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STRENGTHENING OUR HEALTH CARE SYSTEM: LEGISLATION TO REVERSE ACA SABOTAGE AND ENSURE PRE-EXISTING CONDITIONS PROTECTIONS

WEDNESDAY, FEBRUARY 13, 2019

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. Anna Eshoo [chairman of the subcommittee] presiding.

Members present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Lujan, Kennedy, Cardenas, Schrader, Ruiz, Kuster, Kelly, Barragan, Blunt Rochester, Rush, Pallone (ex officio), Burgess, Upton, Shimkus, Guthrie, Griffith,

Bilirakis, Long, Bucshon. Brooks, Mullin, Hudson, Carter, Gianforte, and Walden (ex officio).

Also present: Representatives Schakowsky and Soto.

Staff present: Jeff Carroll, Staff Director; Waverly Gordon, Deputy Chief Counsel; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Saha Khatezai, Professional Staff Member; Una Lee, Senior Health Counsel; Jourdan Lewis, Policy Analyst; Alivia Roberts, Press Assistant; C.J. Young, Press Secretary; Mike Bloomquist, Minority Staff Director; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel for Health; Jordan Davis, Minority Senior Advisor; Caleb Graff, Minority Professional Staff Member for Health; Peter Kielty, Minority General Counsel; Ryan Long, Minority Deputy Staff Director; Brannon Rains, Minority Staff Assistant; Danielle Steele, Minority Counsel for Health.

Ms. Eshoo. The Subcommittee on Health will now come to order.

The chair now recognizes herself for five minutes for an opening statement. First of all, welcome to the first legislative hearing of the Health Subcommittee in the 116th Congress.

Last week we heard testimony and examined what the devastating effects would be if the case Texas v. the United States were to stand, most especially on those who have preexisting conditions and the medically complex children who rely on the Affordable Care Act.

We also discussed how the Trump administration's sabotage of the ACA and the expansion of junk insurance plans are driving up cost by diverting the healthy out of the individual market and weakening patient protections with preexisting conditions.

Today, the four bills before us address short-term insurance plans, waivers to weaken insurance regulations on the private market, funding for marketing and outreach, and legislation that would require short-term insurance plans to carry an advisory informing consumers what the plan does not cover and what ACA requirements the plan does not meet.

It is a top priority of the majority to protect patients with preexisting conditions. On the campaign trail and in our

hearing last week, our Republican colleagues voiced their support for preexisting condition protections. They asked for specific legislation and that is what we are here to discuss today.

Our first bill will rescind the short-term limited duration insurance for junk insurance policies, regulation the Trump administration finalized last August, which expands these junk plans from the current three-month limit, making them available for up to three years.

We know these plans do not cover preexisting conditions. They do not have out-of-pocket and lifetime limits and they do not protect women from being charged more than men.

Representative Castor's bill would rescind the rule that expanded these junk insurance plans. Representative Kuster's bill revokes the Section 1332 waiver guidance issued by the administration last October, which weakens requirements of private insurance plans to provide compressive coverage at an affordable price.

Section 1332 of the Affordable Care Act requires states to meet standards for what qualifies as health care coverage. The Trump administration guidance changes these standards to be less comprehensive and less affordable for patients who rely on private insurance purchased on the individual market.

It also allows tax credits, federal dollars, to be spent

on these expanded and extended junk plans. My Republican colleagues have been highly critical about funding tax subsidies to help Americans afford comprehensive health insurance but support allowing more people to access federal money for these short-term junk insurance plans that do not even cover basic services.

Representative Kuster's bill rescinds that guidance so that all Americans will have health insurance coverage that meets the same standards.

We are also considering the bill authored by Representative Lisa Blunt Rochester to restore the marketing and outreach funding the Trump administration cut by 90 percent in 2017 and banning this funding from being used to advertise the junk insurance plans.

An article published in Kaiser Health News earlier this month described how consumers searching online to enroll in comprehensive ACA plans are most often directed -- redirected to websites and brokers selling junk plans without disclosing that the coverage will not be comprehensive.

And I ask unanimous consent to enter this article into the record. Hearing no objections, we will do that.

[The information follows:]

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

Ms. Eshoo. Federal dollars should not support advertising coverage that will not protect patients with preexisting conditions. The last bill, my legislation will require junk insurance plans to display up front what is and what is not covered so that consumers will know exactly what they are buying.

My bill also requires a disclosure that these plans do not meet the Affordable Care Act's requirements for cost sharing and lifetime limits and prohibits these plans from being sold during the individual market open enrollment.

I want to be clear about the following. I believe the Trump administration's rule that expanded the maximum duration of these so-called short-term plans up to a year and allows them to be renewed for up to three years should be rescinded.

I see that I am over my time and at this point I would like to recognize Dr. Burgess, the ranking member of the subcommittee for five minutes for his opening statement.

Mr. Burgess. I thank you for the recognition, and today we have been convened once again to discuss issues that will not improve the affordability of health insurance for Americans.

Unsustainably high premiums and issues related to silver loading are increasingly becoming a reality for families that rely upon healthcare.gov for their insurance.

Yet, the bills before us today will not make a marked increase

in the availability of reasonably prices plans. I am encouraged to see that we are at least discussing some legislative ideas today, unlike last week's hearing, which I think everyone agreed was an exercise in futility.

Once again, I would like to make it clear that there is bipartisan support for protecting coverage for individuals with preexisting conditions. Many on our side have expressed that sentiment.

Certainly, we have people that we know in our families or in our -- amongst our employers when we -- employees when we were -- before we came to Congress or in our medical practices that are affected by the status of preexisting conditions.

But the constituents in my district are struggling to afford their health insurance and I am sure the district I represent is not unique in that regard.

What good is health insurance if you are afraid to use it because you cannot afford your deductible? I have a lot of people that I represent who cannot afford a flat tire, let alone a $6,800 deductible in the bronze plan sold by healthcare.gov.

This is the issue that I would like to see us tackle and I am disappointed that none of the bills before us today will move that.

What I find most troubling about today's hearing is that

our colleagues are questioning the flexibility that they put into their own law. Section 1332 of the Affordable Care Act provides states the opportunity to apply for state innovation waivers.

These waivers allow states to come up with inventive ways to insure their population while safeguarding their access to quality insurance. Section 1332 of the Affordable Care Act explicitly authorizes the Department of Health and Human Services and the Treasury Department to waive certain ACA coverage requirements it has written into law.

To be clear, I did not vote for this law nor did I receive positive feedback from my constituents about the law's implementation.

However, states like Alaska have had success with these waivers, which gives states room to repair their markets that have been damaged by the Affordable Care Act.

This hearing is another attempt to distract from the Democratic Party's agenda to establish government-run single payer health care. Last week it was said that there are other committees in the House that are holding hearings and drafting legislation to establish such a plan.

On February 7th, the magazine Modern Health Care published an article that says a draft version of the House Democrats' upcoming Medicare-for-all bill proposes a national system that

would prepay hospitals with lump sums while keeping fee-for-service models for individual physicians.

This news outlet obtained a 127-page draft that was dated January 14th but I have yet to see such a draft. It is concerning that the media knows more than the members of this subcommittee about the details of this proposal.

Based on what I have read about the supposed draft, I am concerned. I will tell you, as a physician I know that the critical doctor-patient relationship is threatened and I do not believe that the government should hinder a doctor's ability to act in the best interest of his or her patient.

According to the Modern Health Care article, this proposal would implement a global budget and once that is set hospitals and institutions would need to stick to it for all outpatient and inpatient treatment.

So that is what is truly concerning about this. What happens if the budget runs out? Are patients told, well, we are sorry we are out of money -- maybe you could try this again next year.

This is a recipe for waiting lines. This is a recipe for rationing care and the sooner people understand that the better. Meanwhile, there is a greater percentage of Americans in employer health coverage than at any time since the year 2000.

The number of Americans with employer-sponsored health

coverage has increased by at least 2.5 million and probably much more than that since President Trump took office. Where are the CBO coverage figures on the expansion of employer-sponsored health plans because more people are working now than there were before the president took the oath?

The President's Council of Economic Advisors projects that the administration's recent actions will create $453 billion in net benefits for consumers and taxpayers over the next 10 years.

Again, as a holder of one of the so-called junk policies, I had a health savings account before the previous administration told me I didn't know what I was doing and couldn't manage it and took it away from me.

I welcome the fact that the administration has provided this flexibility, and I will yield back my time.

Ms. Eshoo. I thank the ranking member.

Just something for the record to the ranking member -- I don't agree with your characterization of the last hearing that we had. Everyone does not agree with your characterization. I think your side does but our side doesn't.

With that, I would now like to recognize the chairman of the full committee, Mr. Pallone.

The Chairman. Thank you, Madam Chairwoman.

Today, this committee begins to fulfill the promise we made

to reverse the repeated sabotage of our nation=s health care system by the Trump administration, in addition, to make health care more affordable and to protect the more than 133 million Americans with preexisting conditions.

We will be discussing four bills that will make a real difference in people=s lives. The first bill, introduced by Ms. Castor, would reverse the Trump administration=s regulation to expand junk insurance plans known as short-term limited duration health insurance.

The Trump administration expanded these junk plans from the current three-month term and made these plans available for up to three years. These junk plans are exactly that -- junk.

They discriminate against people with preexisting conditions. They set higher premiums for people based on age, gender, and health status. They deny access to basic benefits like prescription drugs, maternity care, and mental health and substance abuse treatment, and they set arbitrary dollar limits for health care services, leading to huge surprise bills for consumers.

Expanding these junk plans also makes health insurance more expensive for people with preexisting conditions by undermining the market for comprehensive coverage. The business model of the companies that sell these junk plans is to spend as little

as possible on the health of their enrollees.

They accomplish this by denying coverage of preexisting conditions, kicking people off their health insurance if they get sick or seek medical treatment, and pocketing their premium dollars as pure profit.

This profiteering at the expense of peoples= health is simply unacceptable. It is why we passed the Affordable Care Act in the first place -- to rein in exactly these types of abuses by health insurance companies.

And yet, the Trump administration would give insurance companies the green light to once again discriminate against people with preexisting conditions.

Now, Ms. Castor=s bill is an important step in strengthening the individual market and reversing the harm caused by the Trump administration. Ms. Eshoo=s bill requires these short-term plans to bear a consumer warning.

As we will hear from our witnesses today, junk plans are often deceptively marketed as comprehensive coverage and consumers are not always aware of the fine print. This is about a consumer=s right to know.

The bill would require issuers of these plans to display a clear, prominent warning advising consumers that the plan does not cover preexisting conditions, is temporary, and may not cover

most health care costs, and that coverage can be terminated when someone gets sick or seeks medical treatment.

And I believe this bill works in conjunction with Ms. Castor=s bill. While consumer disclosure is important, we must also prevent all of the problems associated with expanding these plans to three years.

We will also be discussing Ms. Kuster=s bill to rescind the Trump administration=s 1332 guidance. Section 1332 of the ACA was designed to give states the ability to examine system reforms that would improve the well-being of their residents.

The key word there is improve. States are also required to maintain the affordability and comprehensiveness of coverage and keep the same number of people insured as under the ACA.

But the Trump administration=s 1332 guidance turns the statute on its head, giving states the green light to undermine protections for preexisting conditions. The guidance also gives states the green light to provide taxpayer subsidies for junk plans and reinvigorates ideas from the failed Republican repeal bill, such as -- such as the flat tax credits that do not keep up with rising premiums and shifts costs onto working families.

This guidance is bad for consumers, bad for individuals with preexisting conditions, and bad for taxpayers. It exceeds the administration=s authority and is contrary to congressional

intent.

And, finally, we will be discussing Ms. Blunt Rochester=s bill to restore consumer outreach and enrollment funding that is so important to making health care more accessible and affordable.

The Trump administration gutted funding for consumer outreach and marketing by 90 percent. The administration=s refusal to invest in outreach and enrollment is making it harder for Americans to get health care and this is leading to lower enrollment numbers.

The administration has overseen three consecutive years of decline in enrollment and new enrollment is down by 50 percent. The administration=s sabotage have resulted in the highest uninsured rate in four years.

So Ms. Blunt Rochester=s bill would fund critical outreach and enrollment at $100 million, which was the level before Trump=s sabotage. Her bill also prevents the administration from using these funds to promote junk plans and her bill is an important step in lowering health care costs and expanding coverage to more Americans.

Now, all four bills we are considering today are important first steps in lowering health care costs and protecting consumers with preexisting conditions and I commend all four members for

their leadership and look forward to continuing to work with my colleagues as we make health care more affordable for all Americans.

And, again, I want to thank the chairwoman. I think this is a very important hearing and this will lead to legislation being passed.

Thank you, Madam Chair.

Ms. Eshoo. I thank the chairman.

And now I would like to recognize the distinguished ranking member of the full committee, Mr. Walden, my friend.

Mr. Walden. Good morning, Madam Chair.

Ms. Eshoo. Good morning.

Mr. Walden. Thank you for having this hearing, and as I said in the hearing down below I know the Dingell family is in all of our thoughts and prayers this morning as they cope with this terrible loss of our distinguished chairman for whom the big hearing room is named, and I know that he taught us all how to legislate and despite, as I said downstairs, our best attempts to emulate his yes or no questioning, nobody else pulls it off like John Dingell could pull it off. So he is in our thoughts.

So good morning, and given the title of today's hearing, I too am concerned for the second time is as many hearings in this subcommittee that we are really not addressing the real

challenges the consumers are facing, which is the high cost of health care.

Madam Chair, I said it last week I'll say it again. We need to work together to help states stabilize health markets damaged by the ACA, cut out-of-pocket costs that consumers are having to pay with these high deductibles, promote access to preventive services, encourage participation in private health insurance, and increase the number of options available through the market.

Unfortunately, today's hearing and these bills I don't think are adequately addressing any of these goals. Why would our Democratic colleagues be opposed to states innovating on behalf of their citizens?

Why would they be opposed to providing patients flexible and affordable insurance options that best fit those patients' needs? I just don't think it makes sense.

The administration is allowing 10 million Americans more choices and more affordable health insurance options. The Democrats' Medicare-for-all proposal would force over 150 million Americans to lose their employer- or their union-sponsored health insurance and I think that is wrong.

You want to talk about sabotage, that is what we should be having a hearing on is Medicare for all and what is coming. I also want to reiterate my call that the Energy and Commerce

Committee hold hearings on that bill.

So today, instead of having a constructive bipartisan dialogue about helping states innovate, about providing options for patients who are struggling to make ends meet, we are here for the second time in as many weeks casting the blame of Obamacare's failures on the current president.

The fact is we all support protecting people with preexisting conditions and we share a desire to stabilize the individual health insurance market. Last Congress, I advocated for policies that would achieve both of these goals, first through the ACA's patient state stability fund, and I made two more attempts at bipartisan stabilization reforms last Congress, working with my colleagues in the Senate.

Unfortunately, House Democrats repeatedly blocked our creative solutions -- solutions like improving 1332 waivers to better meet states' unique needs and modernize programs to stabilize premiums.

Now, my home state of Oregon, which celebrates its birthday tomorrow, we have an active 1332 waiver for a cost-based reinsurance program. I supported my home state's application and approval. I was the only Republican in our congressional delegation.

Why? Because it represents the very fabric of federalism.

What works best for Oregon may not work best for California, Madam Chair.

Take Alaska, for example. In studying their individual market, they found that a conditions-based reinsurance program would better serve their residents. Before they received a waiver, 2017 rates were projected to increase 42 percent.

But after shifting individuals with one of 33 medical conditions into a separate pool, premiums for the lowest cost bronze plan fell by an astounding 39 percent. And in Oregon, the reinsurance program kept premiums 6 percent below what they would have been without it.

These are real savings for patients in my state. Oregon and Alaska -- one pretty traditionally blue, the other pretty traditionally red -- found a way to take advantage of 1332 waivers to best serve their citizens.

They are not alone. Today, eight states have active waivers: Alaska, Hawaii, Minnesota, Maryland, Maine, New Jersey, Oregon, and Wisconsin. Eight diverse and unique states, but they have at least one thing in common, Madam Chair, and that is each of these eight active waivers were approved under the Obama administration's 1332 guidance.

Yet, today we are here to discuss nullifying the Trump administration's 1332 guidance. Why not first observe how states

react and reform their markets through the new guidance?

We should understand that better. Perhaps a better use of our time would be spent discussing bipartisan solutions to reform and improve these waivers. We all want markets that work. We do.

We all want patients to have access to high quality affordable-priced health coverage. Unfortunately, the ironically-named Affordable Care Act had made insurance for many unaffordable, and I heard it again yesterday from wheat growers in my district.

Together, and with the states as partners, not subordinates, we can achieve the shared goals of well-functioning and stable markets that provide Americans affordable health care options.

