. I feel sorry for the panel. It is funny, because it seems like when I go after a panel like that they always get upset because I am badgering the witness or something. I understand everybody's opinions runs high on this, I get that. But I will be real frank with everybody. The federal government should get out of the people's way and we shouldn't be mandating anybody to do anything. That is not the role of the federal

government. The federal government is to provide opportunities and resources for them to have access and affordable access and that is what we are trying to do here, affordable access.

Oklahoma, which I represent, is one of the states that only has one insurer carrier in there. We are one of the one of five. We saw premiums raise by 76 percent last year. It is not because the Blue Cross Blue Shield is trying to be greedy, it is because they are trying to stay in business. I understand that. The regulatory environment is such that they have to continue to change so they can afford to provide the health care.

But because of the regulatory environment underneath, ironically, Affordable Health Care which is anything but affordable, it is causing premiums to skyrocket and then it causes less affordability means less access to our constituents. And all this committee is trying to do is find a way to bring those premiums down and allow access to be created.

So Mr. Wieske -- and I hope I pronounced that right.

Mr. Wieske. You did.

Mr. Mullin. Okay. My first questions to you, could you help explain why the regulatory environment that we are finding ourselves in right now is causing the premiums to literally skyrocket?

Mr. Wieske. Sure. I think it starts with the risk pool. You know, you may have a large risk pool but when you have loaded dice it is very difficult to get a representative, you know, 1

through 6, a representative sample when the dice are loaded. In other words --

Mr. Mullin. What do you mean by loaded dice?

Mr. Wieske. What I mean is, is that the risk pool, the people who are purchasing coverage tend to need it and they tend to -- that the folks who don't need coverage who are young and healthy are outside of the market. And so when you are looking at the people that are buying coverage through the ACA that they are tending to be sicker.

And I think as Doug had indicated that it looks a lot like our high risk pool looked from a risk perspective. It is a little bit better, but it looks a lot like that from that perspective. That is the concern. I think you need to lower the premiums for younger folks to get them into the marketplace.

I think a lot of the burdens, you know, the SEP issue I think is one. There is a number of others where the Obama administration has set such stringent rules that make no sense. Their three Rs program has been a disaster as far as hearing out how you pay for the re-insurance and adequately price for the risk. The timelines are ridiculous. You are pricing a policy in March for something that starts in January. You know, it used to be a month, month in a half before, insurers don't have the data. There is a whole host of -- I could go on probably for hours and bore everybody here.

Mr. Mullin. Well, so if I am hearing you correctly, if we

keep things the way they are right now are we going to create an environment for more access or is it going to drive more insurers out of the market?

Mr. Wieske. I think there will be a few states like Wisconsin that will hang on by our nails for a while, but I think you can see in a number of states where the Tennessee commissioner who testified yesterday in front of Senate Health indicated that her market was near collapse, I think that is what you are going to be looking at over time in a number of states in the current environment.

Mr. Mullin. Well, you know, what we have been hearing is that both people, my side of the aisle and the other side of the aisle, we are passionate about our constituents. What strikes me is that here we are actually holding hearings on trying to fix a problem. I just wonder how much input you guys got to have when this thing was jammed down you all's throat. At least now we are trying to open it up and allow you guys to comment on it. If it is really about our constituents, then why would the other side be so upset that we are actually having public hearings on trying to fix it and get it better? I don't understand that.

So I appreciate, I appreciate that you guys are coming here, giving your perspective, the states' perspective and we are getting input. And I appreciate the chairman who has taken the time to listen and actually put up with some of the shenanigans that is going on on the other side, your patience, as you can tell

I wouldn't put up with. I appreciate you doing that Chairman.

But at the end of the day this is about getting it right and fixing it for our constituents. So thank you for your time, thank you for coming in here and giving your expert opinion and we look forward to working with you to bring down the premiums so it can be affordable and it can create access for our constituents to have health care coverage if they so choose to, not mandate to do. Thank you.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair would advise the subcommittee and the witnesses that a series of votes have been called on the floor. We are going to hear questions from Ms. DeGette for 5 minutes and then I am sure the panel would appreciate a break. We will have one and then we will reconvene back here immediately after the vote series is over. So Ms. DeGette, you are recognized 5 minutes for questions, please.

Ms. DeGette. Thank you, Mr. Chairman. I will just say before I start asking questions, my colleague from Oklahoma says, well, at least we are having hearings on legislation. But I would point out that we just learned today that we are going to have a markup of these bills that we are allegedly having the hearings today on, next Tuesday. And as my colleague from California said, Title II of the bill isn't even a title. It is Continuous Coverage Incentive, placeholder, and we are going to mark this up next Tuesday.

Mr. Mullin. At least we are having an opportunity to read it.

Ms. DeGette. I think we should work together on this. Now I want to welcome the panel here. I especially want to welcome you, Dr. Holtz-Eakin. I know when you were director of CBO you appeared in front of this committee many times and I am glad to welcome you back. I want to ask -- I want to focus most of my questions on you. First of all, you state in your testimony that the ACA is in a downward spiral, correct?

Mr. Holtz-Eakin. Correct.

Ms. DeGette. And a downward spiral -- well, you state in a downward spiral prices rise and insurers will continue to leave the market, correct?

Mr. Holtz-Eakin. Yes.

Ms. DeGette. And the result of that is because people are leaving plans and therefore the programs will not be sustainable; isn't that correct?

Mr. Holtz-Eakin. And there will be less competition and it will affect prices.

Ms. DeGette. Right. So declining enrollment would be one characteristic of a death spiral would it not?

Mr. Holtz-Eakin. Yes.

Ms. DeGette. Yes, it would. So I want to -- my assistant is going to hand you actually a chart from the Congressional Budget Office and it shows that Obamacare enrollment will hold steady

from 2017 to 2027 and there won't be decreasing enrollment. Do you see that chart?

Mr. Holtz-Eakin. I do.

Ms. DeGette. Thank you very much. Now also, Dr. Holtz-Eakin.

Mr. Burgess. Will the gentlelady yield?

Ms. DeGette. No, I will not. Also Dr. Holtz-Eakin, the Congressional Budget Office, your former employer, issued a report in January 2017 called How Repealing Portions of the Affordable Care Act Would Affect Health Insurance Coverage and Premiums. Are you familiar with that report?

Mr. Holtz-Eakin. I am not an expert on it but I have read it.

Ms. DeGette. Okay. So what the report basically looked at was the plan President Obama vetoed before, but what that plan did was it eliminated in two steps the laws mandate penalties and subsidies, but it left the ACA's insurance market reforms in place like the preexisting condition and age 26 and all of that so it is pretty much like what we are talking about here today.

And here is what the Congressional Budget Office found. It found that under a schematic like that, quote, the number of people who are uninsured would increase by 18 million in the first year following enactment of the plan. Later, after elimination of the ACA's expansion of Medicaid eligibility and the subsidies for insurance purchased through the marketplaces that number would

increase to 27 million and then to 30 million in 2026. Are you aware of that finding?

Mr. Holtz-Eakin. Yes, and I think it is wrong.

Ms. DeGette. Okay. Okay, I appreciate that but that was their finding.

Mr. Holtz-Eakin. It is also out of date.

Ms. DeGette. Now let me --

Mr. Holtz-Eakin. You should, no, you should know before you --

Ms. DeGette. No, no. Excuse me, sir. I am asking the questions.

Mr. Holtz-Eakin. I am giving you some question advice.

