March 23, 2021

The Honorable Anna Eshoo
Chairwoman, Health Subcommittee
House Committee on Energy and Commerce
Washington, D.C. 20515

The Honorable Brett Guthrie
Ranking Member, Health Subcommittee
House Committee on Energy and Commerce
Washington, D.C. 20515

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

Introduction

On behalf of National Taxpayers Union (NTU), the nation's oldest taxpayer advocacy organization, I wish to submit a letter for the record for the Subcommittee's March 23 hearing, "Building on the ACA: Legislation to Expand Health Coverage and Lower Costs."

Taxpayers have a significant stake in the performance of the Affordable Care Act (ACA), given the legislation expanded the federal government's role in health coverage in significant and unprecedented ways. As the voice of America's taxpayers, NTU has been regularly engaged in policy debates over the ACA. In the 11 years since the passage of the ACA, NTU has not been short on its criticism of many aspects of the legislation, from premium tax credits (PTCs) to the structure of Medicaid expansion to the expansive nature of the newly-created Center for Medicare and Medicaid Innovation (CMMI).

That said, after 11 years and multiple failed attempts to undo large portions of the ACA through legislation or litigation, it is clear that major aspects of the 2010 health care law are here to stay. To that end, NTU wishes to offer the Subcommittee our thoughts and recommendations on how to improve the ACA for consumers and taxpayers. This often involves a smaller, rather than a large, role for the federal government when it comes to regulating, providing, and/or paying for health coverage for Americans. While certain consumer protections provided by the ACA, such as protection from pre-existing condition exclusions and the prohibition of lifetime coverage limits, are popular with Americans and retain bipartisan support, not every part of the ACA is working well for Americans. We hope to play a constructive role, and to work with Democrats and Republicans on the Subcommittee, to improve the ACA going forward, and we believe that the best path forward for Congress is a bipartisan one.

What follows is our assessment of some of the proposed legislation being considered at this hearing, along with ACA changes made by the American Rescue Plan (ARP) Act, as well as some of our own recommendations for improving the ACA. Thank you for your consideration.

Proposed Legislation in the 117th Congress

The Subcommittee is considering several proposals at this hearing that would expand the ACA and adjust its scale and scope. NTU would like to offer its perspectives on several pieces of legislation under consideration:

H.R. 1796, the "Health Care Enrollment Innovation Act": This legislation would appropriate $600 million over three fiscal years (FYs 2023-2025) for the Department of Health and Human Services (HHS) to award grants to states for "innovative solutions to promote greater enrollment in health insurance coverage." We note that the Centers for Medicare and Medicaid Services (CMS) spent nearly $15.8 billion from FYs 2010-2020 for operating and maintaining the federally run ACA exchanges, an average of more than $1.4 billion per year in that time span.[1] Eligibility and enrollment efforts alone amounted to $3.0 billion from FYs 2010-2020 (or nearly 19 percent of the total), an average of $274 million per year, while consumer information and outreach efforts totaled $5.3 billion from FYs 2010-2020 (or more than 33.5 percent of the total), an average of $485 million per year.

What's more, over five fiscal years (FYs 2010-2014) Congress sent more than $4.8 billion to the states (plus Washington, D.C.) to establish and develop their ACA exchanges, including nearly $4 billion to the 14 states (plus D.C.) running state-based exchanges.[2] While much of the funding for *federal* exchanges comes from user fees, and while separate user fees offset the costs of running *state* exchanges, Congress should more closely study ways to reallocate and reform existing user fee funding for enrollment purposes before appropriating $600 million in taxpayer dollars under H.R. 1796.

H.R. 1872, the "Marketing and Outreach Restoration to Empower Health Education Act of 2021" or the "MORE Health Education Act": This legislation would appropriate $100 million per year for HHS to "carry out outreach and educational activities for purposes of informing potential enrollees in qualified health plans offered through the Exchange of the availability of coverage under such plans and financial assistance for coverage under such plans." While some of the goals in this legislation are admirable (such as attempting to connect with "hard-to-reach populations"), we again raise the existing funding for federally operated exchanges: an average of $274 million per year for eligibility and enrollment, and an average of $485 million per year for consumer information and outreach.[3] Before increasing that budget by $100 million per year (or 13 percent), Congress must assess how existing funding for ACA exchanges is falling short.