So one thing is clear. We need to guarantee our health care system works better for all Americans. That we can agree on, and that is why our goal should be to advance solutions to protect patients, stabilize health care markets, encourage greater flexibility for states, and promote policies to help Americans get and keep coverage.

So, Madam Chair, thank you for having the hearing today. We look forward to working with you, and I yield back.

Ms. Eshoo. And I thank the gentleman.

I now would like to welcome our witnesses for today's

hearing. First, Ms. Katie Keith, the associate research professor and adjunct professor of law at Georgetown University. Thank you for joining us.

Ms. Jessica Altman, commissioner, Pennsylvania Insurance Department. Very important job. Welcome to you.

And to Ms. Grace-Marie Turner, president of the Galen Institute, we thank you for accepting our invitation to join us today and we look forward to your testimony.

And I am going to recognize each witness for five minutes to provide your opening statement, and just a little housekeeping. Our lighting system -- what is in front of you is a series of lights. The light will initially be green and then it will turn yellow when you have one minute to go, kind of like the League of Women Voters debates that we have all been in, right, with the lighting system. And we don't have a bell -- we have a lighting system -- and after that you will have one minute remaining and at that point the light will turn red when your time expires -- not when you expire but when your time expires.

So let me begin with Ms. Katie Keith. You are recognized for five minutes and welcome again, and thank you to you.

STATEMENTS OF KATIE KEITH, JD, MPH, ASSOCIATE RESEARCH PROFESSOR AND ADJUNCT PROFESSOR OF LAW, GEORGETOWN UNIVERSITY; JESSICA K. ALTMAN, COMMISSIONER, PENNSYLVANIA INSURANCE DEPARTMENT; GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

STATEMENT OF MS. KEITH

Ms. Keith. Thank you very much, Chairwoman Eshoo, Ranking Member Burgess, and members of the Committee.

My name is Katie Keith and I am a faculty member at Georgetown University where I study private health insurance. I am also the author of the following: The ACA Blog Series for the Health Policy Journal of Health Affairs where I am responsible for tracking and chronicling implementation of the Affordable Care Act including many of the changes that the Trump administration has made in recent years.

My testimony today will focus on just three of those changes, although there have been many more than that, as you all know. The actions I will discuss today undermine the ACA risk pools, leave consumers who become sick without access to health care, and drive up premiums for people with preexisting conditions.

I will begin with short-term plans. Last August, three departments issues a new regulation allowing short-term plans to be sold for up to 12 months and extended for up to three years.

Short-term plans do not have to comply with the Affordable Care Act and they are allowed to discriminate against patients with preexisting conditions.

These plans are medically underwritten and do not have to cover entire categories of benefits. A recent study showed that 43 percent of these plans do not cover mental health services. Seventy-one percent do not cover prescription drugs.

In the midst of an opioid crisis, 62 percent do not cover substance use services and none of these plans covered maternity care.

Some had out-of-pocket maximums as high as $30,000 and lifetime limits on care. These plans, which are highly profitable for the insurers that sell them, tend to only work for those who are healthy.

The harm to consumers from this new rule is twofold. First, these policies pose a significant risk to the individuals who enroll in them, only to find that the care that they need is not covered when they become sick.

Many newspapers are filled with stories these days of consumers who have enrolled in these plans only to wind up facing hundreds of thousands of dollars in unpaid medical bills.

Second, these policies drive up premiums for those with preexisting conditions, particularly for middle income families

who do not qualify for ACA subsidies.

Moving on to Section 1332, the Trump administration recently issued guidance that encourages states to offer skimpier coverage including short-term plans. The new guidance relaxes the previous interpretation of what we refer to as the statutory guardrails under Section 1332.

This could result in state efforts to advance less comprehensive coverage and drive up premiums for people with preexisting conditions. It is worth noting that there have been questions raised about the legality of both the short-term plan rule and the Section 1332 guidance.

The short-term plan rule has already been challenged in court and a lawsuit brought by consumer and patient advocates, including the Little Lobbyists who I believe testified before this subcommittee last week.

These patient advocates have sued over the rule because of its impact on people living with HIV, people with mental health issues, and people with other chronic conditions and disabilities.

The 1332 guidance has not yet been challenged but approval of a waiver under that guidance would likely be challenged quickly.

Finally, the Trump administration has made dramatic cuts

to funding for ACA marketing and outreach. This includes immediate cuts during the final week of the 2017 open enrollment period followed by a 90 percent reduction for 2018 from $100 million to $10 million.

Those cuts were maintained by CMS for 2019 and CMS has reduced funding for the navigator program by 84 percent. These funding decisions were made even though outreach and marketing helps bring in younger healthier consumers which, in turn, helps keep premiums stable.

At the same time, awareness of the marketplaces and the financial assistance that many people are eligible for remains low. We are finding that enrollment of those key features is still low even after many years. That is particularly true among the uninsured.

We are also seeing that enrollment of new consumers, who tend to be younger and healthier, is down. Enrollment of new consumers has dropped by about 50 percent since 2016 alone.

According to one estimate, there are at least 2.3 million fewer new enrollees that would otherwise be in the marketplace due solely to cuts to outreach and advertising.

In closing, most people are health most of the time. But everyone eventually gets sick and needs access to comprehensive health insurance. The actions discussed today do nothing to

advance high-quality affordable health insurance.

Instead, these actions divide the risk pool between the healthy and sick and increase premiums for people with preexisting conditions.

Thank you again for inviting me. It is an honor and privilege to be here and I look forward to your questions.

[The prepared statement of Ms. Keith follows:]

********** INSERT 2 **********

Ms. Eshoo. Thank you, Professor Keith.

I now would like to recognize Ms. Jessica Altman, again, the commissioner from Pennsylvania Insurance Department. You have -- you are recognized to present your testimony to us.

STATEMENT OF MS. ALTMAN

Ms. Altman. Thank you, and good morning, Chairwoman Eshoo, Ranking Member Burgess, and members of the Health Subcommittee.

As mentioned, my name is Jessica Altman and I am privileged to serve as insurance commissioner for the Commonwealth of Pennsylvania.

I want to thank you for convening today's important discussion regarding short-term plans and for the opportunity to voice concerns about the potential harms for consumers and for the health insurance market, more broadly.

As the name says, short-term plans were created to fill brief gaps in coverage. The plans generally have lower premiums but significant coverage limitations as the protections of the Affordable Care Act, which I will call ACA, do not apply.

By recently extending the duration and renewability of short-term plans, the federal administration is seeking to make short-term plans look and act like a viable alternative to comprehensive major medical insurance without extending the protections of the ACA.

Today, I will highlight my four primary concerns illustrated by actual consumer complaints and conclude by sharing with you a little bit about my department's approach to short-term plans.

Please reference my testimony for a more thorough perspective.

The first primary concern with the plans that I raise today is one Katie covered well. They have very limited benefits and consumer protections. Short-term plans do not have to cover essential health benefits, and in Philadelphia the same study Katie mentioned found that less than 60 percent covered mental health, only one-third in the midst of the opioid crisis that is hitting Pennsylvania very hard covered substance use disorder treatment or prescription drugs, and none covered maternity care.

Short-term plans can impose lifetime and annual limits on coverage, do not include appeal rights, and are not subject to a medical loss ratio requirement that sets a floor for the percent of premium spent on actual medical care.

Instead, for the two short-term insurers with 80 percent market share, less than $0.50 of every dollar collected in premiums was spent on actual medical care.

Recently, my department worked with a woman who fainted at work and hit her head -- something that could happen to any of us -- and it resulted in emergency transport to the hospital.

The short-term plan paid $200 for the ambulance, leaving the patient with $1,250. At the ER, the plan provided $250 while the bill was over $2,400. Then she was admitted to the ICU, where the benefit was, again, $1,250 for a bill that was $9,300.

Finally, the plan paid another $1,250 for an outpatient test while the bill was $4,900. After considering cost sharing, the plan covered just over $1,300, the consumer, $16,000.

My second concern is the lack of consumer disclosure regarding benefits and benefit exclusions. The plans are sold without a consumer's access to provider directories, formularies, sample coverage documents, summaries of benefits and coverage, and a uniform glossary, all of which are required to be provided with Affordable Care Act plans.

The lack of consumer disclosure is so troubling in the short-term market that we are creating our own consumer awareness campaign to try to cut through the noise of robocalls, well-placed online advertising, misleading website URLs, and a lot of fine print that are currently bombarding consumers across the country to purchase these plans.

A recent study found that consumer shopping online for health insurance including those using search terms like "Obamacare" or "Enroll ACA" will most often be directed to websites and brokers selling short-term plans or other non-ACA-compliant coverage and this is, of course, exacerbated by the lack of comprehensive ACA information, outreach, and enrollment.

The third issue is claims practices. I am most concerned by the use of a practice called post-claims underwriting, which

often results in recision or denial of coverage.

As short-term plans often exclude coverage for preexisting conditions, policy holders who get sick may be investigated by the insurer to determine whether a recently diagnosed condition could be considered preexisting and therefore excluded.

We are currently working with a consumer who purchased a short-term plan and was diagnosed with heart failure. After he filed a claim for services, he was denied coverage based on the preexisting condition. But he had never been diagnosed, never sought, and never received care for his heart.

But instead, the insurer indicated that the claim manifested in such a way that an ordinary prudent individual would have sought medical treatment and advice in the year prior to purchasing the plan.

Through the course of working to resolve consumer complaints, the claims practices of short-term plans have repeatedly demonstrated an inclination to deny coverage rather than provide it.

Lastly, and I see my time ticking down so I will be quick, encouraging the proliferation of short-term plans has the potential to destabilize and drive up costs for the ACA market, especially for those with preexisting conditions by segmenting healthier people out of the market.

The federal government does also continue to push for the proliferation of short-term plans through regulatory actions such as the 1332 guidance and a waiver like that under the new guidance would not be one that Pennsylvania would pursue.

Thank you. I will shorten my remarks and welcome any of your questions.

[The prepared statement of Ms. Altman follows:]

********** INSERT 3 **********

Ms. Eshoo. Thank you very much.

It is my understanding that Ms. Altman was an intern under -- with Mr. Waxman of the Energy and Commerce Committee. So congratulations on your climb.

Ms. Altman. Thank you. Congratulations to you.

Ms. Eshoo. And your -- and your great foundational learning here at our committee and, of course, thank you for your testimony.

Now I would like to recognize Ms. Grace-Marie Turner. You are recognized for five minutes and welcome, and we look forward to hearing your testimony.

STATEMENT OF MS. TURNER

Ms. Turner. Thank you, Chairwoman Eshoo. Thank you, Minority -- Ranking Minority Member Burgess and members of the committee for inviting me to testify today.

I am with the Galen Institute, a nonprofit organization focusing on ways to ensure access to affordable health coverage for all Americans. Enrollment in the individual health insurance market is falling. In 2018, 3 million fewer people had individual coverage than in 2015. The primary concern is the cost of coverage.

The administration's new 1332 guidance is designed to allow states to repurpose some ACA money and improve their markets to help those shut out because of high costs. Eight states have so far created programs to separately subsidize patients with the highest health care costs, lowering premiums and leading to increased enrollment.

In addition to Alaska and Oregon, Maryland is seeing huge price drops of 43 percent net this year. Putting the sickest pool of people in the same pool with others, as the ACA does, means premiums are higher, often much higher for those without subsidies.

Virginia State Senator Bryce Reeves told us of an email he

received from a constituent in Fredericksburg who makes a good living and tried to provide for his family but said his insurance premiums now cost $4,000 a month. That is more than my mortgage, he told Senator Reeves, asking what he's supposed to do.

Cost relief is essential. The Trump administration last year did finalize rules to expand access to temporary bridge policies short-term limited duration plans. These policies help people with gaps in employment, early retirees waiting to qualify for Medicare, young people and the gig economy, people returning to school, and entrepreneurs starting new businesses.

These short-term plans typically cost less than half of the cost of ACA plans. Under the Obama administration's previous rule, people would lose their short-term plans after just three months even if they acquired a medical condition within that period.

By extending the contract period to a year, people can be protected and have coverage until the next ACA open enrollment period. While consumers do need to be informed about these plans, for many they may mean the difference between having the security of coverage for a major medical event and being uninsured.

The Council of Economic Advisors issued a report just last week estimating that these policies produce an economic benefit of $80 billion over the next 10 years.

I would like to turn to preexisting conditions. There is a strong bipartisan support for these protections as Mr. Walden and Dr. Burgess both have ensured. The ACA assures that people cannot be turned down or have their policies cancelled because of their health status and these protections remain in place.

People with chronic conditions are vulnerable and do need protection. But a woman with a serious health problem provided us with a testimonial about why more changes are needed.

Janet reports that in 1999 she was diagnosed with hepatitis C. She lives in Colorado and applied for coverage in the state's high risk pool and was accepted. Her premiums in 2010 were $275 a month. Then her liver failed. She needed a transplant. The $600,000 bill was covered 100 percent with $2,500 out of pocket.

Colorado's high risk pool, however, was closed when the ACA took effect. So she moved into the marketplace. Her premiums rose to $450 and by 2018 they were $1,100 a month with a deductible of $6,300.

She said, those of us who are self-employed but make more than the threshold of tax credits wind up footing the whole bill ourselves.

Finally, regarding navigators -- legislation proposed by Representative Blunt Rochester would provide $100 million a year for the navigator program. But CMS found that in 2016 78 percent

of navigators failed to achieve their enrollment goals and navigators enrolled fewer than 1 percent of enrollees while spending $62 million that year.

CMS now funds navigators based upon their ability to meet their enrollment goals and during the previous year -- during the previous year and relies more on brokers and insurance agents who enrolled 42 percent of enrollees.

California spent heavily on marketing last fall to increase enrollment in its state exchange yet it experienced a 24 percent drop in new enrollees. Marketing doesn't work when the main reason that people don't sign up for coverage is because of cost.

I would welcome the opportunity to work with you in developing new ways to help lower the cost of health coverage while maintaining quality and consumer protections including preexisting condition protections.

Thank you, Madam Chairman.

[The prepared statement of Ms. Turner follows:]

********** INSERT 4 **********

Ms. Eshoo. Thank you, Ms. Turner, for your testimony and we have now concluded the opening statements. We are going to move to members' questions and I will start by recognizing myself for five minutes.

I have a lot of things in front of me that have been suggested that I ask. But after listening to your verbal testimony I want to mix this up a little bit.

We heard the first two witnesses, Ms. Keith and Ms. Altman, talk about the shortcoming of these short-term plans and the plan of the administration to stretch them out over three years.

Now, Ms. Turner, you said we have a commitment to preexisting conditions in the coverage. Why is it not included in these short-term plans?

I would also like to give 30 seconds to Ms. Keith and Ms. Altman to ask any questions that they would like of Ms. Turner because there is a difference between your testimony and Ms. Turner's.

But first, can you talk about what -- I think the word commitment is conflated in its use. There is a difference between a commitment to and actually practicing what you say you have a commitment to.

So I don't see these very important insurance reforms that we brought about with the ACA and you say that you have a commitment

to preexisting conditions and the other insurance reforms.

So can you just in a minute or less explain why there is a difference between your commitment and what is in these plans?

Ms. Turner. Short-term plans are really gap coverage. People buy them because they can't afford coverage that has all of the ACA protections.

Ms. Eshoo. Let me ask you this. Are you opposed to an advisory in plain English on the cover of these policies to inform the potential consumer what is not included so that it is very clear about what they are buying?

Ms. Turner. Oh, absolutely. Absolutely. I think consumers very, very much need to be informed about their policy.

Ms. Eshoo. Okay. Good. Good.

All right. Now, Ms. Keith, do you want to ask a question or have a comment?

Ms. Keith. Yes. I don't have a question. Thank you, Chairwoman. What I would say is something that did not get brought up in my oral statement yet is that the limitations of these plans there is no magic about why these short-term plans are cheaper than ACA plans.

They are, on average, about 54 percent less expensive. There is no secret to that. The reason is because they can exclude people with preexisting conditions. That fact alone allows them

to be 38 percent cheaper than ACA plans.

When you add in some of the benefit gaps and out-of-pocket costs that is what makes them half the cost of ACA plans. And so the idea of giving people coverage, you know, is the product worth buying if it doesn't cover anything when you need to use it I think might be the question.

Ms. Eshoo. Ms. Altman?

Ms. Altman. I was going to bring up the same study, and to put it another way, 70 percent of the price difference between short-term plans and traditional ACA plans is due to preexisting condition exclusions. The story you told --

Ms. Eshoo. Can you say that again?

Ms. Altman. Seventy percent of the difference in price between short-term plans and Affordable Care Act coverage is due to excluding preexisting conditions.

You know, the story you told from Colorado was incredibly compelling and, to me, it really reinforces why people need comprehensive coverage so that you can get coverage for that expensive transplant and you can get coverage for your liver failure and your hepatitis C.