Ms. DeGette. The next finding that they made, the next finding what they made on page 1 of their findings -- and I do apologize. I only have 5 minutes. If you would like to supplement your testimony I would welcome that okay.

The next finding was premiums in the non-group market for the individual policies purchased through the marketplaces or direct from insurers would increase by 20 percent to 25 percent. Are you familiar with that finding, sir?

Mr. Holtz-Eakin. I don't remember that one.

Ms. DeGette. You are not. Okay, well, Mr. Chairman, I am going to ask unanimous consent to put both this chart from the CBO and also the report from January 2017 in the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 14**********

Ms. DeGette. Thank you. Now were you -- so if you want to talk about a death spiral, it seems to me that a death spiral would be caused if you left all of the things, the requirements for the insurance companies in place but then you eliminated the Medicaid expansion, you eliminated the exchanges and the subsidies and people left the markets in droves.

One more thing I just want to talk about and that is premiums because there has been a lot of allegations thrown around today that premiums have been skyrocketing. Are you aware of the CMS data that showed from 2000 to 2005 premiums were growing at eight percent, from 2005 to 2010, 5.5 percent, and then under the ACA average premiums were growing at only 3.6 percent, Mr. Holtz-Eakin?

Mr. Holtz-Eakin. What premiums?

Ms. DeGette. Private insurance premiums.

Mr. Holtz-Eakin. Employer?

Ms. DeGette. Yes.

Mr. Holtz-Eakin. The ACA didn't touch employers.

Ms. DeGette. Yes, it did.

Mr. Holtz-Eakin. That is why it continued to perform well.

Ms. DeGette. Yes, it did. Thank you very much, Mr. Chairman.

Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady. I do note the series of --

Ms. DeGette. Mr. Chairman, may I just put this chart, ask

unanimous consent to put this chart in the record, because it also talks about Medicare and Medicaid going down.

Mr. Burgess. If the gentlelady is willing to share that with the committee, unanimous consent request is made and without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 15**********

Mr. Burgess. We have 6 minutes left in our vote on the floor. The chair advises that the committee will stand in recess until immediately after votes.

[Whereupon, at 1:15 p.m., the subcommittee recessed, to reconvene at 1:46 p.m., the same day.]

Mr. Burgess. Call the subcommittee back to order, and to start I want to yield to Mr. Green for a point of personal privilege.

Mr. Green. Thank you, Mr. Chairman, for the time and if I could have everybody's attention. I want to -- there is a decorum requirement we do in this committee, and it was after we went to vote but our witnesses are here as guests and if you get up and insult whether it is Republican or Democrat that is not part of the decorum no matter what. And I am just going to admonish that that is not acceptable.

And so that is enough, Mr. Chairman. I just want to make sure that witnesses know where they are here to answer questions and not to engage in arguments. Thank you.

Mr. Burgess. The chair thanks the gentleman, and certainly once again thanks the witnesses for being here. And I know it has been a long day for all of us.

At this time the chair would recognize the gentleman from New York, Mr. Collins, 5 minutes for questions, please.

Mr. Collins. Thank you, Mr. Chairman. I am going to pretty much direct this to Dr. Holtz-Eakin. And I know we touched on

the SEPs, the special enrollment periods. Representative Blackburn who was chairing the telecom, she is a sponsor of H.R. 706, I am a co-sponsor. It goes back to the last Congress, and to the two of us and I think to many, there is a lot of common sense in working on our special enrollment periods.

And what we have noticed is during the Obama administration the enforcement seemed to be quite lax when it came to the SEPs and in effect giving individuals what I would call presumptive eligibility instead of verified eligibility and in doing so there is always some costs that would come around.

So Dr. Holtz-Eakin, the last time that you testified before this subcommittee you used the term, talking about the verification process, as being extremely generous. I think there was a little bit of tongue in cheek on that. Would you agree that that is still the case today, maybe if you want to expand on that at all?

Mr. Holtz-Eakin. I think this is an important issue simply as a matter of the arithmetic as the risk pool. As many as up to a third of people in the pool entered through an SEP and there are a lot of SEPs compared to other programs, like Medicare has seven.

So, you know, that is a big part of it and in the data these are more expensive participants than other members of the pool. So in a system where the fundamental problem has been the cost and the inability of insurers to appropriately plan for costs and

bake into their premiums those costs, this seems to me like a candidate for reform and a place that you should look right away.

Mr. Collins. So in studying this how would you say it impacts the market?

Mr. Holtz-Eakin. It does two things. It brings costs into the pool and those costs were unanticipated and that leads directly to insurer losses. The second thing it does is it makes insurers quite nervous about next year's unknowables and puts upward pressure on premiums just as a matter of caution to try to anticipate some of these people entering.

Mr. Collins. So Commissioner, in your past life -- and I know you are familiar with the SEPs as well. I think in your written testimony you actually say what we found up in Wisconsin was extremely problematic. Even more problematic, it was clear many consumers were using the process to receive costly medical care and then immediately dropping coverage.

Mr. Wieske. That is correct. We actually did this on a national basis, looked at this on a national basis as well. We chair the Health Care Reform Alternatives Working Group at the NAIC and one of the plans indicated loss ratios on that business in excess of 180 percent, so significant losses and because of the dropping of coverage and they did not maintain it throughout the year.

Mr. Collins. So I will ask somewhat of a rhetorical question, but when that happens who is stuck paying for that?

Mr. Wieske. The whole pool is stuck paying, so the folks who are in the individual market because it is a single risk pool are paying higher premiums as a result.

Mr. Collins. And I think it is also safe to say when -- I will just call this out for what it is, cheating, and when someone is cheating the system they are also cheating the sick and the vulnerable patients and potentially driving up their costs. There is always a cost to someone and, you know, that is just kind of a point taken.

So Mr. Chairman, I will yield back. I know there is some airplanes to catch and thank you all for your testimony.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman and the chair recognizes the gentleman from New York, Mr. Engel, 5 minutes for your questions, please.

Mr. Engel. Thank you very much, Mr. Chairman. We all know the phrase be careful what you wish for. It is a saying that I think my friends on the other side of the aisle are finding particularly poignant lately. I think our colleagues are on the other side of the aisle are finally realizing that it is easy to make promises, it is a lot harder to deliver progress as the Affordable Care Act has. You know, there is no such thing as a free lunch. If all the good things about the Affordable Care Act are going to be kept costs are going to go up and a lot of people will not be insured.

And so I think it is leading us down a primrose path. We

should have been working together all these years not to try to eliminate the Affordable Care Act 62 or 63 times, but to try to improve it.

All major acts, all major bills, all major programs have to be implemented and then you see how it goes, what works, what doesn't and you tweak, you change it, you try to improve it. But all we have had here for the past several years is just ill-conceived votes to eliminate it entirely, and now that they apparently are they are going to be careful what they wish for.

Mr. Green said this hearing is taking place on Groundhog Day. It is fitting because today Republicans are holding another hearing not on new ideas but the same ill-advised bills we have debated before in this committee. There is one exception, a half written draft that they claim would protect Americans living with preexisting conditions, but when you look closely we punish them instead.

So I want to underscore how indefensible the situation is. My constituents are frightened. They are worried that their preventive services that the ACA guaranteed them free of charge are going to disappear. They are worried that insurance companies will again impose caps on their coverage. They are worried that without the ACA's protections they will be charged more for insurance. And my colleagues on the other side of the aisle are really doing nothing to allay their fears.

