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BUILDING ON THE ACA: LEGISLATION TO
EXPAND HEALTH COVERAGE AND LOWER COSTS
TUESDAY, MARCH 23, 2021
House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 11:00 a.m., via Webex, Hon. Anna Eshoo, [chairwoman of the subcommittee] presiding.

Present: Representatives, Eshoo, Butterfield, Matsui, Castor, Sarbanes, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt, Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Burgess, Griffith, Bilirakis, Long, Bucshon, Hudson, Carter, Dunn, Curtis, Crenshaw, Joyce, and Rodgers (ex officio).

Also Present: Representatives Rush, Schakowsky, Veasey, and

28 O'Halleran.

29

30 Staff Present: Jeff Carroll, Staff Director; Waverly Gordon,
31 General Counsel; Tiffany Guarascio, Deputy Staff Director;
32 Perry Hamilton, Deputy Chief Clerk; Saha Khaterzai,
33 Professional Staff Member; Mackenzie Kuhl, Digital Assistant;
34 Una Lee, Chief Health Counsel; Meghan Mullon, Policy Analyst;
35 Tim Robinson, Chief Counsel; Chloe Rodriguez, Clerk; Rick Van
36 Buren, Health Counsel; C.J. Young, Deputy Communications
37 Director; Sarah Burke, Minority Deputy Staff Director;
38 Theresa Gambo, Minority Financial and Office Administrator;
39 Grace Graham, Minority Chief Counsel, Health; Caleb Graff,
40 Minority Deputy Chief Counsel, Health; Nate Hodson, Minority
41 Staff Director; Olivia Hnat, Minority Communications
42 Director; Peter Kielty, Minority General Counsel; Emily King,
43 Minority Member Services Director; Clare Paoletta, Minority
44 Policy Analyst, Health; Kristin Seum, Minority Counsel,
45 Health; Kristin Shatynski, Minority Professional Staff
46 Member, Health; Michael Taggart, Minority Policy Director;
47 and Everett Winnick, Minority Director of Information
48 Technology.

49

50 *Ms. Eshoo. Okay. Good morning, colleagues. The
51 Subcommittee on Health will now come to order.
52 Due to COVID-19, today's hearing is being held remotely.
53 All members and witnesses will be participating via
54 videoconferencing.
55 As part of our hearing, microphones will be set on mute
56 to eliminate background noise and, members and witnesses,
57 remember to unmute your microphone each time you wish to
58 speak.
59 Documents for the record should be sent to Meghan Mullon
60 at the email address we have provided to your staff. All
61 documents will be entered into the record at the conclusion
62 of the hearing.
63 The chair now recognizes herself for five minutes for an
64 opening statement.
65

66 STATEMENT OF HON. ANNA ESHOO, A REPRESENTATIVE IN CONGRESS
67 FROM THE STATE OF CALIFORNIA
68
69 *Ms. Eshoo. Senator Edward Kennedy wrote a letter to
70 President Obama to be opened after his death, and in it he
71 said that the cause of ensuring that, quote, "the state of a
72 family's health will never again depend on the amount of a
73 family's wealth and was the great unfinished business of our
74 society.''
75 When President Biden signed the American Rescue Plan
76 earlier this month, he took another step toward that
77 unfinished cause. Covered California estimates that about 25
78 million Americans stand to benefit from the new and expanded
79 subsidies to lower premium costs in the American Rescue Plan,
80 including three million Californians.
81 For the millions of people who collected unemployment
82 insurance at any time this year, they can now get covered by
83 a health plan with a zero premium and added help to lower the
84 cost of deductibles and copayments.
85 After four years where millions of Americans who
86 depended on the ACA lived in daily fear that they would lose
87 their health insurance because of a decision by the former
88 President, I have good news. Your ACA coverage is safe, and
89 it is a lot more affordable.
90 But the cause is still unfinished, especially in the 14