You know, my only question is today you talked about how the purpose of short-term plans is to fill gaps in coverage and that is the intended purpose, and I suppose my question is if

it is meant to fill a gap why would it need to be three years.

Ms. Eshoo. Can you answer that, Ms. Turner?

Ms. Turner. I think that that is really up to consumers. Many of the people who are uninsured now -- many of the 3 million are uninsured because they simply can't afford coverage.

Senator -- State Senator Reeves' constituent desperately wants to provide for his family until another option is better. So he can't know how long he is going to need to have this protection.

One of the reasons that the new rule extended that coverage is because three months just is too short a time to give anybody the security that they need coverage and in Colorado Janet is actually now in an ACA plan.

Her meds are not covered under the plan that she is in under the ACA so she has $19,000 out of pocket now.

Ms. Eshoo. Well, I think -- if I might say this, I think it is important for consumers to have choice. I am not opposed to that.

What I am worried about is I found this out in health care the two basic things. Everyone knows what they pay in a premium. Most people don't know what they are buying -- what they are getting -- and this can be a really slippery slope for a lot of people and -- or maybe for a few that is going to make them,

especially if they are healthy and they are young, they are betting on their immortality and that nothing is ever going to happen to them. But it is -- there are a lot of questions, so thank you.

My time has certainly expired. I now would like to recognize Mr. Griffith for his five minutes of questioning.

Mr. Griffith. Thank you, ma'am. Right here beside you.

Ms. Eshoo. Yes. Right. Sitting right next to me.

Mr. Griffith. I am glad to hear, Madam Chair, that you are for consumers having choices. I think that is very important. I also look forward to working with you on your bill -- 1147, I believe -- that deals with making sure that consumers have the information that they need.

I would say, as we work forward on that piece of legislation, it looks to me right now that it includes such a huge volume that many consumers probably wouldn't read it.

So what we have to do is try to figure out where the sweet spot is and I look forward to working with you on that because I do think it is important that consumers know if they are buying an alternative product that, A, it is an alternative product and, B, that it doesn't cover everything but here is what it does cover, because, as you pointed out, Ms. Turner, many folks are looking for something because they cannot afford the plans that fall under

the ACA with all the mandates that are there.

Could you repeat the quote from Senator Bryce Reeves? Since I am from Virginia, he is -- while his district is about four hours away, I do think it is instructive to hear from him again. Could you repeat that for us?

Ms. Turner. Yes. Senator Reeves was at an event -- speaking at an event. He had just gotten an email from a constituent saying that he had just received his health care bill for his -- to provide for his family and the premium was $4,000 a month, which he said, that it more than my mortgage -- what am I supposed to do.

Mr. Griffith. Yes. We hear stories similar to that four hours away on the other side of Virginia. I represent the southwest portion of the state.

We hear of a lot of people who can't afford the out-of-pockets and the deductibles -- that that is forcing them to look at bankruptcy options -- the same complaints we heard before that the Affordable Care Act was supposed to fix. Hasn't worked for my constituents.

It, clearly, hasn't worked on the other side of the Commonwealth of Virginia. I can't speak to the country as a whole. But from anecdotal evidence it seems that the same is out there.

And as you pointed out in your testimony, this is one of the reasons why people are looking at some of these alternatives. I think they ought to know what they are getting because some people will just buy something because it is cheaper. But some people buy something that doesn't cover everything because they are desperate. Is that true?

Ms. Turner. That is true and, unfortunately, in many parts of the country and especially Virginia if you live in one county you may not have a choice. This constituent had no other choice in Fredericksburg, and so people are looking exactly for that -- to find other ways they can have health insurance they can afford protect their families but not have it -- not be able to pay their mortgage.

Mr. Griffith. It is interesting that you raise that point about the choice because under the ACA -- I represent 29 different geopolitical subdivisions, and for those that aren't from Virginia, we have separate cities.

So some of those are small cities as well as counties. But I have 29. A fair number of those have but one provider. They just -- the market is just not there to support it.

I am surprised that that is the case in the Fredericksburg area because that is a much bigger area population wise than some of my jurisdiction. But you are saying they have that problem

too -- there was just one provider of insurance?

Ms. Turner. Yes, and I would hope that Virginia would look at the Section 1332 waivers to figure out how they can attract more competitors back into the markets.

Mr. Griffith. And I would hope that that would be the case, too. Let us talk about the woman you spoke of, Janet with hepatitis C. Could you go over the numbers again of how much she was paying under the plan that resembled the -- what the House was trying to do last year, or two years ago now, to do our repeal and replace -- with the high risk pool? She was only paying $275, I think you said, a month for her insurance?

Ms. Turner. When she was first diagnosed with hepatitis C in 1999 her premiums in the state's high risk pool were $275 a month, and then they rose. When she had to first enroll that high risk pool was closed so she had --

Mr. Griffith. So hang on. But before that high risk pool was closed you indicated she had to have a liver transplant?

Ms. Turner. She had to have -- her liver failed and she had to have a $600,000 liver transplant.

Mr. Griffith. And that was covered?

Ms. Turner. Totally covered by the high risk pool. She had $2,500 out of pocket. But then when the ACA took effect, her premiums rose to $450 and by 2018 they were $1,100 a month

and one of the things I didn't mention in my testimony is that none of her anti-rejection drugs are covered under the new plan. So she has to pay out of pocket $19,000 a year.

Mr. Griffith. Wow. Plus, there was a $6,300 deductible, I think you mentioned.

Ms. Turner. Correct.

Mr. Griffith. And so what you are saying is that this high risk pool, which was an alternative before the ACA, was an alternative to the ACA which would work for some people and we should probably have more choice. Wouldn't you agree, yes or no?

Ms. Turner. She said yes and she said, I want the high risk pool back.

Mr. Griffith. All right. I thank you very much and I yield back.

Ms. Turner. Thank you, Mr. Griffith.

Ms. Eshoo. I thank the gentleman.

I will now recognize the chairman of the full committee, Mr. Pallone, for five minutes.

The Chairman. Thank you, Madam Chair, and I just, you know, want to reiterate that, of course, in my opinion the problems that we face with, you know, more people become uninsured and increased costs are directly related to the sabotage that the

Trump administration has implemented and that is why we are having this hearing and trying to deal with these -- with the sabotage and coming up with legislation that would turn that around.

But I wanted to talk about the 1332 -- Section 1332 of the ACA. Ms. Turner -- my questions are of Ms. Keith -- but Ms. Turner's testimony appears to conflate the October 2018 Trump guidance with the Section 32 -- 1332 reinsurance waivers that were approved both under Obama initially and then now under Trump.

So, Ms. Keith, can you walk us through the Section 1332 reinsurance waivers? Those are the ones that, you know, were initially under Obama, now under Trump? What are they and how long have they been in existence and have those reinsurance been successful in reducing premiums in the states that have -- where they have been enacted, including my own, I guess?

Ms. Keith. Thank you, Chairman.

Yes. So a number of states -- seven of the eight states with an approved Section 1332 waiver now have done that for a state-based reinsurance program. I think this is evidence that Section 1332 as is is working -- you know, Congressman Griffith mentioned this, Ms. Turner has mentioned this -- using those Section 1332 waivers that we already have. The federal government has passed through about -- almost $1 billion in federal funds to help states come up with these solutions that

have brought down premiums ranging from 7 percent of the low end to more than 30 percent at the high end and more states, I would expect, are considering that this year to bring those programs to their states as well. There has certainly been bipartisan support, as you can tell, from states ranging from Wisconsin to Maryland to Oregon to Alaska.

The Chairman. And I agree with you and certainly my state is an example of what you said. But now I want to turn to the Trump administration's recent 1332 guidance, which it issued in October of 2018, and these are entirely unrelated to the reinsurance waivers you just discussed.

The Trump administration's recent 1332 guidance creates new standards that are wholly inconsistent, in my opinion, with congressional intent and the Trump guidance would allow states to increase consumer costs, reduce coverage, and undermine protections for people living with preexisting conditions -- in other words, more Trump sabotage.

So, Ms. Keith, do you believe that the new Trump changes to the guidance are consistent with the law and the clear statutory directive that states must provide coverage that is as comprehensive and affordable as under the ACA?

Ms. Keith. Thank you for that question.

In my opinion, I think the guidance is quite inconsistent

with Section 1332 itself. Section 1332 absolutely gives states the flexibility to be innovative but it directs them to do so in a way that builds upon the ACA and is consistent with the goals of the law, which is to improve access to affordable quality coverage, not to undermine it. The guidance itself, by allowing or at least encouraging states to consider options like subsidizing short-term plans, plans that do not cover preexisting conditions, as we have discussed, to me flies in the face of Section 1332 and what it was designed to allow states to do.

The Chairman. All right, and I just want to have you repeat what you said with regard to junk plans specifically. I understand that the Trump guidance would allow states to redefine what counts as coverage to include junk plans. Is that correct?

Ms. Keith. It would allow -- it encourages states to bring forth proposals that would allow that, yes.

The Chairman. And then do you believe -- obviously, you have said you don't believe that this new definition of coverage is consistent with the law, correct?

Ms. Keith. That is right.

The Chairman. And then I also understand that the guidance allows states to direct the ACA's affordability subsidies towards junk plans, so subsidizing junk plans. Do you think that is consistent with the law?

Ms. Keith. I do not. Section 1332 cannot be used to waive any and all provisions of the Affordable Care Act. In particular, it cannot be used to allow states to waive community rating, guaranteed issue, protections for preexisting conditions.

If a state were to try to subsidize plans that did do that, I think it would be an end run around Section 1332 itself and what the law requires.

The Chairman. I thank you, and I agree with you. I think that the Trump administration's guidance is blatantly unlawful, contrary to the plain reading of the statute and wholly inconsistent with congressional intent. It is part of the Trump administration's ideologically motivated efforts to sabotage Americans' health care coverage and I want to comment Ms. Kuster for her work on this important legislation to rescind this guidance and hope that our Republican colleagues will join us in these efforts.

And I just wanted to say, Madam Chair, you know, most -- a lot of the sabotage -- most of the sabotage that the Trump administration is doing, in my opinion, is totally illegal. So you might say, well, then why are we trying to move and have hearings on legislation if you don't think it is legal to begin with.

Well, I guess that is a good question. But the bottom line

is that we are going to do it because we've got to make the point that, you know, that they -- their interpretation -- the Trump administration interpretation of the law is to allow all this stuff that sabotage the ACA so we are going to come back and say, you know, that is not allowed under the law but we are still going to clarify it by moving forward legislation that would make that clear and improve it.

Thank you.

Ms. Eshoo. I thank the chairman of the full committee.

And now I would like to recognize the gentleman from Kentucky, Mr. Guthrie, for five minutes.

Mr. Guthrie. Thank you, Madam Chair. I really appreciate and appreciate all of you being here, and I want to start by what I heard from Dr. Burgess and echo some of his opening remarks on the cost of plans and talk about how it affects people -- people outside of being subsidized that -- just looking for alternatives to have some -- have coverage because they can't afford -- you may have all the mandates and all the guaranteed issues but if they can't afford it they can't afford it.

And, particularly, I have a constituent named Dustin Jones -- he is a resident of Glasgow, Kentucky -- who has called and said he had the coverage that he liked before the Affordable Care Act. Now he is going to have to go uninsured because he says

he is just at the point he can't afford insurance anymore.

And so I will be honest, I have had people stop me and say because of Medicaid expansion in Kentucky they have had coverage they haven't had before. So there are people -- everybody can point to cases such as that.

But I think all of us have people like Mr. Jones that are in that middle income area that health insurance has just become unaffordable because so many of the mandates that are there.

And we want to cover people with preexisting conditions and we need to do it in a way that is affordable. I think Ms. Altman said that plans are 70 percent cheaper because they don't do preexisting conditions so I guess there is that inverse it would be 70 percent more expensive because, and that is what we wanted to do in the Affordable Care Act replace that we looked at.

We got highly criticized but it was examples -- I think Wisconsin had a highly functioning high risk pool and people said they were better off before where you socialize the cost of preexisting conditions across the state instead of just people in the individual market because it puts people like Mr. Jones out of being able to afford health insurance.

And so the -- and the bottom line was that everybody was covered with preexisting conditions. It was just a way to do it that didn't put the burden on just people in the individual

market. It socialized those costs across the state.

But, Ms. Turner, in your testimony you mentioned the additional consumer protection that the Trump administration added for short-term limited duration plans. Just give you an open to explain that further, the additional consumer protections that the Trump administration added.

Ms. Turner. You mean in terms of allowing people to keep these policies for a longer period of time -- that they previously, under the Obama administration, were limited to just three months.

And for many people who may be retiring at age 63 or 64 and they need gap coverage until they qualify for Medicare, people who are starting a new company, people between jobs, that just wasn't long enough and being able to give them the opportunity to purchase these short-term bridge policies was very helpful.

And I agree that people need to be informed consumers. But I think they do understand this is not permanent coverage. This is to fill a need in a particular time for an estimated 2 million people.

Mr. Guthrie. So it is not only the Trump administration giving the patients more health care products to choose from, they are doing so in a way that has additional consumer protections.

So I just want to -- also, Ms. Turner, you mentioned how

states are working within the 1332 waiver to innovate as laboratories of democracy. We have already seen eight states get approved under the strict Obama administration guidance.

Do you anticipate even more innovation as states review and reform their markets in compliance with the Trump administration policies?

Ms. Turner. The states are doing -- yes, absolutely -- and the states are doing everything they can to try to under the -- under the ACA to try to provide access for people who are shut out of the market.

These are -- these are people in the individual market who generally don't qualify for the subsidies under the ACA trying to afford health insurance for their family like Senator Reeves' constituent in Fredericksburg to try to provide a policy that they can afford.

And there are other provisions that the administration is providing as well: the association health plans so small companies can aggregate to get some of the benefits and the lower costs of larger companies; the new health reimbursement arrangement rule that would allow companies to provide a stipend to employees that may have the opportunity to get coverage outside the market, maybe a spouse's coverage, and be able to buy into that policy to get a family plan.

So they are really looking for ways to give people more options and to give states more options to use the existing ACA money in a way that works better for their citizens.

Mr. Guthrie. Okay. Thank you very much.

Just one more example -- a person who does transmission work on cars. Hopefully, you never have to do that but if you do that I -- that I use and been to. It is a single-person shop and he runs his own shop and he told me -- it was about six months ago -- that he closes from -- he doesn't open until, like, 9:00 and then he closes from 3:00 to 5:00 and then comes back and does an evening, and what he's doing he is driving a school bus to pay for his health insurance.

And he said by the fact that he went to work for the county system driving a school bus, by the time he does all of his premiums he really doesn't make any money doing it but he said, but I am making $1,600 a month because that is what I am saving in my health insurance.

So there are people really struggling with this and we need to be mindful of the Affordable Care Act didn't solve everybody's problem.

So thank you very much and I yield back my time.

Ms. Turner. Thank you, Congressman.

Ms. Eshoo. I thank the gentleman from Kentucky.

Now I am pleased to recognize the gentlewoman from California, Ms. Matsui.

Ms. Matsui. Thank you very much, Madam Chair, and I want to thank the witnesses for being here today. It has been very enlightening and interesting here.

The topic of this hearing is incredibly important to me and my constituents and actually all Americans whose lives have been changed by the Affordable Care Act.

Just last week this committee heard testimony from families whose lives have been fundamentally changed by the protections of the ACA, and that brings us to today's discussion and, very sadly, the sabotage of the Trump administration disguised in a disingenuous attempt to expand coverage is shameful.

This administration has done nothing to expand coverage. Rather, they have undermined the progress made by the ACA, leading to further market destabilization and harming patients along the way.

Now, these junk insurance plans sound good. However, they discriminate against people with preexisting conditions and set higher premiums based on age, gender, and health status.

Promoting the use of junk insurance plans is particularly frustrating when this administration has also slashed outreach funding for open enrollment into health care marketplaces.

Expanding junk insurance will undermine the market, taking young healthy individuals out of the risk pool and making health insurance less affordable for consumers with preexisting conditions.

The Trump administration has even acknowledged that the new rule would raise premiums for ACA-compliant plans and could result in adverse selection against individual market risk pool.

Ms. Altman, according to the Kaiser Family Foundation, if an individual loses coverage under a short-term policy, then they may not be eligible for a special enrollment period under the ACA.

In other words, the individual would experience a lapse in coverage. Given this information, I am concerned that these junk insurance plans could put many more individuals at risk.

Could you reiterate to the committee how before the implementation of the ACA how a lapse in insurance coverage impacted your financial situation and physical health?

Ms. Altman. Certainly. I think before the ACA lack of insurance coverage or lack of comprehensive insurance coverage impacted people in the same way that it could today. Their inability to seek the care that they need, their inability to afford the care that they need, and potentially financial devastating debt.