Dr. Lichtenfeld, I would like to give you an opportunity to

speak one more time on a matter you were asked about earlier. Speaking for the American Cancer Society, can you tell me whether you support every American having high quality health insurance?

Dr. Lichtenfeld. Thank you, Mr. Engel, and let me clarify the answer to that particular question which I may have misheard previously was that yes, I personally am the American Cancer Society. I do support universal access to adequate and affordable health care coverage.

Mr. Engel. Thank you. This draft would require insurance companies cover people with preexisting health conditions, however there is nothing in this text that prevents insurance companies from charging you more if you have a preexisting condition like asthma or diabetes.

So is it fair to say, Dr. Lichtenfeld, that under legislation without a ban on medical underwriting Americans with preexisting conditions like cancer could be priced out of the care they need?

Dr. Lichtenfeld. Once again thank you for the question. And it is our read and our concern that in fact that could happen.

Mr. Engel. Before the Affordable Care Act I think you did say in your testimony that cancer patients who could get coverage which didn't always happen were still vulnerable to enormous costs; isn't that right?

Dr. Lichtenfeld. Yes, sir.

Mr. Engel. And that would happen again without the ACA. So I want to talk about that last point for a moment because lately

we often hear Republicans use the phrase universal access as in they want everyone to have universal access to health care.

They are careful to say universal access not coverage because this is what universal access is, a scheme in which insurers must cover you but can charge you whatever they want making it all but impossible for you to actually afford coverage. This is why they chose their words so carefully because the access they are promising isn't truly access at all.

Democrats aren't making pie in the sky promises, they are showing progress. Thanks to the ACA 129 million Americans with preexisting conditions cannot be turned away or charged more because of their health status. Health care costs have been growing at the slowest rate in more than 50 years, and I could continue. Let me just say this.

For 7 years Republicans have claimed to have a better way to reform America's health care system. If that were true then I believe that this hearing would have been the perfect opportunity to lay out that path forward. But instead after 7 years we have the same old bills, tired bills and half of a draft. Our constituents have serious concerns. It is going to take a lot more than this to put those concerns to rest.

So I just want to say that because I think there is nothing more important than people's health care, and I truly believe that if they destroy the ACA there is going to be a lot of people in this country that are going to be angry and scared. Thank you,

I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair now recognizes the gentleman from Georgia, Mr. Carter, 5 minutes for your questions, please.

Mr. Carter. Thank you very much, Mr. Chairman, and thank all of you for enduring this. We appreciate you being here and for seeing through this and for participating.

I want to start with you, Mr. Holtz-Eakin. You pointed out throughout the hearing today that premiums are rising and that insurers are dropping out of certain markets and we know the horror stories of some states don't have but one insurance company that is participating now. And in full disclosure, before I became a member of Congress I was a pharmacist and I owned three independent retail pharmacies at that time and I am a firsthand witness to what has happened to the free market in health care since the Affordable Care Act has taken, and I think that is the worst thing that has happened is that it has taken the free market out of health care.

How do we get it back? How do we get back to where we are competing? I often tell the story that right now Adam Smith is rolling over in his grave to see what we have done to the free market in health care. And how do we get the competition back? That is what is going to drive prices down, competition.

Mr. Holtz-Eakin. It is a hard question. I think in the hallmark of a good competitive system is some flexibility in the

rules that surround competition. And I think the mistake of having something that is the same across all states where, you know, the market structures are very, very different is piece number one.

And piece number two is you compete on whatever you pay for, and so if you pay for procedures people will compete by producing procedures that we want to pay for good outcomes. And that would be --

Mr. Collins. You know, there are really three things that we want to do. We want to make health care accessible, we want to make it affordable and we want to cut out the red tape. We want to get the federal government out of the way of physicians and patients. And right now there are so many, there is so much bureaucracy between the patients and the health care professionals, and that is what we are trying to do is to cut it out.

Mr. Wieske, I want to ask you because you have obviously experience in this. One of the things that I am concerned about is the anti-trust laws as they pertain to the insurance companies, and I really feel like this is hindering the competition in a number of different ways.

I am really big on trying to find exactly what is going on with prescription drug prices and particularly the role that PBMs play in that because I don't feel like they bring any value whatsoever to the health care system. They only raise prices and

cause them to rise. And when you look at the PBMs, you have three PBMs that have 80 percent of the market. That is not competition yet they are protected by the anti-trust laws. I mean did you address that in Wisconsin at all?

Mr. Wieske. So, you know, I think what is interesting about the ACA market from an anti-trust standpoint is actually that the insurers are competing not to get business, and I think that is where the problem is coming in. In fact, in one state they specifically wanted to get out of the cities and one company only wanted to do the rural areas so they would have less enrollment.

And so, you know, I think that is what is interesting is they are actually not competing to get this business, they are competing to survive and just hope to live another day.

Mr. Collins. Okay. Let me ask you this, because you said something earlier that really tweaked my interest. And you said that in your high risk pool that you had in the state of Wisconsin that all providers participated.

Mr. Wieske. They did.

Mr. Collins. Did you require them to?

Mr. Wieske. It was required.

Mr. Collins. How do you require them to?

Mr. Wieske. So it was when they --

Mr. Collins. Do you tie it in with licensing or something?

Mr. Wieske. It was a requirement that they had to accept the high risk pool patients and the rate that the high risk pool

set. They were part of the boards. They got the opportunity to work on setting those rates, but they were expected to contribute 30 percent to the surplus of the cost, 30 percent of the cost --

Mr. Collins. Okay, you explained that. But what was the penalty if they didn't participate?

Mr. Wieske. We never ran into that so we didn't have a penalty because they all participated. The patients went to the doctor, the doctor billed the high risk pool for the services. I mean ultimately if they didn't participate they just wouldn't get paid in the same rate I guess, but, you know, functionally --

Mr. Collins. You know, I find that hard to believe especially if you have a favored nations clause in there and they are forced to accept that rate payment and then they are forced to give it to another insurance company as well.

Mr. Wieske. We had a -- I mean before and after, I mean we do have an extremely competitive market. We don't have a dominant insurer that can get the most favored nation. The market share in Wisconsin, you know, the top about 18 comprise 80 percent, so, and the top 10 only comprise roughly about 45 percent or less of the market. So it is a different market.

Mr. Collins. Well, again I just want to stress, and again thank all of you for being here. I want to stress again what we are trying to do here is to make health care accessible, to make it affordable and to cut out the red tape and to bring the free

market back. Let competition drive prices down. That is what is going to do it. That is what we are trying to do. Thank you again, all of you, for being here. And I yield back, Mr. Chairman.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair recognizes the gentleman from New Mexico, Mr. Lujan, 5 minutes for your questions, please.

Mr. Lujan. Mr. Chairman, thank you very much. Before I begin, there was a line of questioning from Mr. Kennedy to Mr. Wieske pertaining to a Kaiser report titled High-Risk Pools for Uninsurable Individuals-Appendix Tables-8903, the Henry J. Kaiser Family Foundation, which referenced the premium increases in the state of Wisconsin amongst other states. I would ask unanimous consent that that be submitted to the record.

Mr. Burgess. If the gentleman is willing to share it with the chair, without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 16**********

Mr. Lujan. Just to note so that there is no question about this, what this report says is that the premiums were double in Wisconsin, so I know that we will get the chance to maybe go over that a little bit later.

Mr. Chairman, if I could ask the staff to pull up the first slide upon our new smart screen, one thing that I wanted to go over was the question associated with where we are today with the bills that have been presented to this committee.

