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**“Strengthening Our Health Care System:
Legislation to Reverse ACA Sabotage and
Ensure Pre-Existing Conditions Protections”**

**Chairwoman Anna G. Eshoo
Ranking Member Michael Burgess**

**Testimony by Grace-Marie Turner
President
Galen Institute**

Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure Pre-Existing Conditions Protections¹

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Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the opportunity to testify today on ways to strengthen our health care system.

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. We focus on ways to ensure access to affordable health coverage and care for all Americans, especially the most vulnerable. I also have served as an appointee to the Medicaid Commission, as a member of the Advisory Board of the Agency for Healthcare Research and Quality, and as a congressional appointee to the Long Term Care Commission.

Today, I will discuss

- The Trump administration's Section 1332 guidance
- The Short-Term Limited Duration Plan rule
- Commitment to pre-existing condition protections
- Navigator funding outreach and enrollment

New Section 1332 Guidelines: The Centers for Medicare and Medicaid Services in October issued guidance to give states more innovation authority under the Affordable

¹ [H.R. 986](#), the “**Protecting Americans with Preexisting Conditions Act of 2019**”, introduced by Rep. Ann M. Kuster (D-NH), would require the Trump Administration to rescind the Section 1332 guidance of the ACA promulgated in October of 2018;

[H.R. 987](#), the “**Marketing and Outreach Restoration to Empower Health Education Act of 2019**” or the “**MORE Health Education Act**”, introduced by Rep. Lisa Blunt Rochester (D-DE), will restore outreach and enrollment funding to assist consumers in signing up for health care, which has been slashed by the Trump Administration; and

[H.R. 1010](#), **To provide that the rule entitled “Short-Term, Limited Duration Insurance” shall have no force or effect**, introduced by Rep. Kathy Castor (D-FL), will reverse the Trump Administration's expansion of junk insurance plans, also known as short-term, limited-duration insurance plans.

Care Act.² Under the revised guidance, states have new options to repurpose some ACA funding to improve their individual and small group markets while following guidelines in the law.

Section 1332 of the ACA gives states new options to lower costs and increase access to health insurance choices by better tailoring coverage to the needs of their residents. Several states have received waivers to create risk-mitigation programs. Under these waivers, the states separately subsidize patients with the highest health costs, thereby lowering premiums and increasing enrollment. They have seen in many cases dramatic results with no new federal spending.

Doug Badger, senior fellow at the Galen Institute, and Heritage senior research fellow Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.³ “Several states have successfully used a waiver to change market conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care,” they write.

Alaska was the first states to receive a waiver. It moved customers with one of 33 medical conditions into a separate insurance pool with medical claims funded in part by a portion of federal premium-subsidy payments diverted to the pool. As a result, premiums for the lowest-cost Bronze plans fell by 39% in 2018, Badger and Haislmaier report.

In Oregon premiums for the lowest-cost Bronze plans fell by 5% in 2018, and premiums for the highest-cost Bronze plans plunged by 20%. In Minnesota, the third state with an approved waiver, premiums also dropped in both 2018 and 2019. Average premiums for ACA coverage in 2019 will be lower with every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.⁴

According to the paper, “States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce

² <https://www.cms.gov/newsroom/press-releases/trump-administration-announces-state-relief-and-empowerment-waivers-give-states-flexibility-lower>

³ Doug Badger, Ed Haislmaier, “State Innovation: The Key to Affordable Health Care Choices,” The Heritage Foundation, September 27, 2018. <https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices>

⁴ Grace-Marie Turner, Doug Badger, “Several States Have Found Ways To Mitigate Obamacare's Damage To Their Health Insurance Markets,” *Forbes*, October 3, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/10/03/several-states-have-found-ways-to-mitigate-obamacares-damage-to-their-health-insurance-markets/#56d1b71730da>

premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government.”

States are employing various risk mitigation strategies to finance coverage for those with high health costs by repurposing federal money to finance coverage and care for residents in poor health or who have chronic conditions. By separately subsidizing those with the highest health costs, they can lower premiums for individual health insurance, and the lower premiums also mean increased enrollment.