I think one of the perhaps less talked about benefits of the Affordable Care Act has been reductions in Americans going into debt due to medical bills and the reductions in uncompensated care and the burden that is on the economy and on our health care system as well.

Ms. Matsui. Right. Could I just say this too? And I hear from my constituents, both patients and physicians, who are frustrated they are receiving high unexpected medical bills and part of this is because they are enrolled in a junk insurance plan like we are discussing today that have an incredibly high deductible.

A $10,000 deductible doesn't count as real insurance if you have to spend $10,000 out of your pocket before your insurance kicks in. What does that really buy you and shouldn't consumers full understand what they are signing up for?

Now, Ms. Altman, your testimony talking about this -- what steps does your department take to alert consumers to the fine print of these plans?

Ms. Altman. Thank you for that question.

One of the greatest challenges with these plans is trying to counter all of the noise in the marketplace. A lot of the marketing is very aggressive. Some of it is outright untrue and some of it is in a gray area and misleading, at best.

We have undergone a number of efforts to try and get accurate education out in the marketplace, accurate information about short-term plans, about the Affordable Care Act, about the difference about when to enroll -- all of those questions.

But it is definitely an uphill battle as consumers are being bombarded with the marketing that is out there. We are now working on our own campaign that will highlight the questions consumers should be asking themselves and try to be proactive in getting that level of information out in the marketplace.

Ms. Matsui. And shouldn't CMS be a part of this, in essence, to educate the public about all the plans, in essence, of junk plans included about what they include or do not include?

And I have just got a short question here. I think it was brought up -- the extension of a plan to three years, it was said, actually helps consumers. How could it help consumers if they can be kicked off the plan at any time?

Ms. Keith?

Ms. Keith. Sure. Thank you for that question. I do think that is the right question -- how is being in a plan for a longer period of time that offers what can sometimes be illusory coverage. So the idea that these plans are offering coverage but can at any time exclude coverage because of a preexisting condition or engage in post-claims underwriting -- the idea of

extending those plans when the coverage may not be there when the person really needs it I wouldn't call that a consumer protection.

Ms. Matsui. Okay. Thank you. I have run out of time.

I yield back.

Ms. Eshoo. I thank the gentlewoman.

Now I would like to recognize the gentleman from Illinois, Mr. Shimkus, for five minutes.

Mr. Shimkus. Thank you, Madam -- thank you, Madam Chairman.

When my colleague from California was talking about that plan I thought she was talking about an Obamacare plan.

In March 26th, 2018 I got this email from Ms. Penny from Centralia who said, we are a small company that employs five people. We just received our new health insurance premiums for 2018 with a rate increase of $650 per month -- that was an increase of $650 per month -- and a higher deductible ranging from $3,200 to $4,000.

Nothing has been done to resolve the health -- and then she goes -- just complains about being forced to buy an insurance product that she can't use.

And in rural America we heard this quite a bit. Small businesses forced to buy insurance they can't use because they can't use -- it costs so much and then the deductible is so high

that they're not covered.

So that is why this is a really important discussion. I am also glad finally my colleagues -- I was up at a telecom, or down at a telecom hearing so I missed some of this debate. But it sounds like we are talking about, quote, unquote, "junk plans." So let us -- what are -- what are these junk plans?

The -- well, we will see. The Trump administration has permitted workers in small businesses to pull together to buy insurance known as association health plans. I have always been a supporter of that. Farm bureau, manufacturing association, chamber of commerce -- bigger pools negotiating.

Obviously, my colleagues call all these junk plans, even though most of these so-called junk plans comply with ACA mandates. They aren't charging people different premiums based upon health conditions and they are not banning people with preexisting conditions from enrolling.

So, Ms. Turner, do you think labeling association health plans as junk is a fair description for coverage that many hardworking Americans seek out and choose to buy for their family?

Ms. Turner. I am very supportive of giving small companies in particular more options for health insurance, which is what association health plans do, and individuals also need other options, which is what the short-term limited duration plans

provide.

There was a study recently -- I think just last week -- about association health plans and they were in fact providing coverage as comprehensive as larger companies and they were not excluding people with preexisting conditions.

Mr. Shimkus. I think one of the thing that fired us up so much about this debate was the debate who is to determine what policies we have. When we thought this was going to go to the Supreme Court, we thought it would stand on the inability of the national government to tell you what you had to buy.

In fact, when this was debated here in the halls of Congress, that was -- that was the arguing point. We said this is not constitutional.

Then the -- then the administration fought for constitutionality based upon not the right of the individual to make a choice what they want to buy but on the right to tax.

So that is why it was upheld, not on the individual being forced to buy something, especially my constituents were being forced to buy something that they can't use, as Ms. Penny has highlighted here, and she is trying to provide for her employees and she can't do it.

So the employees across the country are already taking advantage of this option to provide more affordable insurance

to their workers. In fact, 28 AHPs have formed already with some showing up to 30 percent savings on premiums.

The Las Vegas Chamber of Commerce is in the process of signing up 500 employees for an AHP, which could save some employees more than $2,000 per year.

Ms. Turner, do you -- again, if these plans are junk why are they so attractive to business owners and their employees?

Ms. Turner. People are just desperate for choices. They feel shut out of the market not only because of the premiums under the comprehensive coverage under the ACA but also because of the deductibles which can be $10,000 a year for -- in the ACA plans.

And so people are looking for other options -- short-term limited duration plans or bridge coverage and other ways to get economies of scale through association health plans and letting states have more power through their 1332 options.

Mr. Shimkus. Yes, and I will end this. I appreciate it.

We Republicans believe in markets and competition, not centralized control dictates from the national government authority and that is why we are -- I am glad we are having this hearing today and I look forward to more discussions.

And with that, Madam Chairman, I yield back my time.

Ms. Eshoo. I thank the gentleman. Just for the record, this hearing is not about association health plans. We are

talking about the short-term, what they cover, what they don't. And so I think it would be wise to stay away from conflating things and putting words in other people's mouths that they haven't -- that they haven't uttered.

Mr. Shimkus. Will the -- will the gentlelady -- will the gentlelady yield --

Ms. Eshoo. No, I want to move on.

Mr. Shimkus. -- for discussion?

Ms. Eshoo. No, because this hearing is on these short-term plans, not on association health plans. So I think it is important to --

Mr. Shimkus. So you appreciate association health plans? Is that --

Ms. Eshoo. I do --

Mr. Shimkus. Okay. Very good.

Ms. Eshoo. -- except for what the administration is doing to some of them. We can have a hearing on that. But today's hearing is not about association health plans.

I now would like to recognize the gentlewoman from Florida, a valuable member of our committee always, Ms. Castor, for five minutes of questioning.

Ms. Castor. Well, thank you, Madam Chair. Thank you for holding this very important hearing on our legislation to address

the Trump administration's sabotage on affordable health care for our families back home, including my bill, H.R. 1010 that will stop the expansion of these junk health insurance plans.

See, working families across America they remember well the attempt by the Trump administration and Republicans in Congress to repeal the ACA in its entirety, including the protection on preexisting conditions.

What the Congress -- the Republican Congress was not able to accomplish here they are now trying to accomplish through administrative rule and that is where they have now adopted an administrative rule that would expand the use of these junk insurance plans that do allow discrimination for -- if you have a preexisting condition like a cancer diagnosis or diabetes or asthma or something like that.

These junk plans also deny basic health benefits. So that is why I filed H.R. 1010 along with my colleagues, Congresswoman Barragan and other members, to address these plans that really don't protect our neighbors as they should.

It really is difficult to understand why the administration is promoting plans that do not provide adequate coverage. It really appears to be a cynical ploy to lure families into these plans that were too prevalent before the Affordable Care Act where benefits were excluded and families faced massive health care

bills.

I am very concerned that the public is being snookered here and, Commissioner Altman, I would like to ask you a few questions about this -- about these junk plans. I understand that these plans often impose lifetime and annual limits on care. Is that right?

Ms. Altman. That is correct.

Ms. Castor. So can you describe what these plans typically look like, how they are marketed, what kind of coverage they provide?

Ms. Altman. Sure. I think to the average consumer the plans can look like they cover a lot of things. They have coverage for hospitalization, coverage for ambulance transport, coverage for doctor's visits -- some of those things.

But when you begin to look beneath that, first of all, there are many exclusions, both in terms of certain benefit categories like mental health and prescription drugs and maternity but also for any care related to a preexisting condition, whether determined before the plan was issued or after, exclusions for any injury that is -- results from sports activities or other risky activities -- things like that.

Then you have cost sharing, high deductibles, co-payments, coinsurance. Then you have annual limits on coverage --

potentially lifetime limits on coverage -- although as a short-term plan it is unlikely someone would be able to retain this plan for a lifetime.

And then you get into what they actually cover within those categories of benefits. I think the story I shared in my testimony is very indicative of the fact that the coverage levels are not reflective of the cost of services.

So a consumer may see it covers $100 or $200 for an ambulance ride, and that may sound reasonable to them and, like, coverage. But, of course, we know an ambulance ride generally costs well over $1,000.

Ms. Castor. So then they are stuck paying that?

Ms. Altman. Correct.

Ms. Castor. Unlike an Affordable Care Act policy. So we have heard a lot of discussion about choice here today and choice is important -- that under the Affordable Care Act individual market policies in your state I read in the testimony you actually have more -- had another insurer come into the marketplace. Are there -- is there adequate choice among those policies that are being offered in Pennsylvania right now?

Ms. Altman. That is correct. We have put in a lot of work to get our individual market in a very good place. I approved statewide average decreases this year. We have --

Ms. Castor. Wait. Wait. You have increased competition and choice and Pennsylvania is now lowering costs?

Ms. Altman. Correct. We have a new entrant. Thirty of Pennsylvania's 67 counties had more insurers offering coverage this past year compared to the year before and we reduced our single-care counties from 20 to 10 simply by working to make the market a place for --

Ms. Castor. But if we had more junk health plans it would seem that that would be a false choice for folks because they would be on the hook for substantial costs. Is that right? Do you agree with that?

Ms. Altman. If they chose that route and, of course, for over one in four Pennsylvanians who have preexisting conditions those plans are no choice at all.

Ms. Castor. And I would like to offer the groups that are now endorsing H.R. 1010. If folks are confused by some of the debate here today here are some trusted organizations that now support the expansion of junk health plans: American Heart Association, American Lung Association, AARP, Cystic Fibrosis Foundation, March of Dimes, to name a few.

Thank you, and I yield back.

Ms. Eshoo. I thank the gentlewoman. I thank her for the legislation that she is offering.

It is now my pleasure to recognize the ranking member of the full committee, Mr. Walden, of Oregon.

Mr. Walden. Good morning again.

Ms. Eshoo. Yes.

Mr. Walden. You must be torn as I am with the other hearing going on downstairs. I know your passion for telecommunications issues as well.

Ms. Eshoo. In fact, I am going to ask Ms. Castor to come to this chair, take the gavel, and have you proceed.

Mr. Walden. Perfect. Thank you.

Thank you, Madam Chair, and I want to thank our witnesses. This is really important issues for all of us to contemplate, and I know -- I met with some wheat growers from my district yesterday, as fate would have it, and guess what issue came up? It was high cost of health care and health insurance -- both the cost of individual items in the health care continuum but also the health insurance.

And I am trying to remember -- I should have made a note on it -- but I think one of the growers talked to me about how his rates per month had gone from, like, $300 to $600 to $900. Now, it is, like, $1,000 a month for him and his wife, and the deductible I am going to say was somewhere between $6,000 and $8,000.

So to my friend's comment about the consumer picking up the difference in charge, there are a lot of consumers now as a result of these enormously high deductibles you have to do to get a premium you might be able to afford you are paying it out of pocket through your deductible.

And so I think what I am trying to get at and Republicans are is how do we have choices out there that fit families that they can afford that will actually give them first dollar -- not first but an affordable family dollar health insurance and not something that amounts to something that is catastrophic.

I do hope we do hearings on association health plans. I do think we have the right to talk about them in the context of this hearing, by the way, and I do hope we will eventually hear from the majority -- Democrats -- about a hearing on Medicare for all because we know by the estimates that would cost $3.2 trillion and do away with the health insurance that 150-plus million Americans have through their unions or their employers. And with the strength of the economy more and more people are showing up on those plans and probably fewer on the others.

And maybe, Ms. Turner, you could address this -- my understanding is under the Obama administration there was a three-month period for short-term limited duration plans. The Trump administration simply said to states, you can go up to 12.

But states have the right to step in here and regulate as they see fit, right? Is that correct?

Ms. Turner. Yes, absolutely.

Mr. Walden. And so there are some 33 states that have left the door open for this innovation to occur, correct?

Ms. Turner. Yes.

Mr. Walden. And so when you're looking at options people can afford that work for them, do these states -- do these plans that are out there -- do they -- do you think they give them options that work, or not?

Ms. Turner. Consumers will determine that, and I absolutely agree that having state flexibility allows the states to -- I mean, they are much better, frankly, at regulating local health insurance markets in their state than Washington can be and really figuring out what other consumers need -- more information about these plans --

Mr. Walden. Right.

Ms. Turner. -- to make sure they are buying insurance that works for them and that they are smart informed buyers.

Mr. Walden. Uh-huh.

Ms. Altman, I am intrigued that the rates went down in Pennsylvania, correct? Is that right? So that is this year? Was that for all the plans?

Ms. Altman. In the individual market.

Mr. Walden. In the individual market. How much over the last five --

Ms. Altman. But that is the statewide average, not all of the plans were done on their own but on average yes.

Mr. Walden. Yes. Understood. Yes.

Over the last, say, five years what has happened in terms of rates in Pennsylvania in the individual market, on average?

Ms. Altman. Sure. There is no question that rates have gone up in this market. I think there are --

Mr. Walden. How much?

Ms. Altman. I don't know off the top of my head the increase.

Mr. Walden. How much did they go up the year before?

Ms. Altman. So the year before they went up around 25 to 30 percent.

Mr. Walden. And how much did they --

Ms. Altman. But that is an important year because they should have gone up 6 percent and in that year the reason they did not was because of the decision to cease paying cost-sharing reductions and uncertainty created by the --

Mr. Walden. How much did they go up the year before that?

Ms. Altman. Around I want to say -- you are testing my memory -- about 15 percent and about 8 the year before that.

Mr. Walden. So 8, 15, 20, what?

Ms. Altman. And then at 20 --

Mr. Walden. Twenty.

Ms. Altman. -- and then minus two.

Mr. Walden. And minus two. So they went down but they went down 2 percent after they had gone up. I am trying to remember that first year with the cost-sharing deal. Twenty-five percent they went up?

Ms. Altman. Sure. It should have been 15.

Mr. Walden. Fifteen and 8. I am a journalism major so I will let somebody else do the math. But the long and the short of it is consumers didn't get a $2,500 per year reductions in their premiums along the way, right?

Ms. Altman. Well, of course, 80 percent of consumers in that market received financial assistance that largely shields them from those --

Mr. Walden. Correct. And so my wheat grower friends that aren't eligible for that are small entrepreneurs. They have gotten socked with rate increases. They don't get the subsidies. They are the kind of working middle class folks that are just off the subsidy side because they are just at that realm.

I had a town hall -- one two years ago in Arlington, Oregon, and actually we had this debate there and this farmer got up and

talked about what his family had faced, and this person who was very much in support of the ACA -- Obamacare -- went up to him afterwards and said, I didn't know people like you existed. He was very serious about it.

So we have this gap out there that some of us are trying to figure out a way to fill and that is what Republicans are talking about -- how do we fill that gap for those people that don't get the subsidies you get on the exchange if you are the right income but you are still left out with a high deductible and premiums off the charts?

My time has expired, Madam Chair? Thank you for your indulgence.

Ms. Castor. [Presiding.] Thank you.

Mr. Schrader is recognized for five minutes.

Mr. Schrader. Thank you, Madam Chair, and I appreciate the previous gentleman's discussion -- the ranking member of the committee -- and there has been a lot of discussion about the cost of the premiums, the deductibles, in the individual marketplace.

I think it is important for America and a lot of people here to understand that that is only one facet of the Affordable Care Act, and the rest of the Affordable Care Act, ostensibly, is working very well.

We heard last Congress of the repeal and replace debate that, frankly, a lot of red state people were very pleased that the Medicaid situation changed dramatically for them.

Many millions of Americans had health care for the first time. So I guess I would like to look to my colleagues and say, hey, let us work on the individual marketplace. I am fine with that, and I think there is an opportunity for us to work together and maybe adjust the cost-sharing stuff, the reinsurance issues or risk pools or and maybe expand the 1332 waivers but under constraints.

You know, the people forget -- I come from Oregon -- people forget that the goal of health care is to provide better health. It is not to get insurance. And, ostensibly, getting better health means you don't have to read the fine print all the time.