President Trump recently said that he insists that everyone will have health insurance, insurance for everybody, he said. President Trump also said that there will be lower numbers, much lower deductibles. He went as far as to say that he is ready to reveal it alongside Senate Majority Leader Mitch McConnell and Speaker Paul Ryan. That was January 16th, 2017. And here is the important quote. It is a very much formulated down to the final strokes.

So if we could go to the next slide, this is what we have today, down to the final strokes. So as we talk about these details I think it is just important that we keep an eye on what those final strokes really look like because that bracket sure is empty.

If we could go to the next slide I wanted to answer a question that was brought up by one of my colleagues about this being shoved down people's throats. This is just a list of some of the hearings in the House and in the Senate that took place associated with

the markup of the Affordable Care Act. I brought my copy in if anyone wants to take a look at it, which is coffee stained and marked up, highlighted up for everyone to see that we used not only to study this bill but to go and explain it to our constituents and answer questions from our constituents.

And if we could just go to the next slide, the next slide shows what this committee alone did with different amendments that came up before this committee. So Mr. Lichtenfeld, I understand that you are -- or Lichtenfeld, I understand that you are a physician. Have you read Chairman Walden's discussion draft?

Dr. Lichtenfeld. I have read the paper that you have shown here to the committee.

Mr. Lujan. Do you remember it saying anything about protecting young people and making sure they can stay on their parents' plans until they are 26?

Dr. Lichtenfeld. My understanding is, Congressman, and so as I said before a work in progress and that there is obviously language that is still to be discussed and debated.

Mr. Lujan. I will ask the question differently. Was it in the text that you read?

Dr. Lichtenfeld. I am sorry, sir?

Mr. Lujan. Was it in the text that you read?

Dr. Lichtenfeld. No, sir.

Mr. Lujan. Do you remember the text reading anything about establishing minimum standards of care to ensure Americans aren't

sold a lemon health insurance plan?

Dr. Lichtenfeld. I do not recall that, sir.

Mr. Lujan. Do you remember it saying anything about making sure behavioral and mental health services are covered?

Dr. Lichtenfeld. Again I don't recall seeing that.

Mr. Lujan. Mr. Lichtenfeld, you are an oncologist, correct, sir?

Dr. Lichtenfeld. Yes, sir.

Mr. Lujan. I thank you for your work. My father sadly passed from a fight with stage 4 lung cancer a little more than 4 years ago. We appreciate the experts that provided our loved one's care. Do you remember in Chairman Walden's bill saying anything about making sure individuals are not penalized by lifetime caps on their insurance coverage?

Dr. Lichtenfeld. I do not recall seeing that, sir.

Mr. Lujan. So the discussion that we are hearing today is that there be an environment set up so that individuals rather than having a 90-day grace period with their coverage would be shortened to a 30-day grace period if they had a preexisting condition. And if they missed a payment, and the text doesn't protect anyone that may be late with a payment, then they lose coverage. What I have heard today is the notion that people with preexisting conditions that would lose coverage would still be able to get coverage from somewhere else, right. But there is nothing saying that they will not pay a higher premium fee.

And under the notion of, again if you could please bring up the first slide. Under the notion that our colleagues are saying that premiums will be lowered, deductibles will be lowered, care will be better, no one is going to be cut off, I just don't see it in anything that has been read to us.

And then the last thing, after 7 years, if they bring the first slide up, please, the one with Fox News, we have not seen the Republican consensus plan before us. There was a lot of talk by one of our witnesses about a plan that was before us. There is no consensus plan before us. This is not a secret. For 7 years, over 60 times my Republican colleagues have voted to repeal the Affordable Care Act. For 7 years we have not seen this text.

I think it is important that when we are having these hearings about how to improve the Affordable Care Act it shouldn't be about repealing the Affordable Care Act. And I will just point that the text in Chairman Walden's discussion draft, in its title it says upon repeal of the Affordable Care Act. So people can spin this all that they want, please look at the text and what is happening right now. And there is a willingness for us to work together to make things better to improve things, but not under the guise of repealing this. Let's find a way to really come together and do the right thing for the American people and not just the political thing.

Mr. Burgess. The gentleman's time is expired. The chair is advised that one of the witnesses needs to catch an airplane.

Is this accurate? The chair would ask unanimous consent that we allow the witness to make their -- no, we don't allow the witness. Okay, the chair would advise that the witness who identified himself as having travel plans will actually be leaving at 2:15.

And I do ask all members to try to adhere to the 5-minute timeline. I have been lenient today because this is such an important topic.

Mr. Green. Mr. Chairman, I ask unanimous consent to place into the record -- if you want me to start the list -- a statement from the Asian Pacific Islander American health care --

Mr. Burgess. Without objection, so ordered. All of your --

Mr. Green. All of it.

Mr. Burgess. -- yes, consent requests will be honored. The chair recognizes Mr. Sarbanes 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman. I just got in here under the wire, so I want to thank the panel. I wanted to ask Dr. Holtz-Eakin, what are some of the pieces of the Affordable Care Act that you think we ought to keep in place?

Mr. Holtz-Eakin. Well, I think that, you know, the ban on, caps on benefits for annual and lifetime, 26 staying on your parents' policy. I certainly think that you should have some sort of provisions for preexisting conditions and access to insurance.

Mr. Sarbanes. What about the efforts to close the exposure in the so-called donut hole in terms of the prescription drug costs

that our seniors had been facing, is that a piece we want to keep in place?

Mr. Holtz-Eakin. I think there is, I would be happier if there was a more comprehensive approach to Medicare reform that sort of put together a more sensible insurance policy A, B and D, provided a broader coverage there.

Mr. Sarbanes. But generally speaking this idea of trying to reduce the exposure that our seniors have to the prescription drug costs which the ACA addressed through this effort to close the donut hole, is that something you think we ought to hold onto?

Mr. Holtz-Eakin. I guess the reason I am hesitating, my understanding is part of this is the private industry's agreement to cover 50 percent of costs in the donut hole. I honestly don't know how that works whether that has the force of law or if that is a voluntary action by them.

Mr. Sarbanes. I think the industry's agreement to voluntarily address 50 percent of their costs in the donut hole was something that they were going to do transitionally as the donut hole was being closed through actually providing additional benefits under Part D.

What about, you probably know that many seniors now as a result of the Affordable Care Act can have certain kinds of preventive screenings, annual wellness exams, other things where they used to have to come out of pocket for those expenses, those are now covered by the Affordable Care Act which is obviously a

huge benefit for our seniors. Is that a piece of the Affordable Care Act that you think ought to stay in place?

Mr. Holtz-Eakin. Truthfully I don't know. The question there is what has been the effectiveness versus the cost, and I would be happy to get back to you on that.

Mr. Sarbanes. Well, I think the effectiveness has been significant in terms of enhancing care and there is actually savings as well, because if you catch some things earlier that then don't lead to acute care on the back end which have high costs associated with it, because you do the screenings and the preventive care service because you actually are reducing costs as well.

So I guess I am asking the questions just to make the point, Mr. Chairman, that once you break -- there is this kind of slogan of repeal the Affordable Care Act, you know, it hasn't delivered, et cetera. When you actually break it down into its component parts and look at the benefits that it is bringing, frankly, the public has a very positive view of a lot of these components to the plan.

And as you just indicated in your answers, I think there is a recognition by the experts that there is many, many pieces of the Affordable Care Act that it would be regrettable to leave behind. So I think we need to start in an honest place of conversation when we are talking about this landmark health care reform and the benefits that it has brought to so many Americans

and move forward from that point. With that I yield back.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The gentleman recognizes the gentleman from New Jersey, Mr. Long, 5 minutes for questions, please.