91 States that have not yet expanded Medicaid. In those States,
92 about 4.3 million Americans are locked out of health
93 coverage, despite being poor, because their governors or
94 State legislatures have so far refused to expand Medicaid.
95 Let's take Texas, for example. According to the
96 nonpartisan Kaiser Family Foundation, if you are a parent in
97 a family of three and make more than $3,700 a year, you would
98 be making too much to be eligible for Medicaid.
99 If you are an adult without kids in Georgia, North
100 Carolina, Florida, Texas or any of the other State that did
101 not expand Medicaid, you are ineligible for Medicaid even if
102 you have no job and no income.
103 There is not any healthcare safety net for childless
104 adults in those 14 States either.
105 The American Rescue Plan offers those 14 States as much
106 as $22.7 billion to correct this injustice. This Federal
107 support is in addition to the guarantee that the Federal
108 Government will pay for 90 percent of the cost of expanding
109 Medicaid to this new population.
110 Beyond Medicaid expansion, unfinished business remains.
111 Today we will consider 18 bills, many of them bipartisan, to
112 increase enrollment, lower costs, and improve coverage,
113 especially for children and people with disabilities.
114 To help us better understand how to finally achieve our
115 North Star of universal healthcare, we will also hear

116 testimony from experts on Medicaid and private insurance, as
117 well as from the patient and provider perspective. And we
118 all look forward to the testimony that we believe will be
119 highly instructive.
120 Senator Kennedy closed his letter to President Obama
121 with the following, quote: "What we face is, above all, a
122 moral issue that at stake are not just the details of policy,
123 but fundamental principles of social justice and the
124 character of our country.''
125 Today on the 11th anniversary of the passage of the
126 Affordable Care Act, we will consider the details of the
127 policies before us. But let's also work to restore the
128 character of our country through this important work as well.
129 [The prepared statement of Ms. Eshoo follows:]
130
131 **********COMMITTEE INSERT**********
132

133 *Ms. Eshoo. The chair now recognizes Mr. Guthrie, the
134 ranking member of our subcommittee, for five minutes for his
135 opening statement.
136 And remember to unmute. It is great to see you, Brett.
137

138 STATEMENT OF HON. BRETT GUTHRIE, A REPRESENTATIVE IN CONGRESS
139 FROM THE STATE OF KENTUCKY
140
141 *Mr. Guthrie. Great to see you. Thank you, Chair
142 Eshoo, and thanks for holding this hearing.
143 However, I do think we have other pressing or more
144 pressing items that we should be looking at within our
145 jurisdiction before looking at how to fix the Affordable Care
146 Act.
147 We have a crisis at the border where HHS Office is
148 taking charge of taking care of unaccompanied children, and
149 they are being overwhelmed. Some reports indicate there are
150 over 15,000 children in their control where there are only
151 13,000 licensed beds for them.
152 We should also be looking at the impact of COVID-19 on
153 mental health and substance abuse disorders, including
154 programs this committee worked in the past, NCARA, 21st
155 Century Cures, and the SUPPORT Act.
156 We also need to be examining how to lower healthcare
157 costs. This hearing's title does discuss lowering healthcare
158 costs, but I am not sure the bills today do, but rather the
159 bills continue to subsidize expensive insurance.
160 The majority has called us here to look at ways to shore
161 up the Affordable Care Act, which became law 11 years ago and
162 is still not working. The ACA has increased premiums

163 dramatically, and many insurers stopped offering coverage.
164 In my home State, Kentucky was found to have the sixth
165 largest rate increase in annual health insurance premiums at
166 27 percent over a 6-year period. This is not sustainable for
167 workers and families.
168 Democrats have chosen to address it by pumping more
169 money into the Affordable Care Act and limiting State
170 flexibility instead of addressing what is the real problem,
171 the high cost of healthcare.
172 Even the generous subsidies that Congress just passed
173 this morning are apparently not enough to make these
174 insurance plans attractive, as we are back again to discuss
175 more spending.
176 By my account, on top of the $1.9 trillion that was just
177 spent, today we are discussing at least another $45 billion
178 or so based on scores I could find from the last Congress.
179 Compared to $1.9 trillion $45 billion may be small, but it is
180 almost the entire annual budget of the National Institutes of
181 Health.
182 Before we authorize billions more on top, we need to
183 first see how the funding from the $1.9 trillion law, which
184 has now been allocated; we need to see how it is being spent
185 and where are the remaining gaps.
186 We also need to be looking at innovative ways to lower
187 healthcare costs. Today we are reviewing recycled language

