



September 22, 2020

The Honorable Anna Eshoo  
Chairwoman, House Energy and Commerce Health  
Subcommittee  
202 Cannon House Office Building  
Washington, D.C. 20515

The Honorable Michael Burgess  
Ranking Member, House Energy and Commerce  
Health Subcommittee  
2161 Rayburn House Office Building  
Washington, D.C. 20515

Dear Chairwoman Eshoo, Ranking Member Burgess, and Members of the Subcommittee:

On behalf of National Taxpayers Union (NTU), the nation's oldest taxpayer advocacy organization, I thank you for this opportunity to submit a letter on the Subcommittee's September 23 hearing, "Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic."

As the voice of America's taxpayers, NTU takes an active role in shaping health policy on Capitol Hill, at federal agencies, and in the states. Sensible health policy that balances a number of competing interests can not only deliver savings for the taxpayers who fund federal and state health programs (like Medicare, Medicaid, and the Affordable Care Act exchanges), but can also encourage innovation and growth in America's private health care sector that benefits both patients and providers. Regulatory flexibility, for example, has not only been critical for the hospitals and medical professionals on the front lines of the fight against COVID-19; it has also contributed to extraordinary growth in the use of telehealth services that promise potential cost savings for patients and taxpayers in the long run.

It is with these goals in mind - delivering savings for taxpayers while encouraging innovation and growth in America's private health sector that benefits patients and providers - that NTU asks the Committee to consider a novel path forward for helping individuals and families who have lost health coverage due to the COVID-19 economic shock. We believe our **Pandemic Health Accounts (PHAs)** strike the appropriate balance between providing relief for families affected by a loss of employer-sponsored insurance (ESI) and properly tailoring a policy solution to the distinct problems at hand.

There should be no doubt that people who lost ESI this year were quickly steered into other options, such as Medicaid and the Affordable Care Act (ACA) exchanges, due to provisions included in the ACA. NTU's purpose with this appeal is not to litigate or relitigate the effects of a decade-old health law. In the same vein, though, Subcommittee members who support the ACA should not use this hearing to gloss over glaring issues with the Medicaid and ACA programs that have been made worse by the pandemic. NTU has studied these issues at length, and it led us to the proposal we share with you today.

The early months of the COVID-19 pandemic and economic shock were filled with confusion as to just how many Americans lost employer-sponsored insurance (ESI). On April 3, 2020, Health Management Associates estimated that between 11.7 million and 35.0 million Americans would lose access to ESI and that, although a majority of these Americans would join Medicaid rolls after losing ESI, between 1.1 and 12.0 million people would either be uninsured or would need to turn to the ACA marketplace.<sup>1</sup> Then, in May, Kaiser Family Foundation (KFF) estimated that, between March 1 and May 2, 26.8 million lost ESI.<sup>2</sup> KFF also found that around half of these individuals (12.7 million) would be eligible for Medicaid, around a third (8.4 million) would be eligible for ACA premium tax credits (PTCs), and the remainder would be uninsured without access to PTCs.<sup>3</sup>

The picture on COVID-19 health coverage losses has become somewhat clearer in recent months. Avalere projected in September 2020 that roughly 12 million people will lose ESI in 2020.<sup>4</sup> The Economic Policy Institute (EPI) also estimated in late August 2020 that close to “12 million people have been cut off from ESI coverage due to job losses in recent months.”<sup>5</sup> Though policymakers cannot be absolutely sure just how many people at present have lost ESI due to COVID-19, several independent estimates are converging around a number of 12 million.

This is, of course, a challenge of unprecedented scale in the history of private health coverage: around 3.6 percent of Americans may have lost ESI in the last six months. Such a challenge requires bold solutions. While Medicaid and the ACA exchanges have presented options to some individuals losing access to ESI this spring and summer, there is little evidence to suggest that permanently expanding these programs is either the best or the most targeted solution for the millions of Americans experiencing a disruption in coverage.

### *Medicaid and the ACA Exchanges Are Inadequate Tools to Address Pandemic-Related Health Coverage Losses*

Evidence suggests that state Medicaid programs around the country are absorbing the brunt of the health coverage shock Americans went through when government shutdowns started in March. As EPI put it:

A new government survey measuring the economic consequences of the COVID-19 shock in real time indicates that for every 100 workers who were covered by ESI before losing their job, about 85 retained access to some form of health insurance in the week after they lost their job.