Mr. Long. Thank you, Mr. Chairman. Mr. Wieske, you mentioned in your testimony that a number of your insurers have lost significant capital because of Obamacare. How has that affected coverage options as well as provider network access for individuals?

Mr. Wieske. So as I said just a few minutes ago, I think there are actually --

Mr. Long. My apologies if you --

Mr. Wieske. No, no, no. My apologies. My apologies.

Mr. Long. I sat here all morning long for my turn to ask and we went to votes, so --

Mr. Wieske. No, no, no. And they are competing not to get the business in a lot of cases and, you know, they want a limited number of coverage and they are losing money on that coverage and so they have dialed back their presence across the state. They have limited their networks. Most plans have gone to narrower and narrower networks. They have changed their networks. They have partnered with providers, provider groups to do it differently. They have done it under different insurance licenses. So they have taken a number of steps to sort of minimize their exposure to the market.

Mr. Long. If nothing changes between now and next November, what would you see at that point?

Mr. Wieske. I think we will see a number of carriers that -- I think we will see every year where we are sort of -- my fear because we deal directly with the filings and I deal directly with the filings, my fear is that I am a little bit panicked that we are going to have counties that are uncovered.

We have one county that has one right now. We have three counties that only had one for a number of years. I am deathly afraid that four or more of our counties will be left uncovered with no insurer offering coverage.

Mr. Long. Okay. And coming from an adverse state in terms of regions, have some areas of your state been hit harder by these changes?

Mr. Wieske. Yes, there were big differences. I mean, you know, one of the issues is it almost feels like, and this is not insurance across state lines, but it narrowed the market considerably. So some of our plans that offered coverage that were near the border left those areas because of the rules and the way things work, and so that left those areas more exposed.

So the areas near the borders have more problems than some of the other areas. Absolutely there has been winners and losers in the ACA.

Mr. Long. And what has that meant for consumers? We call them consumers, I call them constituents, but what has that meant

for consumers and our constituents in those areas?

Mr. Wieske. We have seen, you know, rising costs over time, you know, more than doubling of the average premiums that most consumers pay over the course of, you know, from what they were paying pre-ACA, so there are significant increases. The deductibles have increased over time. They are higher than they were pre-ACA on average.

And the networks are narrower. They are finding, you know, less choice in the type of providers they want to see because there are fewer, you know, they just want to offer narrower and narrower networks.

Mr. Long. When you say they are higher, I remember back at Christmastime went to a Christmas party the Saturday, I think, before Christmas, and a local business owner came up talking about just his family's premium had gone up 360 percent since the advent of the Affordable Care Act. I would hate to think what it was like if it wasn't affordable, but these are the type of stories that we get from our constituents that everybody acts like everything is a panacea and everything is great out there.

But these numbers, I mean health care, health insurance always was going up, and the other side will argue, I have constituents that like it and they say oh, you know, health care goes up anyway. But 360 percent in that short of time is a pretty healthy increase, isn't it?

Mr. Wieske. It is. And I think what I am afraid of is states

like Wisconsin that took advantage of the transition options, so-called grandmother plans, those plans will go the way at the end of '17 in the small group market. Roughly about 180-190,000 of our 225-230,000 small group individuals are on those transition plans. They are going to get a significant increase when we roll from 2017 at the end of this year into '18.

Mr. Long. That is kind of what I was --

Mr. Wieske. On pre-ACA plans, yes.

Mr. Long. That was kind of what I was getting to earlier when I asked you about November, what you foresaw for next November. And what are your projections and concerns of what the market is going to look like after that period in a few years if the current trajectory continues in your state?

Mr. Wieske. We are expecting fewer carriers, probably regional. They happen to be regional in a lot of cases and probably only carriers, insurers that have a relationship, a contractual relationship with a health system. So you will have one health system and one insurer teamed up in a particular area and that will be the only coverage option. That is what we are afraid of in the future, no choice.

Mr. Long. Do you view plan solvency in the market as a basic consumer protection?

Mr. Wieske. Yes, we do. We do extensive work on solvency. Yes, sir.

Mr. Long. What does that mean for consumers when their

insurers exit the market like they have in droves in a lot of places?

Mr. Wieske. It means that they obviously lose the coverage. They end up in what I would call ghost plans or phantom plans that don't exist anymore but they still have coverage, and then you have to deal with the issue of the guarantee funds and making sure the consumers are covered. And it ends up, it is for a consumer it is confusing and it is problematic and it is a little bit of a nightmare if their insurer -- now we have been lucky. We haven't had any go insolvent in the state of Wisconsin. We have had carriers leave the market but we have not an insolvency in health that has had those problems so we have been lucky.

Mr. Long. I have two daughters. One of them has a year and a half left in her residency program in pediatrics, so the future of health care is very concerning to her. And her younger sister just got a report out about 4 months ago from Hodgkin's lymphoma and she has been off chemo for 15 months, I guess.

And so I know how important it is that people have coverage and stay covered because we had a little incident mid-chemo treatment when the Affordable Care Act told us she wasn't covered one day when we got over there for treatment. That was kind of hair raising. So there is no easy answers to any of this that we are doing today.

And like I said, I was late because I was doing, to the first part of it because I had to do a telecom deal on rural broadband

so I wasn't here for the gavel and then I was here by the time we voted.

Mr. Burgess. The chair accepts the gentleman's apology. The gentleman's time has expired. I do need to note it is past 2:15. We have a witness that needs to leave. We will continue our -- and will be excused. We will continue our hearing with the remaining witnesses. Of course written questions may be submitted for Dr. Holtz-Eakin.

And Dr. Holtz-Eakin, we appreciate you being here. You have always been a friend to this committee and we appreciate your participation today. So you are excused.

Mr. Holtz-Eakin. Thank you, Mr. Chairman.

Mr. Burgess. And the chair recognizes the gentleman from California, Mr. Cardenas, 5 minutes for your questions, please.

Mr. Cardenas. Thank you, Mr. Chairman. I am glad we are discussing this incredibly critical and important issue that is critical to every American. I would like to read the following true story from a constituent from my city of Los Angeles, California.

In 2012, and this is before the Affordable Care Act was made available to her and her family. In 2012 I was in between jobs and discovered that I was pregnant. My husband and I were thrilled to be expecting our baby. When I tried to sign up for insurance I was informed that my pregnancy was considered a pre-condition, preexisting condition, and no insurance company

would cover me.

My husband was working as a contract employee and was uninsured. I considered Medi-Cal and Medicaid program in California, but I was told that it could take months until I could actually visit a clinic. Fortunately I was hired about a month later and I got back on a company's insurance. However, if I had not been hired I don't know what I would have done. It was that we almost missed seeing a doctor until the second trimester.

And as I experienced extreme daily stress worrying about whether I would be insured before I gave birth or be charged tens of thousands of dollars, such stress is never good for a baby. The fact that becoming pregnant prevented me from buying insurance was truly outrageous. I was so horrified that our system could do something like this.

True story, it happened, and unfortunately before the Affordable Care Act there were way too many stories like that. What I hope that we can prevent as members of Congress, as legislators, as responsible elected officials that we not go back to those days. This is America and this true story goes to the heart of what we are all here to talk about.