There is some commonality in these plans that are out there and you have the opportunity to buy a product that covers what people would call essential health benefits -- that overall that someone had a mother, someone has got a daughter out there. I mean, you know, being a woman and having maternity care should be an option.

I mean, everyone benefits from that over the long haul and the goal of insurance -- to provide health care -- is to prevent

people from getting too sick to begin with and that has gotten lost, I think, in a lot of the debate.

So I am hoping that we actually get to that.

Ms. Turner, real quickly, with these short-term plans and the expansion of the short term plans, how do you actually justify that when the rules of the road clearly state that the waivers that are granted under 1332 are only supposed to be for those plans that provide coverage that is at least as comprehensive as the coverage under the exchanges and that the coverage and cost-sharing protections are as affordable?

In other words, they go together -- again, getting at the fact the undermining of these essential benefits I think is disingenuous to a lot of American consumers. What is the justification for doing that in these newer short-term plans the administration has put forward?

Ms. Turner. The administration has spent I think about a year with a lot of career federal officials looking at this and how can you write the rule in a way that is compliant with the text of the ACA to make sure they are comprehensive, they don't increase the deficit, they are at least as affordable to make sure that that would be allowed. So the rules would have to allow to make sure if people did buy short-term plan that it fit these criteria.

So all the short-term plans are not junk plans. In fact, I think very few of them are. Buyer beware. People need to be aware, they need to be informed, and there are protections if they are going to use a subsidy for these plans to make sure that they are compliant with the ACA.

Mr. Schrader. Well, and I think you write the rules in the way you would like to write the rules and I think that is challengeable and we are going to see I think that reverse either in the courts or in this particular Congress.

Ms. Altman, a lot of discussion about 1332 waivers and the ability for them to give states the opportunity to innovate. I totally agree with that. Oregon has been doing that for years.

The Affordable Care Act really, I think, points that out as a great opportunity for states. I don't think there is any disagreement with that and it is being done and has been done prior to this current administration very successfully. But it has been with these essential health benefits in play and it hasn't been, I think, a curse or restrictive.

Please talk a little bit about the role those essential health benefits play in the waiver programs.

Ms. Altman. Sure. So essential health benefits are sort of 10 categories of core benefits that the Affordable Care Act was supposed to guarantee access to so that people with health

care needs could have the benefits that they need to get the treatment they need regardless of the type of condition that they have.

Those are what ensure that whether you have a mental health issue, a physical health issue, an emergency or cancer, those benefits will be available and they were intended through the guardrails in the ACA to be extended to any coverage offered through the 1332 waivers.

Mr. Schrader. Thank you.

And Ms. Keith, I mean, given the fact that ostensibly the Health and Human Services Department of the United States of America's goal is to help Americans get quality affordable health care, how do you think the current administration justifies curtailing the enrollment outreach programs? That makes no sense to me.

Ms. Keith. I won't try to speak for them or on their behalf. My understanding is they think this is a more cost-efficient way and that they believe that outreach in enrollment funding is not cost effective.

I would counter there have been other examples from other states -- Covered California is an example -- that attributes a decline in 6 to 8 percent of premiums just from the outreach and marketing work that they did to bring in healthy consumers.

So it does, certainly -- has been shown to help stabilize premiums.

Mr. Schrader. Thank you very much, and I yield back.

Ms. Castor. Thank you.

Mr. Long is recognized for five minutes.

Mr. Long. Thank you, Madam Chairwoman.

Ms. Turner, I would like to talk about the roles that navigators and independent agents and brokers played. You note in the plan in your -- you note that for the plan year 2017 navigators received more than $62 million in federal grants while enrolling less than 1 percent of all enrollees. Seventeen of these navigators enrolled fewer than 100 each at an average cost of $5,000 per enrollee.

The top 10 most costly navigators spent over $2.5 million to enroll 314 people. One grantee received $200,000 and enrolled one person and over three-quarters of navigators failed to achieve their enrollment goals while spending more than $50 million.

Ms. Turner, under the Trump administration CMS has changed how navigators receive funding based on performance measures. Do you think that these changes help ensure accountability within the navigator program?

Ms. Turner. CMS has said in its report that it really is trying to respect that taxpayer dollars be spent wisely and,

basically, they are -- they are making the following year's grant contingent on a navigator meeting their previous year enrollment goals.

And as you say, even with this generous funding, the navigators enrolled less -- fewer than 1 percent of all enrollees in healthcare.gov. And so I think that does need to -- we need to look at how can we get the best benefit and they looked at private brokers and agents who are -- who live and breathe in this space and they were much more successful, enrolling 42 percent of enrollees.

Mr. Long. The subject of this hearing is about reversing ACA's sabotage. Do you consider these efforts by CMS as sabotaging the ACA?

Ms. Turner. No, and the navigators were particularly -- when the ACA was new, people didn't even know what a deductible was. So people needed to be educated about the fundamental principles of insurance.

But now that we see in California, for example, there has been a 24 percent drop in new enrollees, despite their spending $100 million on marketing navigators last fall. But they are finding many more people are having their coverage renewed and sometimes automatically renewed.

So we are in a different space now with the ACA.

Mr. Long. According to the Missouri Department of Insurance, since 2011 the annual cost of coverage per individual has increased by an estimated 235 percent in the individual market and now there is only one option on the marketplace for my entire district -- 7th District of Missouri.

Do you see the efforts of the Trump administration to give states more flexibility to lower premiums and provide more insurance options for individuals as positive steps that can benefit consumers?

Ms. Turner. Absolutely, and I think that is what they are trying to do both with the bridge plans as well as the association health plans and as well as the Section 1332 flexibility.

Being able to tailor the needs -- the insurance funding to the needs of their citizens is something that states can do much more effectively than the federal government.

Mr. Long. So I am assuming you don't consider these efforts as sabotaging the ACA?

Ms. Turner. I think they are really trying to give consumers new options, particularly those who are shut out of the market because of costs and even many of the people with ACA coverage say, I might as well not have coverage because I can't afford the $6,000 to $10,000 deductible.

Mr. Long. Thank you.

And before I yield back, as a point of personal privilege, I was born in 1955. John Dingell was sworn into Congress in 1955. I had the great honor to serve with him for two terms.

Of course, the room downstairs is named after him. Yesterday morning after an hour delay because of weather we loaded up two plane loads of congressmen headed to his funeral in Dearborn and got up there and circled for an hour waiting for the temperature to raise one degree.

If it would have raised one degree we would have made it, and we didn't. We were low on fuel, and so a legend in his own time, John Lewis -- Representative John Lewis -- and Speaker Pelosi, who weren't on the flight, along with Chairman Upton, Chairman Walden was there, Anna Eshoo.

I am not going to name all the names because I will leave people out. But we held an impromptu service for John at 30,000 feet and I just want to send out my best to Debbie. I know that John followed his father in Congress and Debbie has followed him and she has done an outstanding job on this committee, and I just wanted to send my best and thoughts and prayers out to Debbie and the entire Dingell family because we are sure going to miss him.

I yield back.

Ms. Castor. Thank you, Mr. Long, for your comments about

the Dean of the House, John Dingell.

Mr. Ruiz is recognized for five minutes.

Mr. Ruiz. Thank you, Ms. Chairwoman.

I, and everybody in this room, agrees that we need to do something about costs. The premiums are skyrocketing in the exchange. That is not the issue that we are debating here.

When we look back at why the costs have gone up so much, all we have to do is listen to the insurance companies themselves which have said and have warned that if we don't pay the cost-sharing reduction subsidies they are going to increase costs.

The other thing is they talked about the changes that were made by Senate Republicans to the risk corridors. They increased costs because of those. The other is because of the expire reinsurance programs, et cetera, and all of these have been a part of the repeal efforts of the ACA.

So when we look at the junk plans, this is not a solution to the problem of high costs. In fact, these junk plans will make costs higher in the exchange because this will siphon low healthy high corporate profit type patients into this lower risk pool -- junk plans -- leaving behind the higher risk more expensive type of patients for everybody else.

So health care costs for everybody else will go up, and if

there is something that I have learned as an emergency physician is that not every health person stays healthy forever.

So I have seen a 48-year-old man in a motor vehicle collision who was previously completely healthy who will now have traumatic brain injury, symptomotologies for the rest of their lives, and be paralyzed and require very expensive care and lots of medications.

I have seen a 52-year-old man who comes in with yellow eyes and yellow skin who have been newly diagnosed with severe liver problems due to hepatitis, which is going to require expensive medications.

And I have seen young and healthy 30-year-old women who come in with anxiety or depression with new diagnoses of clinical depression and also with a mass in their breast with a working diagnoses of breast cancer that has metastasized which would require expensive chemotherapy.

So even if those younger and healthy individuals buy this junk plan, health care costs will be more expensive for them because under these junk plans they can choose not to cover their medication. They can choose not to cover their mental health coverage. They can start implementing a cap in lifetime coverage for these individuals that will need more care for longer period of times.

We are not invincible. The whole purpose of health insurance is what if you get sick, what if you get injured during an accident. And I have seen them and I have counseled family members and patients about their terrible diagnoses or their terrible prognoses and it is not a fun thing to do.

So I have some questions in regards to costs. Ms. Keith, would junk plans increase costs for everybody else and can you explain it further, please?

Ms. Keith. Yes, that is correct. Every analysis, including the Trump administration's own analysis, has found that expansion of these short-term plans through this new rule are increasing premiums in the ACA marketplaces.

A study by the Kaiser Family Foundation that looked at what insurance companies actually said about their premiums for 2019 showed that short-term plans, the individual mandate, repeal and the association health plan have increased premiums on average by 6 percent in 2019.

Mr. Ruiz. And so, you know, in one way I am hearing this opposing kind of arguments -- yes, we are for preexisting but we need a reduced cost. But it seems like by this junk plan they are going to eliminate protections for preexisting illnesses in order to keep costs down because corporate insurance companies would love not to cover the sick. They would like to cover the

wealthy and healthy.

So can you have it both ways in this junk plan? I mean, do they discriminate with people with preexisting illnesses?

Ms. Keith. They absolutely do. I believe that is their business model, yes.

Mr. Ruiz. So if you support junk plans you are supporting the idea that -- to take us back to a time where health insurances were allowed to deny or charge higher premiums or charge for higher -- or not cover certain procedures for those conditions. Is that correct?

Ms. Keith. Yes, it is.

Mr. Ruiz. Can you describe the medical underwriting process that Americans are subject to under these plans?

Ms. Keith. Sure. So it varies by insurance company but, essentially, if you are applying to enroll in a short-term plan you would fill out a very detailed health questionnaire about your own health, about the health of your family members and maybe a medical history.

You would also grant that insurance company access to all of your medical records. They would look at what prescription drugs you have taken. They would look at what medical exams you have taken.

They would take that information and they would give you

a price or they would decline to cover you at all or they would use that to dictate what benefits they will and will not cover.

Mr. Ruiz. Thank you.

Ms. Castor. Thank you.

Dr. Bucshon, you are recognized for five minutes.

Mr. Bucshon. Thank you, and just in light of my friend Dr. Ruiz's comments, it is about choice. If you have a preexisting condition, don't choose a short-term health plan that is cheap. They don't discriminate at all because it is a consumer choice. So to say that a plan specifically discriminates against people that is just factually not true. They don't discriminate because it is about consumer choice.

We are here today discussing legislative proposals that really do nothing, in my opinion, to address the high cost of health care and the lack of affordable insurance options for patients.

One thing -- again, Congress is here discussing the cost of health insurance plans but, again, we are not really addressing the true problem, in my view, which is the cost of the product is too expensive.

And so if we all continue to chase a product that is too expensive and try to cover it we are never going to catch up, in my view.

The other thing is is insurance is about risk. That is what insurance is about. So your description, Ms. Keith, of all of these things -- about being assessed for what your risk is, that is what insurance is about. And so we need to find out -- figure out a way to cover people who have a lot of risk and that is what Republicans did in our health care bill.

We did it with high risk pools. What is it, 4 percent of the people or 5 percent of the people in the country are 40 to 50 percent of the health care costs?

So we want to cover people with preexisting conditions but we just want to do it in a different way. If you put everybody in the same pool there is no way, based on the history of insurance and how it works, that actuaries will tell you that you can get the costs down for everybody and keep the costs low. It just doesn't work.

So we want to cover people with preexisting conditions. I was a physician before. I had people that I took care of that didn't have coverage. That is wrong. We just want to do it in a different way.

So, Ms. Turner, do you think that any of the legislative proposals today would address the high cost of health care plans?

Ms. Turner. I actually think they would. They would remove options for many consumers. Three million people had dropped

out of the individual market before the first short-term limited duration plan under the Trump administration rules was available.

People are dropping out of coverage because they couldn't afford it. They want some options, and bridge coverage through the short-term plans provides many people an option. They should definitely be informed about these policies.

But if they buy a policy and they -- say they buy a year policy and they are diagnosed with cancer when they have that coverage they are covered and if they didn't have that option they would be completely exposed to those costs.

Mr. Bucshon. Yes. I think everyone here agrees on both sides of the aisle we need more probably disclosure to consumers and make sure consumers -- like someone mentioned, have it in big print right on the front page -- you know, what your choice is here -- you know, what the cost is, number one, but number two, what actually is included in these plans, right.

And it may -- you are right, if you have -- if you are underwritten and you are high risk you are probably not going to be able to get insurance through one of these plans. That is not the point. That is not what we were trying to cover.

But under the Affordable Care Act, I hear from constituents all the time that the plans are just not affordable in the Affordable Care Act and so we need to work together to try to

find a way to improve that and, you know, one of the things I think that we can do is work on the cost to the product and I keep saying that because Congress always works on trying to provide coverage but not trying to get the cost of health care down.

So, Ms. Turner, how do you think repealing the Trump administration's guidance on Section 1332 innovation waivers would impact the affordability for patients in states with waivers?

Ms. Turner. The states that have received waivers so far have been able to reduce premiums anywhere from 43 percent to 7 percent in the states so far that we have numbers for and so those citizens would definitely be adversely impacted by being thrown back into the same pools that don't provide states with the same flexibility and the same options that they would have under this new guidance to be able to provide more affordable options for their -- for their residents.

And about the essential benefits, the essential benefits in the ACA may not be everything that somebody needs. Janet, that I talked about in my example --

Mr. Bucshon. Right.

Ms. Turner. -- needed to have her anti-rejection medicines covered and they were not covered under her ACA-compliant plan.

So states need to be able to make sure the plans work for their citizens.

Mr. Bucshon. I want to briefly talk about cost-sharing reduction payments which everyone is saying is sabotage of the ACA. That was a bailout, in my opinion, put into the law so that if the pools didn't work -- insurance companies were losing money -- they had a federal backstop with taxpayers footing the bill.

I yield back.

Ms. Castor. Thank you.

Ms. Kuster is recognized for five minutes.

Ms. Kuster. Thank you, and thank you for your testimony. I appreciate it.

I want to join my colleagues in honoring John Dingell and our mile-high memorial yesterday for him, and we will all be together with Debbie Dingell, our colleague, and her family tomorrow.

I just want to move on to the Section 1332 and direct my questions, if I could, to Professor Keith. There is clear statutory directive in Section 1332 that states must provide comprehensible and affordable coverage to a comparable number of residents under the ACA.

But, unfortunately, last fall the Trump administration issued new guidance and I am afraid that that is going to hurt

people with preexisting conditions like my dear friend, Bodie, who is a young man with spinal muscular atrophy in my district, necessitating a wheelchair to get around.

Thanks to the ACA, there is no longer broad-based exclusions to wheelchairs or to all the other affordable health care that helps Bodie lead a fulfilling life.

But for Americans like Bodie this concerns me in this Trump guidance because it runs counter to the statutory directives. So last week, I introduced H.R. 986, the Protecting Americans With Preexisting Conditions Act, to nullify the new guidance.

I have heard from my Republican colleagues this morning that they want to protect Americans with preexisting conditions and I would encourage them to sign on to my bill.

If I could, Professor Keith, I would like to suggest a quick lightning round about my concerns of these short-term limited duration insurance products so that Americans will understand our concerns.

If you could just respond -- under these plans are insurers allowed to refuse to offer a policy to an individual with a preexisting condition?

Ms. Keith. Yes, they are.

Ms. Kuster. And are insurers allowed to exclude coverage for preexisting conditions?

Ms. Keith. Yes.

Ms. Kuster. And are insurers allowed to charge higher monthly premiums based on health status and factors such as age and gender?

Ms. Keith. That is correct.

Ms. Kuster. And are insurers allowed to impose annual or lifetime dollar limits on care?

Ms. Keith. Yes.

Ms. Kuster. And are insurers allowed to opt not to cover entire categories of benefits? Here, I am thinking of mental health services, prescription drugs, or maternity care.