---

<sup>1</sup> Health Management Associates. (April 3, 2020). “COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State.” Retrieved from:

<https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf> (Accessed September 18, 2020.)

<sup>2</sup> Garfield, Rachel; Claxton, Gary; Damico, Anthony; Levitt, Larry. “Eligibility for ACA Health Coverage Following Job Loss.” Kaiser Family Foundation, May 13, 2020. Retrieved from:

<https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/> (Accessed September 18, 2020.)

<sup>3</sup> *Ibid.*

<sup>4</sup> Sloan, Chris; Duddy-Tenbrunsel, Robin; Ferguson, Samantha; Valladares, Angel; Kornfield, Thomas. “COVID-19 Projected to Worsen Racial Disparities in Health Coverage.” Avalere, September 16, 2020. Retrieved from:

<https://avalere.com/press-releases/covid-19-projected-to-worsen-racial-disparities-in-health-coverage> (Accessed September 18, 2020.)

<sup>5</sup> Bivens, Josh; Zipperer, Ben. “Health insurance and the COVID-19 shock.” Economic Policy Institute, August 26, 2020. Retrieved from: <https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/> (Accessed September 18, 2020.)

...It is likely the case that Medicaid is the dominant alternative source of coverage when people have lost ESI in the COVID-19 shock, as Medicaid rolls have likely expanded by more than 4 million since the COVID-19 shock began.<sup>6</sup>

This kind of resilience in the health care system - that 85 percent of workers losing ESI can retain access to coverage after a job loss - is good news. That resilience, though, comes at a high cost.

Even after Congress passed a generous 6.2-percent FMAP increase for Medicaid in the Families First Coronavirus Response Act<sup>7</sup> - and this FMAP increase will last through the end of the emergency period - and even though the federal government covers 90 percent of Medicaid expansion population costs,<sup>8</sup> state budgets are buckling under the pressure of surging Medicaid rolls. According to *The Washington Post*:

That 13.5 percent increase [in Medicaid enrollment, from February through August] places Nevada among at least three states, along with Kentucky and Minnesota, where the cadre of people on Medicaid has spiked that much, including families, like the Chapins, who have never before asked for government help. But increases are widespread: Caseloads had risen on average 8.4 percent through July in 30 states for which researchers have enrollment information. And in 14 states with enrollment data through August, the average is 10 percent.<sup>9</sup>

The challenges are so great that even state leaders who strongly support Medicaid, such as Gov. Steve Sisolak (D-NV), have urged “steps to slow the program’s spending”:

With Nevada confronting a \$1.2 billion deficit and a requirement to balance its budget, the legislature has taken steps to slow the program’s spending — notably, curbing payments to doctors, hospitals and others who care for Medicaid patients to save \$53 million through next summer. That 6 percent rate cut is the largest so far in the nation.

...“But with the Nevada Department of Health and Human Services accounting for one-third of the state’s budget through next summer, and Medicaid the department’s biggest expense, the program was a target. To help carve \$233 million from the department, Sisolak urged lawmakers to eliminate a raft of services that Nevada has offered Medicaid patients, beyond what the federal government requires.<sup>10</sup>

---

<sup>6</sup> *Ibid.*

<sup>7</sup> Families First Coronavirus Response Act, Sec. 6008. P.L. 116-127. (March 18, 2020).

<sup>8</sup> Mitchell, Alison. “Medicaid’s Federal Medical Assistance Percentage (FMAP).” Congressional Research Service, Updated July 29, 2020. Retrieved from: <https://fas.org/sgp/crs/misc/R43847.pdf> (Accessed September 18, 2020.)

<sup>9</sup> Goldstein, Amy. “Medicaid rolls swell amid the pandemic’s historic job losses, straining state budgets.” *The Washington Post*, September 14, 2020. Retrieved from:

[https://www.washingtonpost.com/health/covid-medicare-enrollment-increases/2020/09/14/84b6249a-e6f1-11ea-97e0-94d2e46e759b\\_story.html](https://www.washingtonpost.com/health/covid-medicare-enrollment-increases/2020/09/14/84b6249a-e6f1-11ea-97e0-94d2e46e759b_story.html) (Accessed September 18, 2020.)