Why are we spending time analyzing a half finished bill that doesn't take care of all the issues that were promised both by presidential candidates and people all over this United States Congress? Things like to ensure that a woman and a man pay the same price for their plans. This bill here that I have in my hand

which was introduced and what we are discussing today does not guarantee coverage for a preexisting condition. A lot of Americans don't realize that if your 8 year old daughter has asthma that is considered a preexisting condition.

Also to ensure coverage that we actually have access, this bill that I have before me talks about access but it doesn't talk about ensuring coverage. The Affordable Care Act has stronger language such as ensuring coverage. This document speaks to access but it doesn't spell out what we really should be talking about. Are people going to be denied coverage for a preexisting condition? Are women going to be allowed just like before to pay more for their health care than it is for a man at the same age, conceivably right next door?

We have had nearly 8 years of talk about replace, but we have come up with nothing better in that time. Why aren't we talking about enhancing the Affordable Care Act instead of these ideas of just repealing it?

I have a question for Dr. Lichtenfeld. I want to first thank you for coming today and for sharing your expertise with us and also for making sure that we can get some more information before the public. Under the half written plan could individuals with preexisting conditions like cancer, asthma or diabetes be priced out of the care they desperately need?

Dr. Lichtenfeld. Thank you, Mr. Cardenas. And our concern is that that could in fact happen unless it is absolutely laid

out clearly what the plan is that there could be problems down the line.

Mr. Cardenas. And the bill as written today doesn't have any language guaranteeing that that would not happen, correct?

Dr. Lichtenfeld. As I mentioned previously that is correct. Yes, sir.

Mr. Cardenas. Okay. My next question is were the health insurance premiums across America in general going up year over year before the Affordable Care Act or were they on their way down year over year before the Affordable Care Act?

Dr. Lichtenfeld. Premiums were going up.

Mr. Cardenas. Okay. Now on those premiums going up people were still denied coverage because of a preexisting condition, correct?

Dr. Lichtenfeld. Yes, sir.

Mr. Cardenas. But under the Affordable Care Act that is not allowed in America today, correct?

Dr. Lichtenfeld. That is correct.

Mr. Cardenas. Okay. So I just wanted to point out a few things in the short time that I get to speak on this committee and just wanted to make sure that everybody out there understands we are talking about you. We are talking about your health, your grandparents to your grandbabies and everybody in between. We need to get this right. And right now the bill that we have isn't even close. I yield back.

Mr. Burgess. The chair thanks the gentleman. The chair would remind the gentleman he receives the same amount of time as every other member on the subcommittee and some who have waived on the subcommittee, and the chairman has been most generous with not hitting the gavel.

The chair would like to recognize the gentlelady from Tennessee, Mrs. Blackburn, 5 minutes for your questions, please.

Mrs. Blackburn. Thank you, Mr. Chairman, and thank you all for being here. I want to go to the bill that we are looking at on the special enrollment plans, the special enrollment periods. This is legislation that I have drafted and the reason I did it was because of what we saw happening with lack of verification in the special enrollment periods.

And I saw us going down a road that we traveled in Tennessee with TennCare which was back in the mid-90s. No verification, all of a sudden your plan is, your enrollees are being crowded out if you will, people that really need services. You begin to see networks narrow, reimbursements drop, the length of time you wait for reimbursements goes from 30 days to 60 days to 90 days to 120, 180 days. And you all know the path. And my bill is just very straightforward and you need to prove why you need that special enrollment period, you need to prove that you are who you are and that you qualify. I think that is an important thing for us to be able to do.

So the question, I have a couple of questions and I would

like to hear you all weigh in on the need for verification for special enrollment periods. I think it is important for the integrity of any program and I think it is fair for the taxpayers who foot the bill.

But shouldn't we simply be able to confirm if someone qualifies for special treatment that they self-attest that they are eligible that indeed they are, and especially if taxpayer subsidies are involved? Shouldn't we require that? And would a very small, but modest improvement to the plan be to move this verification from post-enrollment, which experience has told us very seldom gets done, to pre-enrollment? And I would like to hear what you all have to say on that.

Mr. Wieske. Your bill is exactly right. I mean this is not actually that hard to get verification in my experience. This is something, special enrollment periods did not start with the ACA. Special enrollment periods existed with HIPAA and existed prior to that in the Newborn and Mothers Act and other pieces. Insurance companies were doing these verifications for years prior to the ACA.

The problem that we have run into is when the federal bureaucracy takes it over that that creates other problems and they don't have the time or the resources to verify. We had one person in our office who had spent months trying to solve the issue because he was not using the magic words that the customer service wanted them to use. So I think it shouldn't be that hard to get

to a verification.

Dr. Lichtenfeld. Well, Mrs. Blackburn, thank you for the question. And we are aware of some of the issues that have come up with regard to special enrollment. However, when we look at it through that cancer lens we also need to understand that there are some other issues that have to be looked at.

So it may be someone who is working and loses their job and has to go get insurance and within the cancer focus how quickly that is going to be done, what is going to be required and will it be done expeditiously. Should it be done pre- with the presumption of correctness and then later, or should it be done later when there may be a gap in care? Those gaps in care can be significant.

Also aware that how the one that administers it, whether it be federal or whether be insurance, insurance company, what the guidelines are that set around those requirements in terms of timeliness, all those are things that have to be considered.

Mrs. Blackburn. I think you might have missed the point that I am trying to drive forward. I think that -- I am not saying you don't need special enrollment periods.

Dr. Lichtenfeld. No, I understand.

Mrs. Blackburn. Just what you are inferring. I am saying that if we have a special enrollment period and one is necessary that it is out of fairness to the taxpayer and to the integrity of a program that an individual before they are admitted to a

program that they prove that they need it and that they prove that they are who they attest to be. That those attestations that they have made to get that coverage that those are vetted before they are allowed into that program.

Dr. Lichtenfeld. Mrs. Blackburn, I apologize if I wasn't clear on my statement. I didn't say we don't need special -- I mean it wasn't my intent to say we don't need special enrollment.

Mrs. Blackburn. Okay, right.

Dr. Lichtenfeld. I said it is the construct of how it is done that is important where we may have discussions about that issue.

Mrs. Blackburn. Okay, thank you. Yield back.

Mr. Burgess. The gentlelady yields back. The chair thanks the gentlelady. The chair recognizes the gentleman from North Carolina, Mr. Hudson.

Mr. Hudson. Thank you, Mr. Chairman, and I thank the panel for your time today. But since I arrived here directly from a dental procedure I will probably yield the balance of time, without objection from you, Mr. Chairman, to Mr. Griffith from Virginia.

Mr. Burgess. The gentleman is recognized.

Mr. Griffith. Thank you very much. I thank my colleague from North Carolina, so I think I ought to ask my North Carolina question first. My district shares a border with North Carolina. Mr. Wieske, you indicated earlier in answering one of the

questions that there were some issues around the borders. Could you tell me what was going on there and how that affected you all?

Mr. Wieske. Sure. I mean I think when you are dealing with the exchange and the subsidy market it sort of shut down the sort of, you know, moving between the borders that happen, that those borders became a little bit harder than they were before. And so because you are one exchange versus another exchange it wasn't just buying health insurance it was that became an issue.

Mr. Griffith. And let me ask you if you ran into any of the problems in your state that I ran into with constituents when it first rolled out. I had folks who were going to medical facilities -- because my district is the corner of Virginia so I border North Carolina, Tennessee, Kentucky and West Virginia. And so one of the things that popped up almost immediately was, and it was particularly a North Carolina situation, I had a constituent who was receiving cancer treatment in Winston-Salem. It might have been Duke, but I am pretty sure it was Bowman-Gray.