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[1] Forsberg, Vanessa C. "Overview of Health Insurance Exchanges." Congressional Research Service, Updated February 16, 2021. Retrieved from: https://crsreports.congress.gov/product/pdf/R/R44065 (Accessed March 18, 2021.)

[2] Data as of October 2014. For more, see: Mach, Annie L., and Redhead, C. Stephen. "Federal Funding for Health Insurance Exchanges." Congressional Research Services, October 29, 2014. Retrieved from: https://fas.org/sgp/crs/misc/R43066.pdf (Accessed March 18, 2021.)

[3] Forsberg, Vanessa C. "Overview of Health Insurance Exchanges." Congressional Research Service, Updated February 16, 2021. Retrieved from: https://crsreports.congress.gov/product/pdf/R/R44065 (Accessed March 18, 2021.)

We are also concerned about the legislation's gag on exchanges providing information about association health plans (AHPs) and short-term limited duration insurance (STLDI). As we explain further below, a global pandemic and ongoing economic recovery is not the time to limit coverage options available to consumers. That principle extends to providing information about all available coverage options. While there may be some legitimate concerns about how certain STLDI plans have been marketed,[4] they remain a coverage option that offers affordability and flexibility to some consumers experiencing temporary coverage gaps. Congress or the administration should crack down on the deceptive marketing of some plans rather than seeking to ban them entirely and gag exchanges from providing honest information about STLDI or AHPs.

Our concerns notwithstanding, we commend lawmakers for pursuing more reporting and transparency requirements on exchange performance throughout Section 3 of H.R. 1872. These reports may help taxpayers and the payers of user fees better understand how effectively exchange funding is being spent by the federal and state governments.

H.R. 1874, the "Expand Navigators' Resources for Outreach, Learning, and Longevity Act of 2021" or the "ENROLL Act of 2021": This legislation would pull $100 million per year from exchange user fees to HealthCare.gov exchange navigators, and would also expand some navigator duties and HHS requirements around the awarding of navigator grants. While H.R. 1874 avoids one pitfall of other legislation under consideration at this hearing, by funding navigator grants *from* exchange user fees rather than from new taxpayer dollars, we echo our concerns from H.R. 1872 that this legislation *also* bans navigators from taking AHPs or STLDI into effect when selecting navigators for the program. Consumers should be empowered with *more* information about the coverage options available to them, not less.

H.R. 1875, a bill to amend title XXVII of the Public Health Service Act to eliminate the short-term limited duration insurance exemption with respect to individual health insurance coverage: This legislation would eliminate the expansion of STLDI plans from the prior administration. We have written before that "such plans are not for everyone, [but] they were designed for precisely the types of brief coverage gaps we expect many Americans will have [in 2020 and 2021] due to COVID-19."[5] As mentioned above, there may be some legitimate concerns around the ways that certain STLDI plans have been marketed. There should be no excuses if an STLDI plan deceives a consumer about the scope of coverage in the plan when the consumer is considering their options, and we would encourage lawmakers and the Federal Trade Commission (FTC) to explore this issue further. Bad practices, though, should be an opportunity for enforcement and reform rather than the elimination of affordable coverage options for Americans. We encourage the Committee to abandon its plans to eliminate STLDI coverage options for consumers, as well as the gag efforts around STLDI and AHPs mentioned above.

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[4] House Committee on Energy and Commerce. (June 25, 2020). "E&C Investigation Finds Millions of Americans Enrolled in Junk Health Insurance Plans That Are Bad for Consumers & Fly Under the Radar of State Regulators." Retrieved from: https://energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health (Accessed March 18, 2021.)

[5] Lautz, Andrew. "House Should Consider Novel, Targeted Ways to Alleviate COVID-19 Health Coverage Losses." National Taxpayers Union, September 22, 2020. Retrieved from: https://www.ntu.org/publications/detail/house-should-consider-novel-targeted-ways-to-alleviate-covid-19-health-coverage-losses (Accessed March 18, 2021.)