<sup>10</sup> *Ibid.*

This is the state of Medicaid *with* FMAP increases that will cost federal taxpayers \$165 billion - the plurality of federal aid provided to state and local governments since the COVID-19 crisis began.<sup>11</sup> What relative proportion states have to cover in normal times, from 23 percent of costs to 50 percent for traditional populations and just 10 percent for expansion populations,<sup>12</sup> still makes for one of the largest program area components of state budgets year to year - around 20.2 percent in fiscal year (FY) 2018.<sup>13</sup>

As states struggle with even a modest share of Medicaid costs, patients “face less generous benefit design, greater cost sharing, and more limited formularies” in Medicaid plans than on the individual market, according to Avalere’s Tom Kornfield.<sup>14</sup> And, according to Avalere, “only 71% of physicians accept Medicaid payments for new patients, presenting further access barriers to patients shifting into Medicaid enrollment.”<sup>15</sup>

None of this is to say that Medicaid does not have a role to play in the American health care system, especially as a backstop for the nation’s most vulnerable families. Clearly, though, any federal proposals to expand Medicaid would have to rely almost exclusively on federal tax dollars for such expansion. Maybe that is the point for some proponents of Medicaid expansion today. Indeed, that was the point of the ACA’s Medicaid expansion in 2010. As explained by ACA architect Jonathan Gruber:

In recent research, we analyzed budget data from all 50 states from 2010 through 2018 to assess the impact of the ACA Medicaid expansion. As expected, we found that expansion states experienced a substantial increase in Medicaid spending since implementation of the expansion, with 24% higher growth than nonexpansion states between 2013 and 2018. Critically, when analyzing the source of funds, we found that this increase in Medicaid spending was subsidized entirely by increased federal funding to expansion states, with no significant changes in spending from state revenues associated with Medicaid expansion...<sup>16</sup>

States can barely afford Medicaid now, even with generous FMAP rates for the traditional and expansion populations. Some would argue that this is a reason to *further* expand the federal government’s role in Medicaid, but such an expansion would have to rely on ever-limited federal tax dollars. With the nation staring down a record \$26 trillion debt and an astonishing \$3 trillion deficit this fiscal year, targeted solutions are vital.

---

<sup>11</sup> Committee for a Responsible Federal Budget. (September 16, 2020). “COVID Relief Includes \$360 Billion of State and Local Aid.” Retrieved from: <http://www.crfb.org/blogs/covid-relief-includes-360-billion-state-and-local-aid> (Accessed September 18, 2020.)

<sup>12</sup> Kaiser Family Foundation. “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.” Retrieved from: <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (Accessed September 18, 2020.)

<sup>13</sup> Schneider, Andy. “Medicaid and State Budgets: Checking the Facts (Yet Again).” Georgetown University Health Policy Institute Center for Children and Families. February 28, 2019. Retrieved from: <https://ccf.georgetown.edu/2019/02/28/medicaid-and-state-budgets-checking-the-facts-yet-again/#:~:text=If%20you%20want%20to%20know.all%20state%20general%20fund%20dollars>. (Accessed September 18, 2020.)

<sup>14</sup> Owens, Caitlin. “Racial disparities during pandemic extend to health coverage losses.” *Axios*, September 17, 2020. Retrieved from: <https://www.axios.com/health-coverage-losses-race-coronavirus-0ca93cd5-ec34-4c6e-8ab8-4784b1b3ff3f.html> (Accessed September 18, 2020.)

<sup>15</sup> Sloan, Chris; Duddy-Tenbrunsel, Robin; Ferguson, Samantha; Valladares, Angel; Kornfield, Thomas. “COVID-19 Projected to Worsen Racial Disparities in Health Coverage.” Avalere, September 16, 2020. Retrieved from: <https://avalere.com/press-releases/covid-19-projected-to-worsen-racial-disparities-in-health-coverage> (Accessed September 18, 2020.)

<sup>16</sup> Gruber, Jonathan, and Sommers, Benjamin D. “Paying for Medicaid — State Budgets and the Case for Expansion in the Time of Coronavirus.” *New England Journal of Medicine*, June 11, 2020. Retrieved from: <https://www.nejm.org/doi/full/10.1056/NEJMp2007124> (Accessed September 18, 2020.)