188 from six bills, two from the 2019 Energy and Commerce
189 hearings. For example, the bill giving grants for State
190 exchanges does not even update the date from January 1, 2019.
191 So States like New Jersey that have already established
192 an exchange since our last hearing could get funding from
193 this grant.
194 Additionally, I am concerned with banning short-term,
195 limited duration plans. CBO has estimated that if the
196 regulations are rolled back on these plans, 500,000 Americans
197 will lose healthcare coverage. Instead of limiting plans, I
198 think we need to allow States flexibility to best serve their
199 residents.
200 Of the ten Medicaid bills, I specifically want to
201 mention Money Follows the Person. This program is valuable
202 for many individuals, and I am a champion of this program.
203 Congress just extended MFP in December, which made important
204 changes to the program.
205 It is premature, in my opinion, to consider a permanent
206 MFP extension before we know the impact of those changes.
207 I also want to note that while the Democrats have called
208 this hearing to talk about building on the Affordable Care
209 Act, over 100 Democrats, including the chairman of this
210 committee and 15 other members of this committee, introduced
211 legislation that would ban ACA plans and Medicaid coverage
212 and replace it with a one-size-fits-all, government-run

213 healthcare system for everyone.
214 I am concerned that innovation would stop fully under a
215 government-run healthcare insurance program, and according to
216 the Heritage Foundation, would decrease the average annual
217 American household disposable income by $5,600, or 11
218 percent.
219 Let us not forget what we were told about the ACA. If
220 you like your plan, you can keep it. Well, today we have
221 bills before us that would do just the opposite, again, by
222 limiting State flexibility and stopping short-term, limited-
223 duration plans.
224 But that would be nothing compared to the over 220
225 million Americans who would lose their health insurance under
226 Medicare for All.
227 I hope we will learn today about some of the unintended
228 consequences of the legislation before us and change course
229 to work together to come up with plans that will actually
230 lower healthcare costs. Americans, not the government,
231 should have the right to pick what health insurance and
232 doctor is right for them.
233 I thank you for the time, and I yield back.
234 [The prepared statement of Mr. Guthrie follows:]
235
236 **********COMMITTEE INSERT**********
237

238 *Ms. Eshoo. The gentleman yields back.

239 The chair now recognizes the chairman of the full
240 committee, Mr. Pallone, for your five minutes for an opening
241 statement.
242

243 STATEMENT OF HON. FRANK PALLONE, A REPRESENTATIVE IN CONGRESS
244 FROM THE STATE OF NEW JERSEY
245
246 *The Chairman. Thank you, Chairwoman Eshoo.
247 And this is a very important hearing. Today is the 11th
248 anniversary of President Obama signing the Affordable Care
249 Act into law, and the bottom line is, contrary to what our
250 ranking member just said, is that the ACA has worked.
251 Many millions of people have health insurance now who
252 would not have had it without the ACA. I am amazed that with
253 the Republican efforts to basically repeal it or basically
254 cut it back that it is still around. It shows its
255 resiliency. It shows how people really want it, despite all
256 of the rhetoric on the Republican side, and particularly by
257 President Trump, who has said it should be abolished.
258 But I do want to say in response to Mr. Guthrie that,
259 look, we do not want to cut healthcare for the sake of
260 lowering cost. My concern has always been that with these
261 junk plans that did not provide essential services, people
262 buy them thinking that they are going to have coverage when
263 they do not.
264 And so I would agree with you that when you provide --
265 and I do not know if that is what you meant -- but when you
266 provide a lot of services because our hallmark of the ACA has
267 been that you have to have essential services; when you do

268 that, it sometimes costs more.