H.R. 1890, the "Health Care Consumer Protection Act": This legislation, however well-intentioned, would squeeze private plans participating in the ACA exchanges in two different ways: first, by requiring "quantitative network adequacy standards" in each ACA plan that are undefined by lawmakers in the bill, and second, by demanding HHS or state agencies "take corrective action" to prevent "excessive, unjustified, or unfairly discriminatory [premium] rates." Network creation and network adjustments are key tools for health insurers to manage costs; or, as the National Association of Insurance Commissioners puts it:

> Health insurance carriers are generally able to define and adjust the number, the qualifications and the quality of providers in their networks. They also may limit the number of providers in their networks as a means of conserving costs or coordinating care.[6]

While narrow networks on some plans may be a legitimate concern for policymakers, especially in rural and/or impoverished areas with fewer medical providers than some urban and high-income areas, H.R. 1890 would place a difficult mandate on insurers: add medical providers to your networks, but do not increase premiums in those plans either. This could squeeze insurers to absorb the additional costs elsewhere, with possibilities including but not limited to: higher deductibles, higher out-of-pocket limits, increased care management and prior authorization requirements, lower reimbursement rates for providers, or the elimination of plans that cannot both meet the adequacy standards and provide insurance at what the federal government determines is an affordable, justified, or fair rate.

H.R. 340, the "Incentivizing Medicaid Expansion Act of 2021": This legislation would incentivize states that have not yet expanded Medicaid to do so by giving those states a more generous federal share of Medicaid expansion costs that previously were only available to states that expanded Medicaid after original passage of the ACA. We stress that in 2020 the Congressional Budget Office (CBO) projected that, on net, federal taxpayers are expected to commit $6.91 trillion from FYs 2020-2030 to federal subsidies for health insurance coverage for individuals under 65 under Medicare, Medicaid, and the ACA exchanges, an average of nearly $700 billion per year.[7] More than two-thirds of that total ($4.74 trillion) is for subsidizing state-run Medicaid and CHIP programs or new Medicaid expansion programs enacted under the ACA. Of that total, more than $1.13 trillion alone is going to near-full federal subsidization of Medicaid expansion populations. With the nation facing down $28 trillion in debt and trillion-dollar deficits for years to come, now is not the time to *further* burden federal taxpayers without asking states—who, by statute, typically need to balance their budgets each year—to pitch in more of a fair share. In fact, one of our proposals for ACA reform below is to keep Medicaid expansion provisions in place while asking states to contribute more to Medicaid expansion population costs.

American Rescue Plan (ARP) Changes to the ACA

Premium tax credit (PTC) expansion: Lawmakers temporarily made premium tax credits much more generous in the ARP, a $35 billion change for plan years 2021 and 2022. There will certainly be a push by lawmakers to make this expansion permanent, a proposition that may cost taxpayers near $200 billion in the first decade alone. To that end, we wrote earlier in March that there are three major problems with permanent expansion of PTCs:

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[6] National Association of Insurance Commissioners. (June 23, 2020). "Network Adequacy." Retrieved from: https://content.naic.org/cipr_topics/topic_network_adequacy.htm (Accessed March 18, 2021.)

[7] Congressional Budget Office. (September 2020). "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030." Retrieved from: https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf (Accessed March 18, 2021.)

1. Expansion is expensive (a $212 billion deficit impact over 10 years, according to the nonpartisan Congressional Budget Office);
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.[8]

We added that taxpayers should assume "policymakers will both a) push to make these provisions permanent in 2022, and b) frame opposition to making these provisions permanent as a tax hike on individuals and families purchasing ACA coverage."[9] We are concerned that this dynamic is already unfolding on Capitol Hill.

We would urge lawmakers to abandon a permanent push for PTC expansion and recognize that the PTC expansion provisions in ARP should remain a one-time, extraordinary measure to assist individuals and families impacted by the pandemic. If lawmakers insist on making PTC expansion permanent, they should at least seek to offset the costs, and we have at least one major pay-for to offer policymakers below.

Traditional FMAP boost for new expansion states: One of the most generous provisions to state and local governments in the various COVID-19 relief bills has been the ongoing 6.2-percentage point boost to the federal government's share of states' Medicaid costs for traditional (not expansion) Medicaid populations. A report from the Government Accountability Office this year indicates that, from January 1 (retroactively) through December 31, 2020, the 6.2-percentage point Federal Medical Assistance Percentage (FMAP) boost was worth $24.4 billion.[10] Assuming the public health emergency (PHE) lasts through at least 2021, and extrapolating from 2020 numbers, the FMAP boost could easily cost federal taxpayers another $20 billion or more in 2021.