Ms. Keith. That is correct.

Ms. Kuster. And are insurers even in states like Pennsylvania, New Hampshire, West Virginia, that had been so hard hit by this opioid epidemic, allowed to offer policies that do not include coverage for substance abuse treatment?

Ms. Keith. That is correct.

Ms. Kuster. And are insurers allowed to retroactively cancel coverage once care is needed?

Ms. Keith. Yes. That has been one of the biggest abuses and something that the Affordable Care Act prohibited.

Ms. Kuster. And are insurers allowed to impose much higher out-of-pocket costs than under the Affordable Care Act?

Ms. Keith. That is correct.

Ms. Kuster. And so I would simply ask you or Commissioner Altman, if you could, we have heard from Ms. Turner about her opinion that these plans protect consumers and bring down costs. Are there alternatives -- waivers such as reinsurance products that could bring down costs for consumers?

Ms. Altman. Absolutely. There are other mechanisms out there -- and reinsurance is a great example -- that can lower costs for those to help afford premiums without putting people in the position of having to choose between no coverage or substandard coverage like the short-term plans provide.

Ms. Kuster. So it is your professional opinion that rather than this list that we have gone through this morning of ways that insurance companies are choosing to make higher profits -- and I believe you have testified the profits are as high as 50 percent of every premium dollar?

Ms. Altman. Actually, even -- there are some even higher than that. The two largest carriers with 80 percent of the market do spend less than $0.50 of every premium dollar on care. The rest is some administrative cost and the rest profit.

Ms. Kuster. Which is shocking to the American people. Rather than all that premium dollar going into profit while families are put at risk, you believe there is alternative that

this committee could consider to focus on reinsurance or risk pools?

Ms. Altman. I do, so that no one has to choose between their health and their financial well being.

Ms. Kuster. Thank you. My time is up but I very much appreciate that.

Ms. Altman. You are welcome.

Ms. Kuster. I yield back.

Ms. Castor. Thank you.

Mr. Gianforte is recognized for five minutes.

Mr. Gianforte. Thank you, Madam Chair, and I thank the panelists for being here and your testimony.

Hardworking Montanans regularly tell me how their health care costs continue to rise and benefits shrink. I just had a town hall this week and individuals in Missoula and Livingstone, Montana, both raised this very issue. It is a real burden on families in Montana.

Obamacare has not provided an affordable option for many Montanans. In the first year of Obamacare, more than 20,000 Montanans lost their coverage because of the law and in the first three years under Obamacare Montanans' premiums have shot up 66 percent, and we had testimony you have had similar experience in Pennsylvania.

Unfortunately, premiums continue to skyrocket for Montanans and Americans across the country under the current scheme. Thankfully, the Trump administration is empowering states to address these rising health care costs by allowing states greater flexibility with the strict federal mandates of Obamacare.

The Department of Health and Human Services is effectively allowing more Americans to get coverage that best suits their needs. The administration has implemented rule changes that expand state innovation waivers to improve access to short-term limited duration insurance plans, eliminate the costly individual mandate penalty, expand association health care plans. These measures entrust consumers to pick the best health care for their family.

Let us be frank. Obamacare has robbed consumers of choice. Obamacare asserted that a Washington bureaucrat knows an individual's health care needs better than she does. The Trump administration changes are empowering consumers so they can make health care decisions that work best for themselves and their families, providing waivers, empower states to promote innovation that benefits patients and consumers.

The state innovation waivers, originally born in the Obama administration and expanded under President Trump, allow states to be creative with health care solutions while saving money and

lowering premiums, which is the issue I hear over and over again as I travel our state.

Alaska has taken advantage of the waivers. We have talked about this. They saw premiums drop in some plans by over 40 percent. We heard testimony today -- similar experience in Maryland and other states.

Unfortunately, for a second week in a row members of the majority here have put on a political theater. They want the American people to believe that there are lawmakers who oppose protections for Americans with preexisting conditions.

I don't know of any Democrats or Republicans on this committee that are in favor of this, who want to strip protections for Americans with preexisting conditions. We all agree on that. There is broad bipartisan support here.

I think we should work together to find permanent legislative solutions that protects people with preexisting conditions.

I also think we should work together to continue empowering states to innovate and address health care affordability -- I know that is the issue back in Montana -- and we should encourage innovation and affordability, not terminate efforts to improve health care and make it more affordable.

Ms. Turner, these state innovation waivers that allow for flexibility and creativity for the states who want to find cost

savings solutions, do you think that we would continue to see this sort of cost savings and innovation if we move to a single-payer government-run Medicare for all program?

Ms. Turner. No, and I think what we would find is that the American people would see -- they would not have any choice. It would be the single-payer government program, whatever form that takes.

And what we are seeing is the states are so much better able to be able to fine tune funding to the needs of their citizens. The American Health Care Act that this Congress passed in 2017 provided specific money to the states, $123 billion, to be able to help with those high-cost patients. So they had better protection than being thrown into the same pool and often having benefits denied.

Mr. Gianforte. Yes. So what would the effect be of stopping these -- the state relief and empowerment waivers on individuals in the states where that ability to innovate was taken away?

Ms. Turner. The states would basically become functionaries for the federal government. It would really undermine our system of government, I think, in giving the federal government so much control.

One of the things that we have learned through these waivers

and through the 70 changes plus that have been made to the ACA so far is that we need to have more flexibility and more state control.

Mr. Gianforte. Okay. Thank you, and I yield back.

Ms. Castor. Thank you.

Mr. Sarbanes, you are recognized for five minutes.

Mr. Sarbanes. Thank you, Madam Chair. I thank the panel for your testimony.

Ms. Altman and Ms. Keith, maybe you could tell me -- the short-term plans that we have been talking about, the people offering those plans can and do deny people or reject people based on a preexisting condition, do they not, in some instances?

Ms. Keith. They do. That is correct.

Mr. Sarbanes. Yes. So it is incompatible, it seems to me, to claim as we are hearing from a lot of the members on the other side that they absolutely want to protect people against discrimination based on preexisting conditions, on the one hand, but to defend the short -- these short-term limited duration plans on the other hand because those plans actually put people in that position of being able to be denied, based on that situation. Would you agree there is some incompatibility there?

Ms. Keith. I think that is correct, and these short-term plans exacerbate, I think, many of the out-of-pocket costs that

everyone in this hearing has said they are concerned about. So folks who maybe are healthy enough to enroll in a short-term plan but then become sick can face catastrophic costs that should concern all of us.

Mr. Sarbanes. It is this -- it is this distinction that we were able to focus on when we put the ACA together originally where people are seduced into thinking that they have got their health situation covered and are doing that relatively inexpensively, only to then find if they do get sick that they are out of luck because the deductibles are incredibly high or the benefits that they thought they would be entitled to are not available to them. There were the caps that the insurance industry would place on how much it would cover.

So, in a sense, you are buying the health care equivalent of a pig in a poke when you are buying these short-term limited duration plans.

Why, by expanding the duration of them up to a year, we wouldn't view that as going back to the bad old days, which were the -- which produced all these stories of heartache that motivated us to try to make these changes, I can't -- I can't understand for a moment why anyone would support that kind of a policy shift.

But I wanted to ask you a specific question, which is that

these short-term junk plans, as we are calling them over here on this side, where they can reject a beneficiary based on HIV status, based on weight, pregnancy, other kinds of things, could somebody apply for one of those plans, check a box saying they don't have a preexisting condition because they are not aware?

And that was the other things we discovered when we were -- when we were doing this. How many things qualify as preexisting conditions that no one would ever imagine would disqualify them from coverage?

So somebody could get into a plan and then when they go to get the benefits of it they would discover then that they are not qualified for those based on this preexisting condition disqualification.

Could that happen? And so then you are trying to access it and, boom, you can't access it and you are -- and not only that, you are thrown off the plan at that point because they say oh, you -- you know, you weren't qualified in the first place after you have paid premiums for I don't know how many months and I don't know whether you would get those back. But is that a fair dilemma that people can find themselves in?

Ms. Keith. That is absolutely correct. What you are describing is something called post-claims underwriting that an insurance company would use to go back and see if there is

something that the consumer did not disclose or something, in their view, they omitted.

What the insurance company would typically do is retroactively cancel the policy altogether.

Mr. Sarbanes. Yes. So basically these -- did you want to comment?

Ms. Altman. I am just going to add I think it is important to note that we are not talking about cases where patients intentionally did not disclose --

Mr. Sarbanes. Right. Right.

Ms. Altman. -- because fraud -- true fraud has always been a reason. Cases where something was noted on a medical record that they may not have remembered, potentially didn't even know about because their doctor --

Mr. Sarbanes. Right.

Ms. Altman. -- wrote it in the notes without explaining to them, or in the case that I listed in my testimony, they were never diagnosed or sought care but were -- experienced symptoms for which the insurer deems they should have sought care.

Mr. Sarbanes. I mean, this is -- I have to yield back my time, but just to say we are inviting people back into a world with mirrors and trapdoors that was exactly the place we wanted to get away from when we passed the ACA. So we got to really

push back against these junk plans.

And with that, I yield back my time.

Ms. Eshoo. [Presiding.] Thank you, Mr. Sarbanes.

I now would like to recognize the gentleman from Georgia, Mr. Carter.

Mr. Carter. Thank you, Madam Chair, and thank all of you for being here. Certainly an important -- an important area that is affordable health care costs.

You know, before I became a member of Congress I practiced pharmacy for over 30 years. I started when I was two. But, nevertheless, I -- you know, one of the things that I heard so often was the cost of health care and particularly the cost of insurance and that is something that I was committed to work on and I am committed to work on and continue to work on as a member of Congress.

Ms. Turner, I read an article in Axios the other day that said that 42 percent of people participating in the individual marketplace weren't able to use their insurance because out-of-pocket costs were so high or their deductible was so high.

And it is my understanding that that is why we have the 1332 waivers is so that states can actually address this issue. I believe in your -- in your testimony you gave examples of some states where it has actually worked -- maybe Alaska, Oregon.

Can you repeat that for me, please?

Ms. Turner. Yes, Congressman.

The 1332 waivers really are designed to give states flexibility to separately subsidize the people with predictably high health care costs that are driving up the premiums for everyone else.

They are the ones who are causing premiums to go up as the healthy people drop out. And a number of states have applied for waivers to in different ways subsidize them.

Alaska said, we will look at these 33 categories and if they -- people qualify for those then they will -- they will be able to get separate subsidies. Others have reinsurance, high risk pools, invisible high risk pools.

States are working to figure out how to do this with dramatic results. We see, for example, in Alaska that premiums went down by almost 20 percent. Enrollment went up by 7 percent. In Minnesota, premiums went down again by almost 20 percent. Enrollment went up by 13, 14 percent, and on and on where you see --

Mr. Carter. And that is the point I am trying to make. I mean, obviously, this has helped. It has helped tremendously and expanding it has helped. Yet, the impetus for the hearing today is a set of bills that are actually going to constrict this

so we are not going to have the ability to expand on this like -- and enjoy the benefits of it working like it has worked.

I am really confused by that because this is our second hearing in the -- in the committee that has the broadest jurisdiction over health care costs of any other committee in Congress and I am just trying to figure out where we are going.

The first week we had a hearing on a lawsuit that has not -- that is still in litigation. It has not been settled yet and may not impact anyone.

Here we are having a hearing this week on what is going on and how we can actually constrict the affordability and make health care costs even more expensive for people. And yet, when I go -- when I am in my district people are talking about, what about prescription drug pricing.

We haven't even discussed prescription drug pricing yet. Yet, there are other committees in this House -- the Ways and Means Committee yesterday had a hearing on prescription drug pricing.

The Oversight and Government Reform Committee has already had a hearing on drug pricing and yet here we are in the most broadest jurisdiction of health care and we haven't had a prescription drug pricing hearing yet.

Madam Chair, I certainly hope that we will get to that at

some point here because it is extremely important. The point here is that people being able to buy health insurance doesn't help anyone if they can't use it.

You know, when I first went into business I read something and it said when is a deal not a deal. It is not a deal when you buy something you don't need or you can't use, and that is what people were being forced to do -- buy insurance that they can't afford to use. That is not helping them and that is what we need to be addressing here and what I hope that we can address.

Let me ask you, Ms. Turner -- when folks have a gap in coverage and employment or people who retire and are not yet eligible for Medicare, what are the options for them?

Ms. Turner. Previously under the Obama administration they had the option to buy a short-term plan. These have been around for decades. But it had to -- it could only last for three months and people generally if they are in gaps in coverage they need coverage for longer than that. So this is what the Trump administration did. They said that you can have the policy for up to a year and it can be renewable for another two years.

Mr. Carter. And in these plans there are options. So they give these people who are in this gap, if you will, the ability to actually fill in that gap and the ability to have coverage, which we all want.

Ms. Turner, I really appreciate all of you being here and appreciate this opportunity and Madam Chair, again, I look forward to the hearings that we are going to have on prescription drug pricing, and I yield back.

Ms. Eshoo. I thank the gentleman. I look forward to them as well.

I now would like to recognize the gentlewoman from Illinois, Ms. Kelly.

Ms. Kelly. Thank you, Madam Chair, and thank you to all the witnesses and I too want to salute Congressman -- yes.

Thank you to the witnesses. Thank you, Madam Chair, and I too want to salute Congressman John Dingell for all of his work and he will be sorely missed.

The Trump administration has recklessly expanded junk health plans that do not offer comprehensive coverage. These junk plans could unwittingly leave, as we have heard, families on the hook for thousands of dollars of health care costs.

According to an article in the New York Times, Kevin Conroy, a patient from California, had a heart attack and underwent triple bypass surgery two months after enrolling in a short-term junk plan. His insurance company refused to pay for any of his treatment, leaving him with a $900,000 bill.

In another case, United Health refused to cover a patient's

breast cancer treatment, leaving her with a $400,000 bill. The insurance company claimed that breast cancer was a preexisting condition even though the patient was not diagnosed with cancer until after she bought the junk plan.

Ms. Altman, according to your testimony, I understand that in your state several consumers have been stuck with large unpaid medical bills because a short-term policy denied coverage even after medical -- even for medical conditions arising after an individual enrolled in a policy.

These conditions should, theoretically, be covered since they arose after individuals enrolled in the plan but often the insurance company, as we have discussed that sell these junk plans, refuse to pay out.

You have explained about post-claims underwriting and also we talked about how consumers need to be more educated. But I want to know where does all the money go if these insurance companies are not using premium dollars to pay for health care?

Ms. Altman. Sure. So as we have talked a little bit about Affordable Care Act plans are subject to a medical loss ratio that ensures that they spend at least $0.80 of every premium dollar on care with the remainder going to administrative costs and profit and if they don't meet that standard they are required to refund dollars to their policy holders.

The short-term market, on the other hand, averages, based on a study, $0.64 on every dollar, the largest carriers average less than $0.50 a dollar spent on care, with one of those carrier spending only $0.34 on the dollar.

So the remaining funds would go some to administrative costs and the remainder to profit. I think all evidence points to these being very profitable lines of business for the insurers that sell them.

Ms. Kelly. Thank you.

And also I agree with my colleagues. I would -- I want us to work together too and get something done for the American people. But as I recall in the last years all I have been given the opportunity to do is vote to repeal the Affordable Care Act or tear up some part of it.

And, Ms. Turner, I know you have been more negative about the navigators but also besides the marketing the time period was cut so short so people -- it was harder for people to register.

And we talk about the economy is better so I would like to think we went down some because people got jobs and so they did have health insurance. So I just want to know from you do you think the ACA has been helpful to anybody.

Ms. Turner. Oh, absolutely, and actually California extended its enrollment period to I think the middle of January

and they still were down 24 percent in new enrollment.

So I think that the real issue is how do we make these plans more attractive to people so that they can afford both the premiums, especially if they are not in the subsidized market as well as the deductibles are low enough that they feel they could actually access the insurance and that is what I am hopeful that states will take advantage of the 1332 flexibility in the law to allow that.

Ms. Kelly. Okay. Thank you for your answer.

I just want us to also recognize that there were many, many millions of people that had no insurance and just like people can talk about the stories they are hearing there are many stories that, even in my own family, how people that weren't insured have insurance and they are very happy.

Ms. Turner. And they are grateful, yes.

Ms. Kelly. I yield back.

Ms. Eshoo. I thank the gentlewoman from Illinois.

And I now am pleased to recognize the gentleman from North Carolina, Mr. Hudson.

Mr. Hudson. Thank you, Chairman Eshoo, and this is my first chance to publicly congratulate you on taking the gavel. I look forward to finding common ground and working with you throughout this Congress.

When I noticed today's hearing title, "Strengthen Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Preexisting Conditions Protections," one word really stood out to me -- the word sabotage.