And all of a sudden found out when she, she had to go on the exchange. She went on the exchange and found out that she could not leave the Commonwealth of Virginia more than one county. Well, that created all kinds of problems because she couldn't keep with her cancer team. Did you have some of those issues as well?

Mr. Wieske. A few of those, but more insurers withdrew from the neighboring counties. So Pierce, Polk and St. Croix County typically use, which is on the western part of our state, typically

use providers in Minnesota, have Minnesota systems. All the Wisconsin systems essentially withdrew from that area and at least exchange wise, and so it was primarily a Minnesota company that provided coverage that was licensed in Wisconsin. So they just had fewer choices. They had to go, they had to go, across the border.

Mr. Griffith. Right. And so it is kind of interesting because earlier one of the folks was making a statement on the other side of the aisle and seemed to indicate that whatever plans we were coming up with they wouldn't work because you couldn't go, you would have to go back to the other state, I believe she said, to see the doctors, and yet my experience in my district was that that problem exists with Obamacare.

And it may be one of the things we need to take a look at it fixing, because that one county rule -- and I described my district to you and I only had problems in North Carolina. But one of the hospitals in the area that specializes in children's care in Tennessee serves a big chunk of southwest Virginia but because independent cities, Bristol, Virginia is an independent city, Bristol, Tennessee, and the county surrounding it is the one county you could go to and the hospital is just over the line in the next county.

So it was not just the problem in North Carolina with cancer treatment, it was also problems with people being able to go see the specialists in North Carolina, because I had Bristol, Virginia

and Tennessee, where as you know from the GEICO commercial the line runs right down the middle of the main commercial street there. And then I also have Bluefield, Virginia, which also has Bluefield, West Virginia, and you have to figure out which side of the line you are on there. It is not quite as clear cut as Bristol, Virginia and Tennessee.

So a lot of my constituents were impacted by that. And I know that it is -- I assume that it is not a good idea to change, Dr. Lichtenfeld, it is not a good idea to change your doctors midstream particularly when you are satisfied with the cancer treatment you have been getting. And so it is not a good idea to switch even though Virginia has some very good medical schools as well; would that be correct?

Dr. Lichtenfeld. Well, actually my son was just interviewed at University of Virginia so we respect the medical schools for sure.

Mr. Griffith. Yes.

Dr. Lichtenfeld. You know, yes, that is correct. I mean continuity of care is important, how it is constructed, what the rules are, whether, what hospitals are allowed in the network, the location of the network, all that is important.

Mr. Griffith. Right, and closeness matters too. And in fact, big parts of my district they are a lot closer to other states' hospitals then they are to the University of Virginia which would be closest to my district. Not to negate MCV, also

another fine institution and others.

Let me switch gears, and I apologize, Mr. Wieske, you may not know the answer to this because it was a question for Dr. Holtz-Eakin about continuous coverage requirements. And he had said that that pushes providers and plans to invest in preventive and wellness programs to keep patients healthy, and the question would have been how does this impact the overall market, the overall risk pool? Are you in a position to answer that question? My team says you are but I don't know.

Mr. Wieske. I think in general, I mean I think if you are able to keep people in the market and they stay in it and they stay with their insurer it provides better health, better health outcomes, and potentially over time it should lower, make the risk pool more representative and overall lower costs.

Mr. Griffith. So similar to what I was talking about before. I see that Mr. Hudson's time is up and I yield back.

Mr. Burgess. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Tonko, 5 minutes for questions, please.

Mr. Tonko. Thank you, Mr. Chair. And Mr. Wieske, first let me thank you for your service to the people of Wisconsin and for your testimony today. In your written statement you refer numerous times to Wisconsin's well-functioning health insurance market pre-ACA and expressed a desire to see the ACA repealed and returned to a pre-ACA marketplace.

So I would like to learn a little more about what Wisconsin's health insurance market looked like prior to the Affordable Care Act. I took and downloaded a publication from your office's website entitled Fact Sheet on Mandated Benefits in Health Insurance Policies, and with the permission of the chair I would like to ask unanimous consent that this document be entered into the record.

Mr. Burgess. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 17**********

Mr. Tonko. Thank you. Now Mr. Wieske, prior to the Affordable Care Act did Wisconsin mandate that all health insurance plans serving the individual market cover hospital services or prescription drug coverage? Yes or no on that by the way.

Mr. Wieske. I don't believe --

Mr. Tonko. Yes or no.

Mr. Wieske. I don't believe it was mandated, but --

Mr. Tonko. The answer is no. Pre-ACA did Wisconsin mandate that all insurance plans serving the individual market cover mental health or substance use care, yes or no?

Mr. Wieske. No.

Mr. Tonko. The answer is no. Pre-ACA did Wisconsin mandate that all insurance plans serving the individual market cover maternity care, yes or no?

Mr. Wieske. No.

Mr. Tonko. Would it be fair to assume that plans in Wisconsin that offered these fundamental health care services in the individual market pre-ACA would be more expensive than plans that didn't offer these services, yes or no?

Sir, can we move --

Mr. Wieske. Well, the problem is --

Mr. Tonko. Yes or no, because I have got to move on with my time here.

Mr. Wieske. I am sorry I can't answer the question because

you have three there.

Mr. Tonko. Well, fundamental health care services in the individual market pre-ACA, would it be more expensive than plans that didn't offer those services?

Mr. Wieske. For maternity and for the mental health the answer is yes.

Mr. Tonko. So given your expressed support for the pre-ACA marketplace where plans that covered even the most basic health care services were astronomically expensive in the individual market pricing out anyone who might actually need care, you clearly support returning to a system where women and all people with preexisting conditions are charged higher prices for the care they need?

Mr. Wieske. No. My assumption is that the states would be able to --

Mr. Tonko. Yes or -- so you are a no on that?

Mr. Wieske. Yes, because the states will reform their laws and better reflect the market.

Mr. Tonko. Well, we are looking at a federal plan that would cover all states, so thank you, Mr. Wieske. To summarize what we just learned for all the folks watching on TV, health insurance in Wisconsin was less expensive before the Affordable Care Act unless you actually wanted to go to the hospital, fill a prescription, be covered for mental health services or see a doctor. Women in Wisconsin were hit particularly hard, paying

up to 42 percent more for their health insurance than men before the Affordable Care Act.

So when my Republican colleagues talk about their supposed desire to protect people with preexisting conditions, it is important to remember that you can't address this problem with a half-baked bill that doesn't actually require insurance plans to offer benefits to those who are sick. Otherwise, insurance companies will deny care to those with preexisting conditions with restrictive benefit designs that fail to cover basic services like hospitalizations, prescription drugs or mental health care.

I appreciate this hearing today because I think it is really critical to clarify the stakes of this health care debate for the American people. What Mr. Wieske and my Republican colleagues want to do is to rip health care away from millions and take us back to a health care system controlled by the big insurance companies, the system where your health insurance is worth less than the paper it is printed on, a system where you get charged through the nose if you need mental health care or are a woman, or God forbid, man or woman, if you get sick and have to go to the hospital. I don't want to go back. The American people don't deserve to go back. We should instead be moving forward and building on the promise of high quality, affordable health care for all. And with that Mr. Chair --

Ms. DeGette. Will the gentleman yield?

Mr. Tonko. -- I yield back the balance of my time.

Ms. DeGette. Will the gentleman yield? Will the gentleman yield me his 39 seconds remaining?

Mr. Tonko. Yes, I will. I will yield.