269 But the answer is not to take a meat ax and say, well,
270 we will get rid of it and sell you a junk plan.

271 I remember going before the Rules Committee, and I love
272 Virginia Foxx. She is a friend, but you know, she basically
273 said at one point that there were plans that were being sold
274 that did not include hospitalization, and that that was okay
275 if people wanted that.

276 But to me, you know, if you buy a plan that does not
277 have hospitalization, you do not have health insurance
278 coverage. So, you know, keep in mind that the answer is to
279 make things affordable, but not in a way that eliminates
280 services like hospitalization and mental health and some of
281 these other things that are what we get with the junk plans.

282 In any case, earlier this month Democrats and President
283 Biden signed into law the American Rescue Plan, which is the
284 largest expansion of health care coverage since the passage
285 of the ACA, and that builds on the ACA so that healthcare is
286 more affordable and more accessible for Americans at a time
287 when they are struggling financially and when coverage is so
288 essential.

289 The new law expands the ACA's tax subsidies, including
290 for the first time to Americans with incomes above 400
291 percent of the Federal poverty line. Millions of Americans
292 will gain healthcare coverage and see the cost of their

293 monthly insurance premiums go down.
294 Just as an example, a family of four with an annual
295 income of $65,000 will save $2,800 each year. A family of
296 four with an annual income of $100,000 will save $7,000
297 annually, and this is a huge benefit considering this item
298 did not qualify for premium subsidies before the American
299 Rescue Plan.
300 It also provides an incentive for States, a new
301 incentive for States, to expand Medicaid by increasing the
302 Federal medical assistance percentage, or FMAP, of new
303 expansion States by five percentage points for two years.
304 And finally, the American Rescue Plan takes steps to
305 address disparities in coverage that have been laid bare by
306 the COVID pandemic by creating a new State option to provide
307 continuous Medicaid eligibility for 12 months postpartum and
308 provides billions in additional funding for home and
309 community-based services, or HCBSes.
310 Now, you know, the 18 bills that we have before us today
311 build on the accomplishments of the ACA and the American
312 Rescue Plan and will make a real difference in people's
313 lives, and these bills fix the four years of sabotage on our
314 healthcare system from the previous Trump administration.
315 We're going to talk about all of these, but I just
316 wanted to mention initially because my time is going to run
317 out Representative Castor's bill that will require short-term

318 plans to comply with the ACA's consumer protections and offer
319 comprehensive coverage.
320 Last year our committee's investigation found that
321 millions of Americans are enrolled in these short-term or
322 junk plans that offer bare bones coverage, discriminate
323 against people with preexisting conditions, and leave
324 patients saddled with thousands of dollars of medical debt.
325 These junk plans have no place in our healthcare system as
326 they are structured today, and that is why we have to ensure
327 they are required to comply with the ACA's consumer
328 protection.
329 I am not going to go into the other bills, but I do want
330 to stress again we want to bring costs down, but we also do
331 not want to allow people to buy coverage that does not
332 include essential benefits like hospitalization because
333 without that, you do not really have healthcare coverage.
334 And many people buy these junk plans, and they are
335 duped. They think it covers whatever condition they have and
336 then find out later that it does not when it is too late.
337 So with that, Madam Chair, thank you again. This is a
338 very important hearing to say what we can do to make the ACA
339 coverage even more expansive and less expensive in the long
340 run.
341 Thank you, Madam Chair.
342

343 [The prepared statement of the Chairman follows:]

344

345 **********COMMITTEE INSERT**********

346

347 *Ms. Eshoo. The gentleman yields back.

348 The chair now is pleased to recognize the ranking member

349 of the full committee, Congresswoman Cathy McMorris Rodgers,

350 for your five minutes for an opening statement.