More importantly, perhaps, the majority of Americans do not want an aggressive expansion of government-provided coverage. In a national survey of 4,000 voters, 65 percent of Americans said it is more important to “[build] on our current health insurance system” than to “[create] a public option,” with majority support from Republicans, Democrats, and “swing” voters.<sup>17</sup> Nearly two-thirds of Americans (66 percent) said they would rather keep their current coverage *than pay the same amount* for equivalent public option coverage.<sup>18</sup>

Efforts to permanently expand the ACA are distinct from Medicaid expansion efforts, especially since the ACA marketplaces host privately sponsored plans. However, bills like H.R. 1425, recently passed by House Democrats, are also poorly targeted at the current crises. As we wrote in June:

Title I of the bill features two permanent, major expansions of the Affordable Care Act’s (ACA) PTCs. First, the legislation would make the values of PTCs more generous by lowering the share of income that households contribute to their ACA premiums. Second, the bill would make PTCs eligible for households beyond 400 percent of the federal poverty line (FPL), which in 2020 is \$104,800 in annual income for a family of four. There are three major issues accompanying the expansion of PTCs: 1) expansion is expensive (with a \$212 billion deficit impact), 2) targeting generous PTCs to households making six figures or more is a poor use of limited taxpayer dollars, and 3) PTCs are not designed to bend the cost curve for private health coverage, and will only increase in cost as premium hikes outpace wage increases.<sup>19</sup>

A different kind of solution is needed, one that: 1) responsibly reduces the budget burdens Medicaid places on state and federal taxpayers, 2) offers displaced workers and their families the maximum amount of plan choice and flexibility, including access to plans on the ACA marketplace, and 3) is targeted and temporary, so that the federal government can maximize limited tax dollars and put them to use solving a number of problems facing Americans during the COVID-19 pandemic and economic shock. We believe our **PHA proposal**, outlined below, meets the challenge.

### *Pandemic Health Accounts (PHAs) Strike the Proper Balance Between Coverage and Choice*

NTU introduced our concept for Pandemic Health Accounts (PHAs) in April, when Congress had passed the CARES Act and the COVID-19 public health and economic crises were just beginning. The concept is simple:

We propose creating for every household that loses access to ESI - and does not have access an adequate insurance option - a Pandemic Health Account (PHA).

These accounts, which share many similarities with Health Savings Accounts (HSAs), would serve as a bridge between a household’s loss of ESI and the start of their next job with ESI benefits. For that reason, we propose a federal credit designed to help a displaced worker (and, if applicable, their family) afford and choose the health insurance option that best suits their own needs. This credit could be

---

<sup>17</sup> Locust Street Group. (September 2020). “Voter Vitals: A Health Care Tracking Poll Edition IV.” Retrieved from: <https://americashealthcarefuture.org/wp-content/uploads/2020/09/PAHCF-Voter-Vitals-IV-Survey-Analysis.pdf> (Accessed September 18, 2020.)

<sup>18</sup> *Ibid.*

<sup>19</sup> Lautz, Andrew. “NTU Urges Representatives to Oppose Expensive, Partisan Health Care Bill.” National Taxpayers Union, June 25, 2020. Retrieved from: <https://www.ntu.org/publications/detail/ntu-urges-representatives-to-oppose-expensive-partisan-health-care-bill> (Accessed September 18, 2020.)

applied to COBRA premiums, an ACA marketplace plan, or a short-term limited duration (STLDI) plan for around four months. Congress may elect to extend that benefit, depending on the duration of the economic crisis.

...we propose a PHA benefit amount of roughly \$2,000 for individuals and \$6,000 for joint or family accounts. (This comes out to \$500 per month for individuals and \$1,500 per month for families.)<sup>20</sup>

Though PHAs would operate *like* HSAs, they would be unshackled from some of the requirements that we believe do not make sense for either PHAs or HSAs, such as the high-deductible health plan (HDHP) requirement and the limitation on using HSA dollars for insurance premiums.

The fundamental benefit of PHAs over either Medicaid, COBRA coverage, or even the ACA marketplaces is *choice* and *flexibility* for the account holder. We envision, for example, that someone receiving a PHA could use the funds to subsidize their COBRA coverage for several months. Unlike a COBRA subsidy, though, the PHA holder could also decline their COBRA coverage and turn to the ACA marketplace.<sup>21</sup> If the PHA holder is unsatisfied with ACA marketplace options, they could turn to off-marketplace options for coverage that costs less such as a short-term limited duration insurance (STLDI) plan. While such plans are not for everyone, they were designed for precisely the types of brief coverage gaps we expect many Americans will have this year due to COVID-19.