Putting the sickest people in the same pool with others, as the ACA requires, means premiums are higher for everyone, often much higher, especially for those without subsidies. Virginia State Sen. Bryce Reeves told us of an email from a constituent in Fredericksburg: He made a good living and tried to provide for his family but said his insurance premiums cost \$4,000 a month! “That’s more than my mortgage,” he told Sen. Reeves. “What am I supposed to do?”⁵

Cost relief is essential. Unfortunately, more and more healthy people are dropping out of the individual exchange market.

Premiums have risen sharply since exchange coverage began in January of 2014. Average premiums more than doubled between 2013 and 2017.⁶ HHS reports that premiums for the lowest-cost plan available to a 27-year-old in states using the healthcare.gov platform rose by an additional 17% in 2018.⁷

Not surprisingly, enrollment in the individual health insurance markets is falling . A net of three million people dropped coverage in the individual health insurance market between 2015 and 2018. According to a study published by the Kaiser Family on “Changes in Enrollment in the Individual Health Insurance Market,” there were 17.4 million policyholders in the individual market in 2015, dropping to 14.4 million by the first quarter of 2018.⁸

⁵ Grace-Marie Turner, “Health Care Choices Proposal: A New Generation of Health Reform,” *Forbes*, June 22, 2018. <https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation-of-health-reform/#1106ce6664f1>

⁶ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Individual Market Premium Changes: 2013–2017,” Data Point, May 23, 2017.

⁷ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, “Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange,” https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf (accessed September 21, 2018).

⁸ Ashley Semanskee, Larry Levitt, Cynthia Cox, “Changes in Enrollment in the Individual Health Insurance Market,” July 31, 2018, Kaiser Family Foundation. <https://www.kff.org/health-reform/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market/>

Short-Term Limited Duration Plans: The Trump administration last year finalized a rule to expand access to short-term, limited-duration plans to give Americans access to health insurance coverage that better fits their needs. The Obama Administration had limited the policies to three months of coverage and prohibited their renewal. Under the new rule, these plans can be offered for up to 364 days and renewed for up to 36 months, subject to state regulation.

Short-term plans⁹ are helpful to people with gaps in employment, to early retirees who no longer have employer-sponsored health insurance and need bridge coverage before they qualify for Medicare, people between jobs, young people who no longer have coverage from their parents and are working in the gig economy, people who are leaving the workforce temporarily to attend school or training programs, and entrepreneurs starting new businesses. Premiums for short-term health plans typically are less than half those of ACA plans.

The administration's rule also extended consumer protections. Under the Obama administration's previous 2016 rule, people could lose their coverage after three months if they acquired a medical condition during the three-month period. By extending the contract period, people can be protected from a period of uninsurance until the next ACA open enrollment period.

The plans are not required to cover the comprehensive list of benefits required by the ACA, and consumers education is important in understanding how they differ from ACA-compliant plans.

An estimated 1.7 million people who would otherwise be uninsured are expected to enroll in an STLD plans.¹⁰ Several states limit their residents' access to STLD plans, but in so doing, they deny them what may be their only realistic option for coverage.¹¹

Council of Economic Advisers: A new White House report on "Deregulating Health Insurance Markets: Value to Market Participants"¹² provides important data showing the positive impact of this consumer-friendly health policy change. They estimate that

⁹ <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>

¹⁰ Linda J. Blumberg, Matthew Buettgens, Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 2018. https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

¹¹ Doug Badger and Whitney Jones, "Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternatives to Obamacare Policies," The Heritage Foundation, April 26, 2018. <https://www.heritage.org/health-care-reform/report/five-steps-policymakers-can-take-permit-the-sale-and-renewal-affordable>

¹² Council of Economic Advisers, "Deregulating Health Insurance Markets: Value to Market Participants," February 2019. <https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf>

STLDS would produce a marginal social benefit of \$80 billion over ten years, even taking into account concerns that they might raise premiums for some people with ACA-compliant coverage.

While some say that STLD plans are “junk” insurance that sabotages the ACA, this report provides solid evidence that consumers will benefit, both in expanded coverage and lower costs. The Trump administration believes this policy option, together with other deregulatory reforms, will generate benefits to Americans that are worth an estimated \$450 billion over the next 10 years.