351

352 STATEMENT OF HON. CATHY McMORRIS RODGERS, A REPRESENTATIVE IN
353 CONGRESS FROM THE STATE OF WASHINGTON
354
355 *Mrs. Rodgers. Good morning, Madam Chair, and to all my
356 colleagues, good morning.
357 Mr. Guthrie discussed some of the concerns with the 18
358 bills before us, and I am not going to talk further about
359 those bills. These bills, unfortunately, divided Republicans
360 and Democrats in 2019, and I am disappointed that we continue
361 to focus on what is dividing us.
362 Instead I want to talk about what we can accomplish in
363 healthcare when we work together, and ask that we continue to
364 build on our past bipartisan successes and lower healthcare
365 cost I hear about every day from constituents in Eastern
366 Washington.
367 With the fast-paced, partisan and polarized start to
368 this year, I want to remind my colleagues that this committee
369 worked together to lower healthcare costs for the American
370 people last Congress. The December omnibus and COVID relief
371 bill was large, and so you may have missed that it included
372 the most significant legislation to reduce healthcare cost in
373 over a decade.
374 The December bill included solutions we worked together
375 on to end surprise medical billing for patients, saving the
376 government almost $20 billion in the process by lowering

377 premiums.

378 Provide long-term funding for public health, Medicare
379 and Medicaid programs, and we fully offset that spending.

380 Improved transparency so employers who provide health
381 insurance for their employees have a right to find out the
382 cost of what they are buying.

383 Support for rural and underserved areas by increasing
384 funding and providing more flexibility for hospitals in those
385 areas.

386 Provide funding so that Medicaid enrollees with life-
387 threatening conditions can participate in clinical trials.

388 Address drug prices by requiring reporting to Health and
389 Human Services.

390 And closing loopholes that may delay competition, and
391 many more.

392 There are more opportunities for us to work together and
393 build on the great work of last Congress. We can work
394 together to modernize the Medicare Part D program, to reduce
395 what seniors pay for prescription drugs out of their own
396 pockets.

397 We could also examine the drivers of healthcare
398 consolidation, which is contributing to ever-increasing
399 healthcare costs.

400 I want to hear about how mental health and substance
401 abuse disorder programs are working and how we can improve

402 them, especially in light of the epidemics of despair made
403 worse by COVID-19.
404 We have also seen breakthrough innovation in the last
405 year for COVID-19. Let's work together to find out what
406 lessons we can take away from that and how to apply them to
407 find cures for other diseases like ALS and Alzheimer's.
408 Lastly, we must figure out how we can be better prepared
409 against future pandemics.
410 However, the bills today show us that the majority is
411 choosing to go down a path for government-run healthcare
412 rather than have these important discussions. Their end goal
413 would include kicking every American off their health
414 insurance plan of choice, whether it is employer-based,
415 Medicare Advantage, or plans through labor unions.
416 Americans would lose the few coverage choices they have
417 left to make personal decisions about what is best for their
418 family and be forced into a one-size-fits-all, government run
419 healthcare program.
420 Just last week half of the Democratic members of this
421 committee introduced Medicare for All, including Chairman
422 Pallone. We apparently will be having a hearing on that
423 legislation at some point, according to the press reports.
424 And the bills today continue us down the path towards
425 socialized medicine that Obamacare started, expanding the use
426 of Federal taxpayer dollars to subsidize, and removing

427 patient choice by promoting the insurance the Federal
428 Government thinks is best for you.
429 My hope is that we can get to work in a bipartisan way
430 soon to lower cost, increase transparency, address the mental
431 health crisis, enable innovation, and prevent pandemics.
432 Addressing just one of those issues would take months of
433 work, but I stand ready and hopeful that we can get started
434 on that in April.
435 And I yield back.
436 [The prepared statement of Mrs. Rodgers follows:]
437
438 **********COMMITTEE INSERT**********
439