PHAs are better for the taxpayer, too - using KFF's earlier estimates of coverage loss (nearly 27 million), we estimated PHAs could cost between \$56 billion and \$67 billion - significantly less than the \$98 billion cost for nine months of a 100-percent COBRA subsidy.<sup>22</sup> Though policymakers could benefit from an updated estimate on the cost of a COBRA subsidy, since the last Joint Committee on Taxation (JCT) estimate was in May, we believe that if 12 million individuals were to benefit from a PHA (instead of 27 million) then the cost would range from between \$24 billion and \$36 billion. This figure would likely still be less expensive than a 100-percent COBRA subsidy, and is also significantly less costly than the cost of permanent ACA expansion (\$212 billion over 10 years).<sup>23</sup> It's also important to note that if policymakers were to allow people who *have* joined Medicaid since losing ESI to *opt in* to taking a PHA instead, then Congress could reduce state fiscal burdens at a perilous time for many states and their Medicaid programs.

---

<sup>20</sup> Lautz, Andrew. "Pandemic Health Accounts (PHAs): How Congress Can Best Help Millions of Americans Who May Soon Be Uninsured." National Taxpayers Union, April 8, 2020. Retrieved from: <https://www.ntu.org/publications/detail/pandemic-health-accounts-phas-how-congress-can-best-help-millions-of-americans-who-may-soon-be-uninsured> (Accessed September 21, 2020.)

<sup>21</sup> We do not envision allowing a PHA holder to access premium tax credits (PTCs) in the marketplace as long as they have federal funds remaining in their PHA; however, we believe that the PHA subsidy combined with unemployment insurance (UI) support for a displaced worker would be enough to help most Americans through the designated four-month period. Should an account holder run low or out of PHA funds while on an ACA exchange plan and still require the ACA plan as a bridge to ESI, we believe lawmakers could explore allowing an account holder to then receive PTCs.

<sup>22</sup> The Joint Committee on Taxation. (May 28, 2020). "Estimated Budget Effects Of The Revenue Provisions Contained In H.R. 6800, The "Health And Economic Recovery Omnibus Emergency Solutions ('HEROES') Act," As Passed By The House Of Representatives On May 15, 2020." Retrieved from: <https://www.jct.gov/publications.html?func=startdown&id=5261> (Accessed September 21, 2020.)

<sup>23</sup> Congressional Budget Office. (June 26, 2020). "Estimated Effect on the Deficit of Rules Committee Print 116-56, the Patient Protection and Affordable Care Enhancement Act, as Amended by Amendment Number 6 (Pallone, Neal, Scott) on June 25, 2020." Retrieved from: <https://www.cbo.gov/system/files/2020-06/Combined%20Tables.pdf> (Accessed September 21, 2020.)

We left several design and implementation questions open to lawmakers, believing that their expertise is best suited to settling these questions. However, NTU stands ready to work with *any and all* lawmakers interested in this novel option to support Americans that have lost ESI this year. We believe that this plan offers the financial support for ESI that many congressional Democrats have asked Congress to consider during the crisis, while offering the plan choice, flexibility, and fiscal restraint stressed by many Congressional Republicans. I stand ready to answer any of your questions, and thank you for your consideration ahead of the Committee's hearing.

Sincerely,

Andrew Lautz

Policy and Government Affairs Manager

CC: The Honorable Frank Pallone, Chairman, House Energy and Commerce Committee  
The Honorable Greg Walden, Ranking Member, House Energy and Commerce Committee  
The Honorable Eliot Engel  
The Honorable G. K. Butterfield  
The Honorable Doris Matsui  
The Honorable Kathy Castor  
The Honorable John Sarbanes  
The Honorable Ben Ray Luján  
The Honorable Kurt Schrader  
The Honorable Joseph P. Kennedy  
The Honorable Tony Cárdenas  
The Honorable Peter Welch  
The Honorable Raul Ruiz  
The Honorable Debbie Dingell  
The Honorable Ann M. Kuster  
The Honorable Robin L. Kelly  
The Honorable Nanette Diaz Barragán  
The Honorable Lisa Blunt Rochester  
The Honorable Bobby L. Rush  
The Honorable Fred Upton  
The Honorable John Shimkus  
The Honorable Brett Guthrie  
The Honorable H. Morgan Griffith  
The Honorable Gus M. Bilirakis  
The Honorable Billy Long  
The Honorable Larry Bucshon  
The Honorable Susan W. Brooks  
The Honorable Markwayne Mullin  
The Honorable Richard Hudson  
The Honorable Earl L. "Buddy" Carter  
The Honorable Greg Gianforte