I know my colleagues and I on this panel agree that we should strengthen our health care system. I talk to constituents of mine every time I am home who need better access to more affordable care and I know my colleagues and I want to ensure protections for preexisting conditions. That was universally accepted at our hearing last week.

But the word sabotage really stuck out at me. Unfortunately, this conversation around health care has become increasingly partisan. We saw this with the Affordable Care Act and we saw it again with the American Health Care Act last Congress.

But this conversation should be bipartisan because health care is an issue that affects every single American. From the time we are born until the time we die there will never be a time when the health care industry doesn't touch our lives.

I was talking to a constituent last week who he and his wife are in their 50s. He told me his wife couldn't afford to buy health insurance on the exchanges. But because of the short-term insurance plans now being offered she was finally able to purchase

insurance that they could afford.

He noted that on a previous insurance if they paid all their premiums and met their deductible they would have spent $18,000 out of pocket before they accessed the first bit of health care.

So that brings me to today and this word sabotage. I don't think these short-term plans are a long-term solution for people buying health insurance and the administration agrees with that, which is why they are only available for up to three years.

But they do help provide option for folks back home who feel like they have no place else to go. I definitely don't see them as sabotaging the ACA; more so as enhancing the intent, however misguided the execution of the ACA, of providing more people with health insurance.

Ms. Turner, in your testimony you noted these plans were helpful for early retirees like my constituent who needed to bridge the gap after losing employer-sponsored health care. I think that is definitely true with the folks I have talked to.

But one criticism of the short-term plans I have heard today has been that consumers may not be sufficiently educated on the restrictions and limitations that come with these policies. They may not understand the tradeoffs for lower premiums.

In my conversation with my constituent he recognized his wife did not have coverage for everything but that the plan covered

everything they needed.

Ms. Turner, yes or no -- the final rule provides a disclosure notice that must be prominently featured on the insurance materials. Is that correct?

Ms. Turner. Yes, sir.

Mr. Hudson. It appears from my anecdotal experience that those disclosure notices are working. Would you agree with that?

Ms. Turner. Yes, sir.

Mr. Hudson. I appreciate that. One other issue that has been raised -- and if I could stick with the John Dingell yes or no answers -- Ms. Keith, I believe New Jersey and California have limited or banned the sale of short-term limited duration insurance plans. Is that correct? Yes or no.

Ms. Keith. That is correct, yes.

Mr. Hudson. And Commissioner Altman, do other states have the authority under the Trump administration's action to limit or ban short-term limited duration plans if they choose?

Ms. Altman. Yes.

Mr. Hudson. So if that is true then, that if any state doesn't like the new arrangements they are free to pass their own laws limiting or banning short-term limited duration insurance plans.

I think that is just important to note for the record that,

you know, states have the option here and states are looking for solutions for their constituents, a lot of them in the cases like the one I described of my constituent who are just trying to bridge a gap who are trying to find a way to afford insurance for their families.

So I think it is important to note that we are not forcing anyone into this. We are giving flexibility to the states and I would love to see us do an extended hearing, Madam Chair, where we bring in some folks from the states to talk about are these plans really working.

We hear a lot of discussion from the other side about this could do that, it could be that. But let us look at what the facts are and what is really happening on the states. I think that would be really important.

So with that, I will yield back.

Ms. Eshoo. I thank the gentleman.

I now would like to recognize the gentlewoman from Delaware, Ms. Blunt Rochester, a new member of the committee. We are thrilled that you are here. You are recognized for five big minutes.

Ms. Blunt Rochester. Thank you, Madam Chairwoman, and also thank you to the -- to the witnesses today. I also would like to send my condolences to the Dingell family on the passing of

such a legend as John Dingell.

In 2017 in January, the Trump administration halted all ACA marketplace outreach for the final week of the 2017 open enrollment and then slashed ACA enrollment funding for advertising and outreach by a staggering 90 percent -- 90 percent.

Delaware's marketplace, forced to do more with hundreds of thousands of dollars less in funding, saw a decrease in enrollment every year since then, down 20 percent since the state's peak enrollment in 2016.

The administration's repeal efforts and damage to the Affordable Care Act have resulted in new enrollments going down and costs going up for the over 22,000 Delawareians and 8.5 million Americans receiving their health insurance through the individual marketplace.

These Delawareians are now paying more than $100 in premium costs over what they paid before over the national average and I really -- I heard my colleague, Mr. Hudson's, point about the word sabotage and as I was sitting here thinking of what I would even say, you know, the saying if it walks like a duck and quacks like a duck it must be a duck came into my head.

And it came into my head because when you shorten the amount of time that people have to apply and then you couple that with slashing information and outreach to people, it appears and it

feels like sabotage and I am really proud to have been able to introduce the More Health Education Act to restore funding for educational outreach.

All of the bills that we are discussing here today will help Americans enroll in quality comprehensive plans in the marketplace and they will ultimately lower costs. But, more importantly, the goal is to make Americans healthier.

And so my first question is, number one, I just want to clarify, Ms. Turner, that this particular bill was for marketing and outreach and not the navigators. But you will probably see more coming forward.

But I wanted to ask Ms. Keith to clarify something that was stated, that marketing doesn't work. Can you just talk about does marketing work? People say we already know about the ACA -- why do we need to have marketing.

Can you share a little bit about that?

Ms. Keith. Thank you for that question. It is very important.

Multiple studies including studies conducted by CMS itself have shown the value of advertising and marketing outreach under the ACA in particular. One of the changes by making such dramatic cuts to the advertising budget is that beginning in 2018 CMS ran no TV advertisements, even though that was one of the most cost

efficient ways of reaching people and had a measurable impact on people enrolling.

I think Ms. Turner has cited California having lower new enrollees this year. I think it is worth noting that California has had the same enrollment overall and I think part of that is that new enrollees -- California had strong enrollment of new enrollees in previous years and I think the state would point to things like loss of the individual mandate as reasons why perhaps new enrollment is lower. But I did want to clarify that, that enrollment in California is stable.

Ms. Blunt Rochester. Got you. Great. And also, I wanted to follow up with that. Why do you think we still need outreach and marketing?

Ms. Keith. Awareness remains low. Documented studies have shown this. Even as of November of last year there were about 69 percent of uninsured consumers and consumers who had purchased individual coverage who did not know the deadline was December 15th or had the date wrong. Sixty-nine percent of folks who we are trying to reach for this type of coverage who would be eligible are not aware of their options and outreach and marketing plays a key role in that.

I would just emphasize that we are seeing very aggressive marketing of the short-term plans as well and so as we have seen

cuts to ACA outreach and marketing it is being filled. This void is being filled by these short-term plans and it is very confusing for many consumers.

Ms. Blunt Rochester. And Commissioner Altman, can you talk about the state of Pennsylvania and what impact these kinds of cuts have had?

Ms. Altman. Sure. So Pennsylvania, under a prior administration, chose to use the federal exchange. So we rely on CMS and the federal government to operate our exchange, and marketing and outreach are supposed to be a core element of that.

And so in my perspective, when the federal government ceased doing that and ceased trying to reach out to Pennsylvanians, they weren't meeting those obligations. But they still needed to be met because people are not aware -- the number of consumers I talk to who don't know basic information.

We have tried to fill that gap with our own campaign but our resources are certainly limited.

Ms. Blunt Rochester. Great. Thank you so much for your questions.

I would yield back my time in a minute just to say that even as a member of Congress we were limited in what we could say. So I applaud the work of the committee and I yield back the balance of my time.

Ms. Eshoo. I thank the gentlewoman, and we are thrilled that you are part of the committee.

It is a real pleasure to recognize the gentlewoman from Indiana, a wonderful colleague and a good friend, value added no matter where she is in the Congress -- Mrs. Brooks.

Mrs. Brooks. Thank you, Madam Chairwoman, and I just want to also have the opportunity -- this is my first opportunity to publicly congratulate you on leading this important committee and I look forward to continuing our work that we have done in the past, particularly on Pandemic All-Hazard Preparedness Act and many other areas, and look forward to your work and working with you on this most important subcommittee.

I want to focus a little bit on the marketing because my colleague talked about marketing and, Ms. Turner, marketing and outreach is an incredibly important aspect of any product. I assume you would agree with that.

However, the more products and the more choices there are, marketing -- there have to have products that people want to consume and/or want to -- and/or understand what it is they are consuming.

And, like so many others, I have many Hoosiers who have shared with me that the high cost of the premiums and the high deductibles are what so many -- you know, their barriers have been to

purchasing a lot of the products.

So can you help us understand why having more choices, however, it needs to be informed choices, and I agree that there is a concern whether it is with different types of products people have to understand what they are buying and that is, I think, what the biggest problem is with these short-term products is they don't quite understand what is covered and what is not covered.

Can you please talk with us about why having more choices is better for health care overall for consumers regardless of their health status?

Ms. Turner. It does give them options. It gives them options of networks, doctors, the hospitals that are available to them and, unfortunately, and I think about half of counties people in ACA coverage have a choice of one plan. It is take it or leave it, so there is really no choice there at all.

And people who can't afford that coverage are now being given other options through short-term plans and other administrative ideas.

Mrs. Brooks. Can you share with us a little bit about how the federal government might be able to increase enrollment? Are there other ideas that any of you might have as to how the federal government might be able to increase enrollment in health

insurance aside from spending money on marketing and navigators?

Ms. Turner. If the policies were more affordable, if there were more competition in the market so that the one provider doesn't have the opportunity to buy up all the doctors and hospitals and charge higher premiums, giving people more competition in these markets so looking at the anti-competitive monopolies that some of these hospitals and systems have is important, but also providing more options through Section 1332 for states to tailor their risk models so that the highest risk people are not in the same pool with everybody else and driving up premiums, driving the healthy people out. I think this has got to be a state-based solution and the 1332 that was a part of the original ACA was envisioned to give states that flexibility.

Mrs. Brooks. Talking a bit more about that, how have Section 1332 waivers -- have they increased access to care in the states that have approved waivers and can you give any examples --

Ms. Turner. Absolutely.

Mrs. Brooks. -- of access to care?

Ms. Turner. Access to care and which is, of course, in many people's case it is access to coverage to help finance that care. But in Arkansas, Minnesota, Oregon, Maryland, Maine, New Jersey, Wisconsin, those are many of the states that already have

requested waivers to spend some part of the ACA money themselves in a way that does a better job of risk mitigation -- high-risk pools, reinsurance, invisible high risk pools -- to give -- to separately subsidize the people who have the highest costs so that you can then lower premiums for others in the individual market and attract more people, which then further lowers premiums.

Everybody wants more healthy people in these insurance pools. The ACA is working against that. Section 1332 gives states tools to be able to get more healthy people into their markets.

Mrs. Brooks. Thank you. I yield back the balance of my time.

Ms. Eshoo. I thank the gentlewoman.

And it is a pleasure to recognize from California another new member of our subcommittee and she is so welcome, the gentlewoman, Ms. Barragan.

Ms. Barragan. Thank you, Madam Chairwoman.

I want to thank you all for joining us here today. We have heard a lot about these junk plans in my first term as a first -- as a new member of Congress. It feels like we just had all kinds of conversations about health care and it was centered around repealing the Affordable Care Act, which would limit access

to health care to people.

So it is nice to be able to have this conversation and actually have a debate on what some of what has been happening over the last two years is doing to pricing and as a result of some of the policies that have been implemented for the last two years.

I myself am a co-sponsor of what we are talking about today -- to eliminate these junk plans -- and I want to talk a little bit about that. One of my colleagues on the other side said let us talk about the facts -- let us talk about what is happening.

You know, we received the story of Sam Bloshall from Chicago and I want to share his story because I think it is important to highlight what is happening and what people are going through.

Now, Sam's story was brought to us by the Leukemia and Lymphoma Foundation. Sam unknowingly enrolled in a junk plan after he was deceptively steered into it by a broker.

Now, Sam had been experiencing back pain and he was completely transparent about this when he talked to the broker about his condition. Sam writes in a letter to the committee that he thought it would be smart to talk to a broker about upgrading his coverage so he could have better health care access for any future medical care.

Now, the broker assured Sam that the junk plan was the right

insurance plan for him, given his back pain. After enrolling in the junk plan Sam was diagnosed with an aggressive form of blood cancer -- non-Hodgkin's lymphoma.

After undergoing six months of chemotherapy and radiation, his insurance company informed him that they were not going to pay for the treatment, leaving him with $800,000 in medical bills.

The insurance company also refused to pay for a bone marrow transplant, treatment necessary to allow Sam to achieve lasting remission. Now, Sam writes in his letter that the insurance company claimed that cancer was a preexisting condition because he had previously visited a chiropractor for his back pain.

Sam was left with almost a million dollars in medical bills and no insurance -- and no health insurance for the treatment that he needed in order to stay alive.

Now, while fighting cancer Sam is also trying to figure out how to avoid bankruptcy. Sam is only 32 years old and a business owner. He writes that instead of planning for his future with his fiance and building his business, he is left up at night wondering how to stay afloat.

So I want to start by entering Sam's letter to the committee into the record now. And I also -- Madam Chairwoman, can I enter that into -- thank you very much.

[The information follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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

Ms. Barragan. Ms. Keith, can you discuss how insurance companies are able to essentially defraud patients like Sam?

Ms. Keith. Certainly. So it sounds like Sam was a victim of something called post-claims underwriting, which is something we have been discussing where his back pain, which he disclosed, was used as a reason to deny coverage for his cancer treatment and care, leaving him on the hook for all these bills.

I think other ways that short-term plans have exposed consumers to high out-of-pocket costs like this is through their refusal to cover preexisting conditions, the benefit gaps.

But even when you think you fully understand the product and you disclose your back pain and you think you know what you are getting, to be surprised that your cancer treatment wouldn't be covered I think is something that is very troubling for patients and consumers -- the stories that we are hearing all across the country.

Ms. Barragan. Right.

Commissioner Altman, could you describe the impact of the Trump administration's decision to expand the junk plans on patients who may be in a similar situation to Sam?

Ms. Altman. Yes, and thank you for sharing that story. I think that story is so indicative of many of the pieces we have talked about today, from limited benefits to deceptive marketing

practices which are, for the record, illegal, to post-claims underwriting and, frankly, also to the fact that something like this can happen to anyone and that is why every person needs comprehensive health insurance to cover things like unexpected cancer diagnoses, and the story is also one that demonstrates the short-term plans are not that.

Ms. Barragan. Well, thank you. I know. Sam writes that somebody shouldn't have to worry about filing for bankruptcy or getting stuck with $800,000 in medical bills. I agree. I think that is why we are having the hearing today. I also think that is why having legislation to protect individuals like Sam and reverse the administration's attacks on Americans with preexisting conditions is important.

And with that, I yield back.

Ms. Eshoo. I thank the gentlewoman.

I am now pleased to recognize the ranking member of the subcommittee, Dr. Burgess, for five minutes.

Mr. Burgess. Thank you for the recognition. Thanks to our witnesses for being here. I know it has been a long morning and now afternoon, but I appreciate your input into this important subject.

Ms. Turner, let me ask you -- probably two years ago, I guess in March of 2017, the Health Affairs published the article on

the invisible high-risk pools that the state of Maine had used to rescue its insurance industry after their attempt at community rating guaranteed issue got them into so much difficulty in the individual market. The invisible risk pool was a -- was a way to sort of reconstitute that market. Would you qualify those as junk plans?

Ms. Turner. I think that the risk pools actually provide the social safety net so that if somebody does wind up in a situation like Janet that I describe in Colorado who had insurance but when she was diagnosed with hepatitis C the high-risk pool in the state was there to provide her care and, ultimately, pay for her $600,000 liver transplant. So there are other options available than the ACA and we have seen those in the past, and Maine is another example.

Mr. Burgess. Great. Thank you.

Madam Chairwoman, just before we finish up I am going to have another -- a couple of unanimous consent requests so that I don't get gaveled out. I just would like to make that information available to you.

Now, Ms. Turner, staying with you, one of the issues I brought up in my opening statement was the issue of global budgeting. Can you speak to the -- how a global budget system would impact patients and the health care system at large?

Ms. Turner. Whoever controls the money is going to control the choices, and whoever is controlling that global budget, whether it is a regional health administrator, whether it is a federal bureaucracy, whether it is a hospital system, is going to control the choices for that patient and they are going to allocate the money in a way that I am sure they will believe is going to be the fairest way possible but it always winds up they wind up with shortages, they wind up with waiting lines.

We have seen in California -- I am sorry, in Canada -- that hospitals have to close in December because they have run out of money. So I think that it significantly diminishes individual patient choice and it often leads to rationing of care.

Mr. Burgess. While we are on the subject of Canada, it is my understanding that Canada is opposed to the system in the United States where if a bill is submitted by CMS it is paid. In Canada, there is a fixed budget and once that budget is exhausted the bills are held until the next year. So a fundamental difference in the approach.