440 *Ms. Eshoo. The gentlewoman yields back.
441 The chair would like to remind members that, pursuant to
442 committee rules, all members' written opening statements
443 shall be made part of the record.
444 I now would like to introduce our witnesses, and we are
445 so fortunate to have each one of them with us today.
446 First, Ms. Katie Keith, Associate Research Professor at
447 Georgetown University. Welcome and thank you to you.
448 Mr. Dean Cameron, Director of the Idaho Department of
449 Insurance. Welcome back to the subcommittee, Mr. Cameron.
450 We are happy to see you and have you with us.
451 Ms. Cindy Mann, partner at Manatt, Phelps & Phillips,
452 and former Director of the Center for Medicaid and Trip
453 Services.
454 Ms. Marni Jameson Carey, Executive Director, Association
455 of Independent Doctors. Welcome to you and thank you for
456 being with us.
457 And Ms. Laura LeBrun Hatcher, Board Vice President of
458 Little Lobbyists, just a really extraordinary advocate.
459 So welcome to each one of you. Thank you for being with
460 us.
461 And, Ms. Keith, you are now recognized for five minutes
462 for your testimony, and please remember to unmute.
463

464 STATEMENT OF KATIE KEITH, ASSOCIATE RESEARCH PROFESSOR,
465 GEORGETOWN UNIVERSITY; DEAN CAMERON, DIRECTOR, IDAHO
466 DEPARTMENT OF INSURANCE; CINDY MANN, PARTNER, MANATT, PHELPS
467 & PHILLIPS, LLP; MARNI JAMESON CAREY, EXECUTIVE DIRECTOR,
468 ASSOCIATION OF INDEPENDENT DOCTORS; AND LAURA LeBRUN HATCHER,
469 BOARD VICE PRESIDENT, LITTLE LOBBYISTS
470
471 *Ms. Keith. Thank you and good morning. Thank you,
472 Chairwoman Eshoo, Ranking Member Guthrie, and members of the
473 subcommittee.
474 My name is Katie Keith, and I am a faculty member at
475 Georgetown University, where I study private health
476 insurance.
477 I am also the author of the Following the ACA blog
478 series for the Journal of Health Affairs, where I am
479 responsible for tracking and chronicling ongoing
480 implementation of the Affordable Care Act.
481 I am especially honored to appear before you today on
482 the 11th anniversary of the law, in mere weeks after
483 enactment of the historic American Rescue Plan.
484 The Affordable Care Act has already extended coverage to
485 20 million Americans, helped narrow racial and ethnic
486 disparities in coverage, and served as a critical part of the
487 safety net throughout the pandemic.
488 We have seen enrollment through Medicaid and the

489 marketplaces increase during the pandemic as demand has
490 surged, and Congress leveraged existing Affordable Care Act
491 standards to quickly mandate the coverage of COVID-19 testing
492 and vaccines.
493 On the law's 11th anniversary, it is more than safe to
494 say that millions of families who would otherwise be
495 uninsured have been able to enroll in Medicaid or the
496 marketplace and get the coverage that they need for COVID-19
497 treatment, testing, and vaccines.
498 Simply put, the Affordable Care Act has been there for
499 millions of Americans when they needed it most. Enrollment
500 is only expected to increase under the American Rescue Plan.
501 As you all know, affordability has long been a challenge
502 for many, even before the pandemic. This has been especially
503 true for older middle-income Americans living in rural areas
504 where costs tend to be the highest.
505 We all recognize that families who did not receive
506 financial help before have had to make very difficult
507 decisions, including remaining uninsured or enrolling in non-
508 comprehensive coverage options.
509 Sadly, the media has been filled with stories of
510 families who enrolled in these non-comprehensive options only
511 to be left with devastating medical bills when their plan did
512 not cover the healthcare that they need.
513 Fortunately, the American Rescue Plan puts that behind

514 us. The new law significantly increases financial help for
515 lower income people and, for the first time ever, extends
516 financial help to more middle-income Americans. Of the 14.9
517 million uninsured people who qualify for subsidies, 3.6
518 million of them are newly eligible based on their income.
519 Savings will vary, but many middle-income people who
520 purchase their own health insurance will soon see significant
521 premium relief.
522 The American Rescue Plan also helps with high
523 deductibles that many consumers have struggled with in recent
524 years. More people will be able to afford a plan that is
525 much more generous than in the past, which means lower
526 deductibles and lower out-of-pocket costs.
527 Millions will be able to find a Silver Marketplace plan
528 for $10 a month or less or opt into more generous Gold
529 coverage with even higher cost-sharing protections.
530 These reforms could not have come at a more important
531 time, given the pandemic. Americans across the political
532 spectrum want Congress to lower patient healthcare costs and
533 protect people with preexisting conditions.
534 The Affordable Care Act, as enhanced by the American
535 Rescue Plan, does exactly that, and the legislation that you
536 are considering today furthers those goals as well.
537 The bills before you will increase awareness of this new
538 financial help, will protect patients with preexisting