Protection for Pre-Existing Conditions. There is strong bi-partisan support for pre-existing condition protections.¹³ A number of provisions were included in the Affordable Care Act (ACA) to ensure that coverage is available and affordable to those with pre-existing conditions.¹⁴ The law stipulates that people cannot be turned down or have their policies cancelled because of pre-existing conditions and that they are able to purchase policies without facing huge spikes in premium costs because of their health status. These protections are still in place.

Legislation passed by the House of Representatives in 2017 preserved pre-existing condition protections, and other legislative and policy proposals offered since then to improve the private health insurance market also provide pre-existing condition protections.¹⁵

Last week, at a hearing before this committee on pre-existing conditions, you heard Energy and Commerce Committee Republican Leader Greg Walden affirm on behalf of his colleagues: “We fully support protecting Americans with pre-existing conditions. We’ve said this repeatedly, we’ve acted accordingly, and we mean it completely. We could—and should—inject certainty into the system by passing legislation to protect those with pre-existing conditions.”¹⁶

At a separate hearing on this issue, also last week, before the House Education and Labor Committee, Ranking Member Virginia Foxx said in her [opening statement](#), “Americans with pre-existing conditions need health insurance. This is a fact and a value that Congress and the President have affirmed countless times.

¹³ Morning Consult+POLITICO, National Tracking Poll, Sept. 6-9, 2018. https://morningconsult.com/wp-content/uploads/2018/09/180919_crosstabs_POLITICO_v1_DK.pdf

¹⁴ Karen Pollitz, Testimony before the House Committee on Ways and Means on pre-existing conditions and health insurance, January 29, 2019. <http://files.kff.org/attachment/Testimony-of-Karen-Pollitz-Committee-on-Ways%20and-Means-Pre-existing-Conditions-and-Health-Insurance>

¹⁵ See for example, the Health Policy Consensus Group’s Health Care Choices Plan, June 2018, www.HealthCareChoices2020.org

¹⁶ <https://republicans-energycommerce.house.gov/news/press-release/republicans-fully-support-protecting-americans-with-pre-existing-conditions/>

“It’s also the law,” she affirmed. “Insurance companies are prohibited from denying or not renewing health coverage due to a pre-existing condition. Insurance companies are banned from rescinding coverage based on a pre-existing condition. Insurance companies are banned from excluding benefits based on a pre-existing condition. Insurance companies are prevented from raising premiums on individuals with pre-existing conditions who maintain continuous coverage.”

She cited existing protections under the [Health Insurance Portability and Accountability Act](#) (HIPAA)¹⁷ and Republican support for further protections in the House-passed [American Health Care Act of 2017](#).¹⁸

As Ranking Member Walden detailed, under the AHCA:

- Insurance companies were prohibited from denying or not renewing coverage due to a pre-existing condition. Period.
- Insurance companies were banned from rescinding coverage based on a pre-existing condition. Period.
- Insurance companies were banned from excluding benefits based on a pre-existing condition. Period.
- Insurance companies were prevented from raising premiums on individuals with pre-existing conditions who maintain continuous coverage. Period.

More than 300 million Americans are in plans that protect them from pre-existing condition exclusions:

- About 173 million Americans are covered through employer-sponsored health insurance plans¹⁹ and have further protections if they leave their employer.²⁰
- Nearly 60 million seniors and disabled people are on Medicare, which provides solid guarantees of continued coverage regardless of health status.²¹

¹⁷ <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html>

¹⁸ <https://www.congress.gov/bill/115th-congress/house-bill/1628>

¹⁹ Doug Badger, “Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers,” Galen Institute, December 2018. <https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf>

²⁰ If an employee leaves their employer, they can continue their coverage through COBRA, and if they are continually insured and move to a new group, they cannot be denied coverage for a pre-existing condition.