One of the things that has concerned me for some is that you do see that there is an effort to create a single-payer government-run system and you see this not just in the United States.

I mean, this has been something that has been ubiquitous

across the world. Why is that? Why does a country want to control something that inherently should be an individual issue?

Ms. Turner. Now, I have thought about this for many years and I do believe that there is a sense of fairness -- that if everybody is in the same system that everybody will be treated the same.

But that is not the way that it works in any country that has some form of a government-centralized health care system. People -- the affluent people always find a way to buy out of it and people who have fewer means always wind up with their care rationed and limited.

Mr. Burgess. So does it concern you the -- some of the statements we have heard about pushing to that type of system, particularly those that say we are going to void any private insurance? The large group market would disappear of necessity under a single-payer system in this country.

Ms. Turner. With 173 million people in the employer health insurance market that value their coverage, I think that would be very problematic. When you have 60 million people on Medicaid that value that coverage and that would see it compromised if we had another 200 and what would be 70 million people on that program.

So I think that there -- the system as it is is -- has evolved

over decades and I think it is important to build on that system and figure out how do we help these 15 million people who are in the individual market who are the most exposed to the high premiums and the high cost, the high deductibles, and the possibility of losing their coverage.

Mr. Burgess. I do know when I ran my medical practice, obviously, I was in the small group market when I bought insurance for my employees. I would have welcomed the ability to go into an association health plan.

If county medical societies across the country had put together a group health insurance model that would have been welcome news for me and those patients would have been protected from preexisting conditions, unlike others in the individual market.

So thank you so much for your time today and I will yield back.

Ms. Eshoo. Thank you, Dr. Burgess.

Let us see. It is now my pleasure to recognize the gentleman from California, Mr. Cardenas.

Mr. Cardenas. Thank you very much, Madam Chair and Ranking Member, for putting this very important hearing together in full view of the public and I want to thank the witnesses for being here as well -- the ones I agree with and the ones I disagree

with. Thank you so much for providing your perspective.

Since the passage of the Affordable Care Act in 2010, more than 20 million Americans have gained meaningful access to insurance coverage. Before Donald Trump became president, the uninsured in this country fell from 18 percent to 11 percent, the biggest jump in any period of time in the country's history.

Yet, basically, since day one the Trump administration has actively undermined the law and attacked Americans' health care. The administration cut the advertising and enrollment budget from $100 million to $10 million. This has had a very real consequence and I have heard stories from my own district where constituents mistakenly believed that the health care exchanges ended with the presidency of President Obama.

The administration's sabotage efforts have resulted in the highest uninsured rate in four years. According to a Kaiser Family Foundation study, over 80 percent of uninsured adults were not aware of the deadline to enroll in coverage in 2017. Again, it was this Trump administration that reduced the enrollment administration's advertising budget from $100 million to $10 million.

Another survey by the Commonwealth Fund that said that 41 percent of uninsured adults are still unaware of the ACA marketplaces or that subsidies are available to help them pay

for coverage.

The Trump administration is strangling health care for millions of people and undermining the law of the land.

Ms. Keith, I understand that uninsured Americans are less likely to be aware of the deadlines or availability of affordable coverage. Is that a correct statement of today?

Ms. Keith. That is correct, yes.

Mr. Cardenas. Okay.

Also, Ms. Keith, can you briefly describe how gutting funding for outreach and enrollment impacts new enrollments?

Ms. Keith. Certainly. New enrollees tend to be younger and healthier. As you can imagine, patients who are older and have health conditions are very motivated to enroll in coverage.

It is really younger and healthier consumers who aren't aware and need to better understand the marketplace options available to them. What we have seen is since 2016 new enrollment through healthcare.gov is down by about 50 percent.

We need younger and healthier consumers to help keep the risk pools stable and help keep premiums down. I believe I mentioned earlier Covered California attributes its marketing in 2015 and 2016 to a reduction in 6 to 8 percent in premiums. So advertising can pay off in terms of sort of bringing in younger

and healthier people who need coverage for themselves but also help the risk pool.

Mr. Cardenas. Now, Ms. Keith, can you describe how what you just described -- younger healthier patients not enrolling -- how that affects other Americans' ability to get comprehensive health care?

Ms. Keith. Sure. By not having younger and healthier folks in or having fewer and fewer new enrollees there is a possibility that premiums will increase.

Mr. Cardenas. Okay.

Ms. Altman, what is the level of awareness among consumers in Pennsylvania, for example, about the ACA and their health care options in the ACA marketplaces?

Ms. Altman. I would say that my experience with -- in speaking to Pennsylvanians is very reflective of the study that Ms. Keith mentioned. In particular, there seems to be a significant lack of awareness about the financial support available under the Affordable Care Act.

Many consumers come to enrollment events and think there is no way they will be able to afford the coverage only to find out that it is all more affordable than they ever thought it could be.

Mr. Cardenas. Thank you. And also, Ms. Turner, you

mentioned something that, as a former business owner, on the face of it I would probably agree with but I don't agree with in this case about how we are trying to provide comprehensive health are to as many Americans as possible, and I quote, "individual patient choice."

When I was a little boy, my parents had an individual patient choice and they chose to go without insurance coverage because it was too far out of reach for my family's single income first-grade-education immigrant father who was a gardener.

He couldn't be a CEO, couldn't -- didn't aspire to be or what have you. But he provided food on the table for 13 people every single day and I am so proud of him and my mother for doing what they could with what little they had.

Also, my parents' individual choice was to not participate in preventative medicine practices like going to see a doctor because even that was too expensive for us to do as a low income family.

My parents' individual patient choice was to look at us and pray for us when we got a bad fever or something and then now and again, once in a while, say, it is time to go -- time to take us to the emergency room.

Not to our regular care doctor, not to a place where we could actually be preventative in these measures, but the dangerous

choice of waiting to the last minute to decide, I think my child is in vague -- very serious danger. Now it is time to go to see a doctor. That is individual choice that the Affordable Care Act, as flawed as it is, has been trying to overcome and it was able to overcome that for tens of millions of people that before were like my family when I was growing up.

Thank you very much, Madam Chair. I yield back.

Ms. Eshoo. I thank the gentleman. You just saw and heard passion on display.

Now, we have two members that have been waiting very, very patiently. They are members of the full committee. Ms. Schakowsky is also a chair of the subcommittee and the rules of the committee allow for members that are not part of this subcommittee to come and to participate but they have to come last.

So thank you to the gentlewoman from Illinois and for her great service on this subcommittee in previous Congresses. I recognize her for five minutes of questioning.

Ms. Schakowsky. I thank you, Chairman Eshoo, for allowing me to waive onto the subcommittee, a subcommittee I served on for 16 years and I am happy to be here today.

I just wanted to point out that the state of Illinois passed legislation preventing these short-term -- we call them junk

plans because there was a robust debate about those.

And while we saw 7 percent lower enrollment I think it could have been even higher had -- that we could have done better had the -- I call it -- I do call it sabotage of limiting the navigators.

Ms. Turner said that only 1 percent of the navigators had anything to do with it. Has the public program that was essentially defunded been helpful and would we have had more enrollment had we had the dollars to advertise the programs?

Both of you, actually.

Ms. Keith. Absolutely, and I think when we talk about navigators who we are really talking about is community-based organizations, United Ways, legal aid societies, American Cancer Society, organizations like that who are sort of bedrock institutions in the community.

Although some of that data I think has been disputed on navigators, I will say under the statute navigator enrollment is only one of the five things that navigators are supposed to work on. Their real goal is to help folks with limited English proficiency, lower income folks.

They have a lot of other things they are doing that aren't just enrollment. So I think having those navigators there is really helping families with complex conditions, families who

need a little bit of extra help to get enrolled.

And then to your question, I tend to agree -- if we had outreach and marketing funding you would -- the marketplaces sort of remain stable even with these cuts but at least one study has showed that we should have 2.3 million more new enrollees at a minimum. So the marketplace should be much bigger than it is.

Ms. Altman. Just speaking for Pennsylvania, I can say that the navigator organizations in Pennsylvania are incredibly committed and incredibly effective in reaching people and helping the most challenged individuals through their healthcare questions and issues and enrolling people both in the marketplace and in Medicaid as well, particularly with the expansion, and especially in reaching groups of people who are not going to be reached otherwise -- those who have specific health care needs.

One of our navigator organizations focuses on individuals with mental health conditions, focusing on groups for whom English is not their primary language. We have other navigator organizations focused on certain communities in that category. And so they do fill a very unique void.

Ms. Schakowsky. Let me interrupt. I have little time left. I wanted to refer to a bill, H.R. 1143, that Representative Eshoo

sponsors. But I wonder if either of you are knowledgeable about the Georgetown University Health Policy Institute findings about really what has happened when brokers are telling people about these plans and how they concluded that insurance brokers selling these plans engaged in deceptive marketing practices.

Ms. Keith. Thank you for that question. This was a study done by my colleagues on the really aggressive marketing and outreach we've seen in short-term plans. By and large, there is a lot of ads funded going towards marketing of these short-term plans.

Brokers -- we found instances where brokers were very aggressive by phone -- you have a lot of robocalls -- brokers who would refuse -- really wanted someone to purchase while they were on the phone and refused to provide written information at all. You are seeing plan -- or website -- web brokers saying that they sell ACA plans and short-term plans but then only allowing enrolment in short-term plans. I worry --

Ms. Schakowsky. And did some of those people think they were getting a comprehensive ACA plan?

Ms. Keith. I am sure that is true. It is very confusing.

The other thing I was going to add is that we have seen steering. So even when patients might be eligible for subsidies or consumers might be eligible for subsidies through the

marketplace, being directed to a short-term plan when they might qualify for a much cheaper, more comprehensive policy.

Ms. Altman. I will just add very quickly that my department has had to revoke the insurance licenses of a number of agents and brokers who have done exactly what you said and lied to consumers and told them these plans are things that they are not and it is falling to states to do what we can to be vigilant in a very active marketplace with a lot of marketing that is very questionable.

Ms. Schakowsky. Let me just say choice is as good thing. It needs to be informed choice. People really need to know what is going on and these plans -- I am happy that they were outlawed in the state of Illinois.

I yield back. Thank you very much for letting me be here.

Ms. Eshoo. Thank you for your patience and your attendance.

I now would like to recognize another member of the full committee -- not of the subcommittee but always welcome here and a new member to the full committee, the gentleman from Florida, Mr. Soto. You are recognized for five minutes.

We are going to vote pretty soon, too.

Mr. Soto. Thank you. Yes, I will be efficient. Thank you, Chairwoman Eshoo.

So sabotage of the ACA -- allow me to count the ways.

Let me just go through the top five as I see it: first, eliminating cost-sharing subsidies that raised rate; second, cutting enrollment period in half; third, cutting marketing dollars in half or more; fourth, eliminating high-risk corridors, hurting competition; and fifth, eliminating individual mandates.

One that we still need to talk about is there was an attempt to eliminate preexisting conditions in the Trumpcare bill that did not pass, thank God, but if we didn't stop them we would have saw even that sabotaged.

I think all parties can agree this was a big issue in the last election and that Americans want us to get to work on bipartisan solutions on it. I come from the state of Florida, home to the largest federal exchange in the nation -- 1.7 million Floridians are on the ACA exchanges, up 50,000 from last year.

So, first, I would like to get a potential consensus here from the witnesses. Yes or no -- did eliminating the cost-sharing by the Trump administration and the last Congress raise rates altogether?

Yes or no, and we'll start with Ms. Keith.

Ms. Keith. Yes, it did.

Mr. Soto. Ms. Altman?

Ms. Altman. Absolutely.

Mr. Soto. Ms. Turner?

Ms. Turner. It was not -- funding was not included in the original law and this Congress was trying to provide the funding in context of larger reforms.

Mr. Soto. So I will take that as a no. Okay.

And then for my second and final question, why would a state like Florida still have an increase in ACA enrollment even with these five clear sabotages of the ACA opinions?

We will start with Ms. Keith.

Ms. Keith. One response is that there is still continued demand for the type of coverage that the ACA provides for comprehensive affordable quality coverage. At the same time, you still have subsidies available for most folks who enroll through the marketplace and that has been, I think, the enduring stability of these programs.

Mr. Soto. Ms. Altman?

Ms. Altman. Just reiterating, I think that demonstrates the value proposition that the comprehensive coverage along with the financial assistance available on the marketplace provides to millions of Americans.

Mr. Soto. And Ms. Turner?

Ms. Turner. Maybe sort of ending on a bipartisan note, there is such broad agreement that we need to help people to purchase

coverage who are shut out of the market for whatever reason and make it more affordable. I hope to work with you in doing that.

Mr. Soto. Just to conclude, you know, Florida is a giant state, third largest in the union, and a lot of our constituents don't have access to the foundational plans of this nation -- employer-based plans -- that so many Americans are on, particularly because they may work in the service industry or the agriculture industry, which is why the ACA continues, despite all the sabotages, to be a smashing success in my state because this is really the only option people have.

So from Florida's perspective, we cannot let this fail and despite attempts to make it fail it has still thrived for us to still be the largest federal exchange in the nation.

So I look forward to hearing from all of you on that in the future and work with the committee and thank Chair Eshoo for the opportunity.

And with that, I yield back.

Ms. Eshoo. You are always welcome here. I would -- I think that this is -- we have concluded the questioning of both the guests of the subcommittee and all the members.

I want to thank the witnesses again. I think that each one of you did an outstanding job. I don't necessarily agree with you, Ms. Turner, but you worked hard to answer the questions and

I certainly appreciate that.

Ms. Turner. Thank you, Chairman.

Ms. Eshoo. I also want to thank the authors of the -- of the legislation. They are not here now but I think to say this for the record that they have worked hard on these bills and I want to thank Congresswoman Castor, Kuster, and Blunt Rochester.

And I also would like to ask for unanimous consent to place into the record the following: the letter of endorsement from the AARP for all of the bills that were discussed today, a letter of endorsement from the American Academy of Physicians, the testimony for the record from Sam Bloshall, a letter of endorsement from the Federation of American Hospitals -- that is an endorsement of the legislation that was discussed today -- the same from the American Medical Association on the four bills, the letter from the American Lung Association in support of H.R. 987, letter from the American Lung Association in support of H.R. 1010, statement from the American Lung Association in support of legislation repealing 1332, statement from the American Heart Association in support of H.R. 1010, statement from the American Heart Association in support of H.R. 986, statement for the record from the Association for Community Affiliated Plans, a statement for the record from the America's

Health Insurance Plans, a letter from 23 health partners and patient advocacy groups to the Trump administration expressing strong concerns with the Section 1332 waiver guidance, a letter from 23 -- I am almost done -- 23 health partners and patient advocacy groups to the Trump administration expressing strong concerns with the short-term limited duration insurance final rule, a letter from the American Hospital Association and a statement of support from Families USA.

Without -- not hearing any opposition, these will be -- these items will be placed in the record.

[The information follows:]

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

Ms. Eshoo. And I would like to recognize Dr. Burgess for his request for items to be placed in the record.

Mr. Burgess. So, Madam Chair, I have a unanimous consent request to place into the record a statement for the record submitted by the Coalition to Protect and Promote Association Health Plans.

I also would like to submit for the record an article from the Washington Post, the Health 202 Association Health Plans expanded under President Trump -- looks promising so far -- and I appreciate your offer to have a hearing on association health plans.

We have heard some discussion about lifetime limits and I would point out that even under Medicare there are sometimes what are called therapy caps. Therapy caps were repealed for physical therapy and occupational therapy last year in the bipartisan Budget Act of 2018.

But I would just like to submit for the record the members of the committee who voted against that and therefore voted against repeal of therapy caps in the bipartisan Budget Act, and I thank you for the consideration.

[The information follows:]

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

I will yield back.

Ms. Eshoo. I thank the gentleman.

We don't often enough say thank you to the staff to the committee, and so on behalf of all of the members of the subcommittee I want to thank both the majority staff and the minority staff for the work that they do to help prepare us, to bring the witnesses forward, to draw up some of the talking points and the answers to questions that may be asked, and it is sincere thanks from all of the members of the subcommittee.

So with that, I think we will make it over to the floor and maybe even be there, Dr. Burgess, before the bells ring.

Thank you again to the witnesses, the time that you have given to us, and, you know, your commitment to these issues by dedicating your lives to them. It is in no small measure, I think, a gift to the country.

Mr. Burgess. So do we have five legislative days to submit questions for the record?

Ms. Eshoo. We do, and we have 10 business days to submit additional questions for the record to be answered by the witnesses who have appeared and, of course, we trust and I ask that the witnesses respond promptly to any questions that you may receive and we have already placed what we wish to place in the -- into the record.

So at this time, the subcommittee is adjourned.

[Whereupon, at 1:28 p.m., the committee was adjourned.]