539 conditions from plans that discriminate against them, and
540 will help States experiment to further expand access to
541 coverage, to lower healthcare costs, and further advance
542 health equity.
543 In closing, health insurance has always been about
544 access to healthcare and financial security. Under the
545 Affordable Care Act and the American Rescue Plan, millions of
546 families have access to affordable, comprehensive coverage
547 and the financial security that having high quality health
548 insurance brings.
549 The time is now to continue building on these important
550 reforms.
551 Thank you for the opportunity to address you, and I very
552 much look forward to your questions.
553 [The prepared statement of Ms. Keith follows:]
554
555 **********COMMITTEE INSERT**********
556

557 *Ms. Eshoo. Thank you very much for your important
558 testimony.
559 Next, Mr. Cameron, you are recognized for five minutes
560 for your testimony, and as I said a few minutes ago, welcome
561 back to the committee.
562 Please unmute.
563

564 STATEMENT OF DEAN CAMERON

565

566 *Mr. Cameron. You bet. Thank you, Chairwoman Eshoo,
567 and it is a pleasure to be back, and Ranking Member Guthrie
568 and members of the subcommittee.

569 My name is Dean Cameron. I am the Director of the Idaho
570 Department of Insurance.

571 Thank you for this important hearing and this
572 opportunity to testify and tell about Idaho's experience with
573 the ACA and short-term plans, in particular.

574 I firmly believe that the solutions to health insurance
575 will be found at the State laboratories of creativity, and I
576 completely support each State's right to try different
577 approaches that meet their individual State's needs.

578 A fundamental tenet to all insurance is the spreading of
579 risk, the ability to share risk with each other. Idahoans,
580 like many other States, are being priced out of the
581 marketplace, in spite of even this latest improvement to the
582 APTC.

583 The ACA has become too expensive, and many do not
584 qualify or can avail themselves of the subsidy. These are
585 people like teachers and spouses of teachers who, because of
586 the family glitch, do not qualify, or ranchers or farmers
587 who, because of their unpredictable income, cannot avail
588 themselves of the subsidy. They want coverage, but they

589 simply cannot afford it.

590 They are being forced to the unenviable position of
591 either going without coverage or obtaining products such as
592 those offered through Health Sharing Ministries or short-term
593 plans.

594 As prices for ACA plans continue to rise, more and more
595 citizens are forced out of coverage, especially the young and
596 the healthy, the healthy of all ages. And I can tell you
597 story after story of older citizens who are being forced out
598 of coverage.

599 As more and more young and healthy citizens move out of
600 coverage, prices continue to climb and more leave and the
601 market is caught in a vicious cycle. Since 2015, Idaho
602 consumers, who are buying insurance on the individual market,
603 continue to decline.

604 Now, this is at a time when our population growth is one
605 of the highest in the country.

606 So the question before Idaho and really before many
607 States was how do we provide quality yet affordable products
608 to our citizens.

609 And how do we improve the overall risk pool of the ACA,
610 or how do we attract the young and the healthy back into the
611 ACA market?