²¹ CMS Fast Facts based upon CMS/Office of Enterprise Data & Analytics/Office of the Actuary. July 2018

- 75 million are on Medicaid. Same protections.
- Nearly 5 million children are on the Children’s Health Insurance Program. Same.
- Still others have coverage under Department of Veterans Affairs, the Indian Health Service, etc. All provide built-in guarantees of protection for chronic, pre-existing conditions.

Only 5 percent of Americans got their policies through the individual market in 2018—about 15 million people—according to the Congressional Budget Office.²² This would be the only segment of the market subject to a *Texas v Azar* decision.²³

Republicans strongly support maintaining protections for them. Surely Congress can come to bi-partisan agreement to protect them without disrupting coverage for well over 300 million Americans who already have built-in coverage.

Guaranteed protection programs are key for policymakers to protect those with pre-existing conditions and also to ensure access to affordable coverage for those who need insurance to guard against future health risks. A woman with serious health problems provided a testimonial about why further reforms are needed.²⁴ Janet reported to us:

“In 1999, I was diagnosed with Hepatitis C, which made me ineligible for insurance, (denied for pre-existing conditions),” she said. “I live in Colorado, and they had a high-risk pool that covered people like me. I applied for that and was accepted.

“My premiums in 2010 were \$275/month with a total out of pocket of \$2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved without a question. My \$600,000 transplant was covered 100% with a \$2,500 out of pocket maximum!”

When Obamacare went into effect, Colorado’s high-risk pool was closed. “I was forced into the regular marketplace that everyone was telling me was a good thing because I couldn’t get denied. I think my first year on that policy, my premiums were in the \$450 range—which I thought wasn’t too terrible, but still more than I had been paying.

“The thing I noticed from the start was that instead of full coverage, almost everything I

²² CBO 2018b projections

²³ One recommendation to assure protection for Americans subject to this decision would be for Congress to pass a simple bill saying that the individual mandate is severable from the Affordable Care Act and therefore the rest of the law would stand should higher courts agree with the district court about the unconstitutionality of the individual mandate absent the tax penalty for non compliance.

²⁴ From HealthCareChoices2020.org testimonials:
<https://www.healthcarereform2018.org/testimonial/janets-story-high-medical-costs-worse-coverage/>

needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the basic care I needed.

“Since then, my premiums skyrocketed. In 2017, I paid \$735 a month with total out-of-pocket costs of \$5,500. In 2018, my premiums went up to \$1,100 a month with a deductible of \$6,300. Once I hit that mark, I’m covered 80%.

“Further, none of my anti-rejection meds are on the formulary of my insurance. If I could not afford them, my body would most certainly reject my liver, causing another liver transplant that would not be covered 100%.

“I don’t get any [tax] credits from the government to reduce my premiums. Those of us who are self employed but make more than the threshold for tax credits wind up footing the whole bill ourselves. I have to spend \$19,500 before my insurance pays anything, and it doesn’t cover all my prescription costs. My old plan was almost a third of what I have to pay now.

“I have many friends and work associates in the same boat as me. Many of them are doing without insurance and are betting that they won’t need more than what they can afford to pay out of pocket. I cannot do that, because if something happened and I needed another transplant, it would bankrupt my family.”

Janet has coverage for pre-existing conditions, but her access to care is inferior to the state high-risk pool coverage she had before, and the cost of her coverage is much higher.

The current system is not working for Janet and others like her in receiving the care she needs.

Navigators

The Centers for Medicare and Medicaid Services says it is focusing on spending taxpayer dollars effectively. An analysis by the Centers for Medicare and Medicaid Services (CMS) showed the high cost of the Navigator program relative to signups. During the 2016 open enrollment period, Navigators received more than \$62 million in federal grants while enrolling 81,426 individuals—or fewer than one percent of all enrollees. Seventeen of these Navigators enrolled fewer than 100 people each at an average cost of \$5,000 per each enrollee.²⁵

The top 10 most-costly Navigators spent a total of \$2.77 million to enroll 314 people. One grantee received \$200,000 and enrolled ONE person, enough to have covered more than 30 people for the whole year.²⁶

²⁵ <https://www.cms.gov/newsroom/press-releases/cms-announcement-aca-navigator-program-and-promotion-upcoming-open-enrollment>

²⁶ <https://www.cnbc.com/2017/11/22/obamacare-assistance-group-got-200000-in-funds-signed-up-one.html>

Seventy-eight percent of Navigators failed to achieve their enrollment goals while spending more than \$50 million.