Ms. DeGette. Mr. Wieske, I thought that what Mr. Tonko was asking you was really important, which is with this bill that we are looking at today there is no requirement that the states not charge people with preexisting conditions. That is just your hope that states wouldn't do that, right?

Mr. Wieske. We had limits in place --

Ms. DeGette. Yes, Wisconsin did, but maybe --

Mr. Wieske. Correct.

Ms. DeGette. -- Utah or Colorado or Idaho didn't, right?

Mr. Wieske. Right.

Ms. DeGette. That is just your hope?

Mr. Wieske. Correct.

Ms. DeGette. Thank you.

Mr. Burgess. The chair thanks the gentleman. The gentleman yields back. The chair once again observes that I have delayed my time for questions until the end because I was delayed arriving this morning, so I recognize myself for the balance of the time.

No, and I do appreciate our witnesses being here. I am sorry Dr. Holtz-Eakin had to leave because he always brings a lot to the discussion. Mr. Wieske, let me just ask you, and again I asked you while we were kind of in between on the votes, you have not

testified before our committee before, have you?

Mr. Wieske. I have not.

Mr. Burgess. And so that graphic that one of our members put up of all the hearings that were held prior to the Affordable Care Act you never participated in any of those hearings, did you?

Mr. Wieske. Correct.

Mr. Burgess. And I think that is a shame because I think you would have added to the discussion and you would have added to the debate and maybe some of the problems that we are now encountering and trying to fix could have been avoided had we listened to sane, rational voices like yours. I will also point out our two members from Indiana have had to leave, but we didn't hear from Governor Mitch Daniels, and Mitch Daniels was reported in the Wall Street Journal, while all the discussion of the Affordable Care Act was going on during the 2008 election cycle and we were having hearings here in this very room, Mitch Daniels with his Healthy Indiana Plan had actually reduced costs by 11 percent over 2 years' time when every other HMO, PPO, Medicare, Medicaid was going up by seven or eight percent across the country.

Why would not we have asked people who were experts and who were performing well, why would not have asked their opinions before writing this big law that changed health care from soup to nuts in this country? And I, it is obviously a rhetorical question. I think we should have.

Much was made at the beginning of this session about the fact

that Republicans wouldn't help, and I have to tell you that is not true. I contacted the transition team in 2008 and I said, look, I didn't give up a 25-year medical career to come sit on the sidelines while you guys do this. Talk to me. I am willing to talk to you.

Dr. Lichtenfeld, they could have put me in a tight spot, you know, because what if I had been offered to choose between -- you talked about toxic financial situations, what about our medical liability in a lot of states? That is a toxic situation. What if they had said to me, Dr. Burgess, we know you care a lot about medical liability. We would like to help you, but we have got to have your help on the public option. I don't know what I would have done. That would have been a pretty tough spot to put me in.

I don't know, maybe somebody who is familiar with making a deal might have, that might have occurred to them, but I was frozen out. I was frozen out by the then chairman of this committee, Henry Waxman. I went to see him personally and said I didn't give up a career in health care to come sit on the sidelines. So the notion that we have simply dug our heels in and refused to help, it is offensive to me when I hear that espoused on the panel.

Now let me just ask in particular with these bills that we have that we are considering, just on the issue of narrow networks now. Dr. Lichtenfeld, I mean you encountered narrow networks probably before the ACA was passed and after it was passed. Do

you have a feeling? Is it better or worse? Are narrow networks less restrictive now than they were before?

Dr. Lichtenfeld. Speaking personally they are certainly are more restrictive and the testimony to that effect was made earlier. So the answer to that question is yes, they are more narrow.

Mr. Burgess. You know, we all give our own experiences. There was a -- and I will confess that there was a special deal set up for members of Congress, the Grassley Amendment required us all to buy insurance under the Affordable Care Act and there was a special deal worked up between President Obama and then-Majority Leader Reid in the Senate that allowed us to receive a subsidy and walk it into the exchange. I didn't do that because my constituents back home would never understand that kind of a special deal.

So I understand the difficulties that people felt in the individual market. My insurance was canceled at the end of 2013. I was one of the 5.7 million people who lost their insurance. I liked my coverage. I liked my doctor. But I couldn't keep it because I was told I had junk insurance and I had to get rid of it. I had to do something else. I had to buy all of these other things. It was not something that I asked for.

And when my constituents come to my town halls and say why did I have to do this, why did I have to make these changes, I wasn't asking for that -- well, I felt their pain. And so I didn't

have an answer for them but I could look them in the eyes and say, yes, I agree with you. I think it was bad policy. I hope we get a chance to rectify things someday.

So when people ask me did you lose your doctor or did you go on a narrow network, to tell you the truth I don't even know, because unlike every other American I bought on price, show me the cheapest Bronze Plan out there and that is what I bought and I really have no earthly idea who the people are that I had available to me.

On the issue of this 30 days, 90 days, I worried about that when the law was in the enactment phase in 2014 because, Dr. Lichtenfeld, now correct me if I am wrong here, but you have a 90-day grace period. You know, the insurance companies actually were talking a lot to the Democrats in those days, they weren't talking to Republicans. But 30 days, the insurance company is on the hook for that coverage. What happens to the rest of those 60 days, Dr. Lichtenfeld? Who covers that bill if the patient doesn't pay their premium?

Dr. Lichtenfeld. The answer to your question is that the person who provides the service ends up not getting paid under the current situation, if in fact the patient or the family doesn't pay that bill by 90 days.

Mr. Burgess. And I do need to point out this is only for someone receiving a subsidy in healthcare.gov exchange, because I actually thought I had a 90-day grace period on my premium. It

turns out, no, you only get 30 days because you are not receiving a subsidy, so that 90-day period does not cover you.

But I did worry about that because I worried that former colleagues who practiced medicine would in fact be on the hook for those bills and it hasn't turned out to be the problem I thought it was going to be, but I think it is a problem that should be corrected. We shouldn't allow for the system to be manipulated where physicians and hospitals actually don't receive the compensation for the care that they provide.

There are a lot of things that we could still talk about. I have some questions that I will submit for the record. We have been here a long time. I do appreciate both of you being here. This is not easy. This is complex. I don't know. I don't know at the end of the day where this all shakes up but I do know this. If it was working perfectly, if it was working perfectly we wouldn't be here today. It is not working perfectly. There are serious problems. There are serious fractures and we have been charged with fixing them.

So that is what this subcommittee does. You have got some of the smartest members of Congress on this subcommittee and I appreciate each and every one of them, those that are here and those that have had to leave. This is a good subcommittee, a great subcommittee. We are up to the task and we will deliver.

So with that I will yield back the balance of my time and then -- oh my gosh, what have I got to do, all of these unanimous

consent requests. Seeing there are no further members wishing to ask questions I would like thank all of our witnesses again for being here today.

Before we conclude the hearing I would like to submit the following items for the record, a statement from Representative Bill Flores, a statement from Blue Cross Blue Shield, a statement from the American College of Obstetricians and Gynecologists, a letter from the Alliance for Retired Americans, a letter from the Healthcare Leadership Council, and a statement from America's Health Insurance Plans.

[The information follows:]

**********COMMITTEE INSERT 18**********

Mr. Burgess. Pursuant to committee rules I remind members they have 10 business days to submit additional questions for the record. I ask the witnesses to submit their response within 10 business days upon receipt of the questions. Without objection, the Subcommittee is adjourned.

[Whereupon, at 2:50 p.m., the Subcommittee was adjourned.]