Lawmakers should resist the urge to extend the FMAP boost beyond the length of the PHE, though, and may even consider pulling back the FMAP boost sooner for two reasons: 1) the PHE began when COVID-19 cases were still low[11] and may continue for well after the U.S. has managed to bring the pandemic's spread under control, and 2) ARP gave state and local governments $350 billion on top of $150 billion appropriated in the CARES Act, and the continued FMAP boost should be measured against this extraordinary and potentially unnecessary amount of aid to state governments.[12]

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[8] Lautz, Andrew. "Beware $200-Billion, Permanent Premium Tax Credit Expansion." National Taxpayers Union, March 16, 2021. Retrieved from: https://www.ntu.org/publications/detail/beware-200-billion-permanent-premium-tax-credit-expansion (Accessed March 18, 2021.)

[9] *Ibid*.

[10] Government Accountability Office. (January 2021). "COVID-19: Critical Vaccine Distribution, Supply Chain, Program Integrity, and Other Challenges Require Focused Federal Attention." GAO-21-265. Retrieved from: https://www.gao.gov/assets/gao-21-265.pdf (Accessed March 18, 2021.)

[11] Musumeci, MaryBeth. "Key Questions About the New Increase in Federal Medicaid Matching Funds for COVID-19." Kaiser Family Foundation, May 4, 2020. Retrieved from: https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/ (Accessed March 18, 2021.)

[12] For more, see: Lautz, Andrew. "COVID Bill Proposes Nearly $200 Billion for States. They May Only Need $6-16 Billion." National Taxpayers Union, March 4, 2021. Retrieved from: https://www.ntu.org/publications/detail/covid-bill-proposes-nearly-200-billion-for-states-they-may-only-need-6-16-billion (Accessed March 18, 2021.)

NTU Reform Recommendations

Reduce the enhanced FMAP for Medicaid expansion populations so it matches traditional Medicaid populations: One of the most impactful deficit reduction options Congress can undertake, as it pertains to the ACA, is reducing the FMAP rates for expansion populations so that they match the traditional Medicaid FMAP. While states may indeed see fit to continue covering expansion populations under Medicaid—and should have the choice to continue doing so—there is no compelling reason outside of state budgetary pressures for the federal government to continue footing 90 percent of the bill. A reduction in the expansion FMAPs, to match traditional FMAPs, would still have federal taxpayers covering a majority of the bill, but would ask states to kick in a fair share for growing Medicaid expansion population costs.[13]

As CBO notes, "some states would discontinue coverage for that category of enrollees, and all states that would have adopted such coverage in the future would no longer choose to do so."[14] When accounting for increased PTCs for those who lose Medicaid coverage, the net savings to taxpayers would be $500 billion over 10 years. These savings can and should apply to deficit reduction, but at worst could more than offset the cost of expanding the more generous PTCs passed in ARP. For lawmakers concerned about coverage losses, as states weigh whether or not to continue Medicaid expansion under traditional Medicaid terms, Congress could soften the blow to states by extending the phase-out period for the expansion FMAP. For example, reducing the expansion FMAP by three percentage points per year would give the average state 10 or 11 years to adjust to the harmonization of traditional and expansion population FMAPs. This could reduce coverage loss and/or give states more flexibility to assist residents coming off Medicaid.

Reduce, rather than increase, distortionary rebates in Medicaid and Medicare: The ACA expanded distortionary rebates in Medicare and Medicaid, including line extension rebates in Medicaid and brand-manufacturer rebates in the coverage gap of Part D.[15] NTU has argued for years that, as tempting as statutory rebates are to policymakers, mandatory pharmaceutical rebates in federal health programs merely push the cost bubble for researching, developing, seeking approval for, marketing, and producing prescription drugs and biological products onto other payers or other parts of society. The statutory rebates are particularly burdensome in Medicaid, as we have noted before.[16]

When rebates force manufacturers to sell a significant portion of their products for less than it costs to bring them to market, make them, and distribute them, policymakers risk one of two policy impacts (or both): 1) increased prices paid by private payers, and 2) less capital available for manufacturers to research and develop new products, or to improve existing products.

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[13] Per-year federal costs for the Medicaid expansion population are expected to grow 74.4 percent from FY 2020 to FY 2030, a much faster rate than the 50-percent cost growth in federal subsidies for all other Medicaid populations from FY 2020 to FY 2030. For more see: Congressional Budget Office. (September 2020). "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030." Retrieved from: https://www.cbo.gov/system/files/2020-09/56571-federal-health-subsidies.pdf (Accessed March 18, 2021.)

[14] Congressional Budget Office. (December 2020). "Options for Reducing the Deficit: 2021 to 2030." Retrieved from: https://www.cbo.gov/system/files/2020-12/56783-budget-options.pdf (Accessed March 18, 2021.)