Since then, CMS set up a system in which Navigator grantees receive funding based on their ability to meet their enrollment goals during the previous year.

Enrollment began to decline before any changes in Navigator grants by the Trump administration. “The subsidized and unsubsidized enrollment report shows enrollment began to decline in some states between 2015 and 2016, and in particular among the unsubsidized portion of the market. Over that period, 23 states experienced a decline in unsubsidized enrollment, with 10 states experiencing double-digit declines,” according to a CMS study.²⁷

CMS believes that independent agents and brokers can be more cost-efficient in assisting people in obtaining exchange coverage.

“CMS increased efforts to leverage the capabilities of the private sector by expanding the role of health insurance agents and brokers who supported 3,660,668 health plan enrollments, 42 percent of plan-year 2018 open enrollments on Federal platform Exchanges. In contrast, Navigators enrolled less than 1 percent of total enrollees,” the report found.

Because many people on the exchanges are automatically reenrolled, there is less need for assistance than when the program was new. The “effectuated enrollment” report shows that enrollment through the Exchanges remained steady for subsidized people who were automatically re-enrolled in plan year 2018 and paid their first month’s premium. In February 2018, 10.6 million individuals had effectuated their coverage through the Exchanges.²⁸

Finally, California spent heavily on marketing to increase enrollment in its state-based exchange last fall, yet it experienced a 23.8% drop in new enrollees over 2018.²⁹ Covered California is encouraging the state to establish an individual mandate. But it is hard to boost enrollment through added spending on marketing or using the mandate club when the main reason people are not signing up is the high cost of premiums and sky-high deductibles.

²⁷ <https://www.cms.gov/newsroom/press-releases/centers-medicare-and-medicaid-services-releases-reports-performance-exchanges-and-individual-health>

²⁸ *Ibid.*

²⁹ Covered California had 388,344 new enrollees for the 2018 coverage year but only 295,980 enrollees as of January 31, 2019, a decline of nearly 24% or more than 92,000 enrollees, according to the California exchange website. <https://www.coveredca.com/newsroom/news-releases/2019/01/30/covered-california-plan-selections-remain-steady-at-1-5-million-but-a-significant-drop-in-new-consumers-signals-need-to-restore-penalty/>

I appreciate your invitation to testify today. I would welcome the opportunity to work with you in developing more ways to help lower the costs of health coverage, providing employers and employees and those in the individual market with more choices of affordable health coverage while maintaining quality and consumer protections, including pre-existing condition protections.

APPENDIX

The Trump administration is providing two additional options for consumers to obtain more affordable health coverage options, Association Health Plans and Health Reimbursement Arrangements.

Association Health Plans: A new White House report on “Deregulating Health Insurance Markets: Value to Market Participants”³⁰ provides important data showing the positive impact of major consumer-friendly health policy changes made by the Trump administration. It explains:

On October 12, 2017, President Trump signed Executive Order 13813, “Promoting Healthcare Choice and Competition Across the United States” (White House 2017b), which directed the Secretary of Labor to consider proposing regulations to ease employers’ abilities to form Association Health Plans (AHPs) that allow small businesses to group together to self-insure or purchase large group insurance. AHPs enable employers to band together, which decreases administrative costs through economies of scale. The Department of Labor finalized this new rule on June 21, 2018, pursuant to its authority under the Employee Retirement Income Security Act (known as ERISA).

Small and medium-sized firms have new options through the administration’s new Association Health Plans rule.³¹ This rule expands an organization’s ability to offer AHPs on the basis of common geography or industry and offers other options for enrollees.