[15] Cubanski, Juliette; Neuman, Tricia; Damico, Anthony. "Closing the Medicare Part D Coverage Gap: Trends, Recent Changes, and What's Ahead." Kaiser Family Foundation, August 21, 2018. Retrieved from: https://www.kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/ (Accessed March 19, 2021.)

[16] "[I]n fiscal year (FY) 2017 manufacturer rebates made up more than half of Medicaid's gross spending on outpatient prescription drugs ($34.9 billion out of $64 billion, or 54.5 percent)." For more see: Lautz, Andrew. "A Taxpayer- and Market-Oriented Path Forward for Federal Prescription Drug Policy." National Taxpayers Union, February 25, 2021. Retrieved from: https://www.ntu.org/publications/detail/a-taxpayer-and-market-oriented-path-forward-for-federal-prescription-drug-policy (Accessed March 19, 2021.)

Instead, we have urged lawmakers to *reduce* distortionary rebates in a few key places:

- The MDRP, where the base rebate amount is typically 23.1 percent of the average manufacturer price (AMP) for a drug;
- MDRP inflationary penalties, which as we note above further distort prices in the market; and
- The Medicare Part D 'donut hole' 70-percent drug rebate.[17]

Doing so may lead to fewer price distortions, less 'sticker shock' drug costs for private payers, more research capital for pharmaceutical manufacturers, and more competition in the prescription drug market.

Repeal the ban on growth of physician-owned hospitals: Reversing this particular provision of the ACA could help medical providers deal with future demand constraints, which was a major concern in the early months of the COVID-19 pandemic. As we wrote in March 2020:

> At a time when hospitals are expected to experience significant restraint due to an influx of COVID-19 patients, policymakers should look at loosening up the Affordable Care Act (ACA)'s restrictions on physician-owned hospitals (POHs). The ACA effectively halted the construction of new POHs and "generally prohibited [existing POHs] from expanding facility capacity." The Trump administration has called for repealing the rules, writing that according to the Physician Hospitals of America "37 planned hospitals have not been constructed, and over 30,000 planned healthcare jobs have gone uncreated" because of these restrictions.

Reform CMMI: Fortunately, one of the few current ACA reform ideas with bipartisan agreement is reining in the Centers for Medicare and Medicaid Innovation (CMMI), whose authority presidents in both parties have abused since its creation. We wrote in March 2020 that bipartisan legislation in the House, championed by Rep. Terri Sewell (D-AL), would put a number of important guardrails on CMMI going forward:

> The legislation would limit CMMI models to five years and a "statistically valid sample" of individuals. It would also re-establish judicial review for "the elements, parameters, scope, and duration of such models for testing or dissemination," and "determinations about expansion of the duration and scope of a model."
>
> The bill goes even further in the right direction by providing for expedited Congressional disapproval of a CMMI model.
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> ...We also support the higher bar the Strengthening Innovation in Medicare and Medicaid Act would set for public input into CMMI models; namely, that CMMI must consult the public on the development, testing, modification, and evaluation of models. This will increase the opportunities stakeholders have to raise legitimate concerns with the scale, scope, and design of certain models.[18]

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[17] *Ibid*.

[18] Lautz, Andrew. "Bipartisan Legislation Would Put Prudent Guardrails on Medicare Innovation Center." National Taxpayers Union, March 9, 2020. Retrieved from: https://www.ntu.org/publications/detail/bipartisan-legislation-would-put-prudent-guardrails-on-medicare-innovation-center (Accessed March 19, 2021.)

We hope lawmakers consider the Strengthening Innovation in Medicare and Medicaid Act and additional CMMI reforms in the 117th Congress.

Conclusion

NTU did not agree with many aspects of the ACA upon passage, and we continued to express concerns during the challenging subsequent years of the ACA's implementation. Furthermore, some of the legislation considered by the Committee today may add costs for taxpayers without meaningfully addressing access or affordability issues in the ACA marketplaces.

We believe that going forward taxpayers are better served by an ACA that works well for those who most need assistance obtaining health coverage and is responsibly narrowed by lawmakers in the many areas of the law where federal overreach leads to inefficiencies and additional costs in the health marketplace.

To that end, we are at your disposal as lawmakers seek to address ACA reform in a bipartisan and targeted manner. Thank you for your consideration.

Sincerely,

Andrew Lautz,
Director of Federal Policy