The ACA required small businesses to cover all of the law’s expensive essential health benefits—more benefits than larger employers are required to cover. That, coupled with higher administrative costs, had put health insurance increasingly out of reach of many small businesses. Association Health Plans provide them an option by organizing to receive the same economies of scale and ability to tailor benefits as larger companies. A recent study found that AHP insurance is comparable to the comprehensive coverage provided by these larger companies.³²

The Washington Post reported recently that: “Chambers of commerce and trade associations have launched more than two dozen of these ‘association health plans’ in 13 states in the seven months since the Labor Department finalized new rules making it

³⁰ Council of Economic Advisers, “Deregulating Health Insurance Markets: Value to Market Participants,” February 2019. <https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf>

³¹ <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/association-health-plans.pdf>

³² Kev Coleman, “First Phase of New Association Health Plans Reveal Promising Trends,” Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces.”³³

The February 2019 Council of Economic Advisors report found that 28 AHPs have formed already, with more under development. Some AHPs show up to 30% savings on premiums.

The Las Vegas Chamber of Commerce is in the process of signing up 500 employers for an AHP, with expected savings of \$2,000 per year. The Georgia Chamber of Commerce is in the process of setting up a self-insured AHP that it expects may eventually enroll 800,000 people. Most, if not all, are using established insurance companies to manage their AHPs.

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.³⁴ “We’re not seeing skinny plans,” he said.

According to the CEA report:

Noting the greater flexibility to form larger AHPs, we assume that the AHP rule will increase the average AHP group size by 100 percent. Based on the relationship between group size and administrative costs, this implies that the AHP rule will reduce the share of premiums accounted for by administrative costs by 27 percent. Assuming that before the rule the average administrative cost share was 15 percent, this corresponds to a reduction of about 4 percentage points.

Beyond just AHP plans, the report shows that short-term plans, association health plans, and repeal of the individual mandate penalty together will yield \$450 billion in economic benefits over ten years. This means an average of \$3,500 in net benefits per household over that time period. CBO projected that more than 6 million people will enroll in AHPs options, including one million who would otherwise be uninsured

They used data from the Congressional Budget Office and other reliable statistical sources for the analysis and found “the reduction of the individual mandate penalty to

³³ Paige Winfield Cunningham, “The Health 202: Association health plans expanded under Trump look promising so far,” January 30, 2019, *The Washington Post*. https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm_term=.6435676a70d4

³⁴ Kev Coleman, “First Phase of New Association Health Plans Reveal Promising Trends,” Association Health Plan News, January 2019. <https://www.associationhealthplans.com/reports/new-ahp-study/>

zero accounts for \$14 billion per year; the AHP rule accounts for \$8 billion per year; the STLDI reform accounts for \$8 billion per year; and the reduction in the excess burdens of labor taxation accounts for \$15 billion per year.”

Health Reimbursement Arrangements: The administration also is finalizing a rule to enhance employer and employee options through Health Reimbursement Arrangements (HRAs), originally created by the Bush administration to give employers more options in their benefit offerings. Under those rules, HRAs, which are tax-preferred, notional accounts, can be integrated with group health coverage sponsored by the employer. They cannot be integrated with individual health insurance coverage. Many workers who are offered health coverage at work do not participate in their employer plans, often because of costs, and therefore are more likely to be uninsured.

In a 2017 executive order, President Trump directed administration officials to “increase the usability of HRAs, to expand employers’ ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage.”³⁵

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.³⁶

The Galen Institute submitted public comments encouraging the administration to take the rule one step further by allowing spouses to integrate HRA funds to obtain a family plan.³⁷ We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.³⁸

As an example, consider that one spouse is offered health insurance at work. The employer may allow the plan to be extended to cover the family but only if the employee pays the full extra costs, which may be prohibitive for this lower-income worker.

If the other spouse’s employer offers an HRA contribution, that employee could use the funds to buy into the first spouse’s plan. This working couple could benefit from the ability to combine the HRA funds and obtain a family health insurance plan.

³⁵ Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>

³⁶ <https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

³⁷ <https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/>

³⁸ Doug Badger and Grace-Marie Turner, “Give Working Families A Break,” *RealClearHealth*, January 7, 2019. https://www.realclearhealth.com/articles/2019/01/07/give_working_families_a_break_110856.html

We believe the administration has the authority to include this change when it publishes the final rule. This would provide a new funding option and could expand insurance coverage, especially for those currently shut out of the market.