612 Given the existing parameters of the ACA, Idaho decided
613 to restrict the traditional short-term plans to six months

614 while creating another product, an enhanced short-term plan
615 for those with coverage longer than six months, which has all
616 of the essential health benefits as required by the ACA.
617 In fact, of the five plans created in Idaho by two
618 different carriers, four of them have better actuarial values
619 than the Bronze Plans, and two of them have better actuarial
620 values than Silver Plans, and if sold during open enrollment,
621 are prohibited from preexisting condition clauses.
622 Additionally, these plans could only be offered by
623 carriers that are currently in the exchange alongside of ACA
624 plans and, most importantly, in the same risk pool.
625 By requiring enhanced plans to be part of the ACA pool,
626 we protect the ACA plans, and we lower the cost for those in
627 the ACA marketplace, while attracting young and healthy back
628 into the marketplace.
629 Madam Chairwoman and members of the subcommittee, in my
630 opinion I would respectfully suggest the following regarding
631 short-term plans.
632 First, I would suggest to you that all STPs are not
633 alike.
634 Second STPs are not junk insurance just because someone
635 dubbed them as such. As I have said before, I have STPs in
636 my State which are better quality than some of the ACA plans.
637 Third, I would respectfully suggest that STPs fill a
638 need for those who are in between jobs, those who are in

639 between coverage, or in Idaho's case, those who cannot afford
640 ACA plans. They act as a bridge between those who miss open
641 enrollment until the next open enrollment.
642 Fourth, and this is rarely acknowledged, STPs assist in
643 early diagnosis of serious health conditions, which
644 ultimately save money to the entire system, including ACA
645 plans. Without this product, consumers will be forced to go
646 uninsured, which will cost us more as their conditions go
647 undiagnosed and untreated.
648 Lastly, I would respectfully indicate for you that I
649 believe passage of H.R. 1875 would harm thousands of Idahoans
650 and hundreds of thousands of Americans and would not,
651 underline "would not,'' benefit the ACA.
652 In fact, passage of H.R. 1875, in my opinion, would
653 potentially kick Americans off of their plan, increasing the
654 number of uninsured, which would potentially lead to
655 additional cost sharing and higher costs to those that are
656 purchasing the ACA plan.
657 Madam Chairman, I appreciate the opportunity to speak to
658 you and would welcome questions and the opportunity to speak
659 on the other bills. Thank you, Madam Chair.
660 [The prepared statement of Mr. Cameron follows:]
661
662 **********COMMITTEE INSERT**********
663

664 *Ms. Eshoo. Thank you, Mr. Cameron.

665 Next, Ms. Mann, you are now recognized for five minutes
666 for your testimony. And, again, thank you for being with us
667 today, and please unmute.
668

669 STATEMENT OF CINDY MANN
670
671 *Ms. Mann. Thank you for inviting me today. It is a
672 pleasure to be here, Chairman and Ranking Member Guthrie.
673 I am Cindy Mann, and I am a partner with Manatt Health,
674 a division of Manatt, Phelps & Phillips, and I do a lot of
675 work with States and with households, health systems,
676 consumer organizations, foundations about delivering system
677 payment reforms and focus particularly on the Medicaid and
678 the CHIP Programs.
679 Previously, before coming to Manatt, I was a Deputy
680 Administration of CMS and the Director of the Center for
681 Medicaid and CHIP Services and was there during the
682 implementation of the Affordable Care Act.
683 I appreciate the opportunity to testify today.
684 Many important changes to Medicaid were, of course,
685 ushered in by the Affordable Care Act, but the most prominent
686 and far-reaching change is the one that sought to close a
687 longstanding coverage gap in the program.
688 Before the ACA, the public generally believed that
689 Medicaid covered poor people, but in fact, until the ACA,
690 Medicaid left out a large segment of poor adults.
691 Who are they? Well, some of them are the children that
692 Medicaid covers, but when they turn 18 in Medicaid parlance,
693 they are considered childless adults.

694 They are also the women who, when they become pregnant,
695 they will be covered by Medicaid, but before their pregnancy,
696 they too are childless adults and were left out of coverage.
697 And whatever their situations, most are working, many at
698 multiple jobs scraping by to pay rent and feed their
699 families.
700 The ACA did not add a new group of strangers to the
701 Medicaid Program. It ended arbitrary coverage exclusions
702 and, with the marketplace, created a continuum of coverage
703 for those without access to affordable, job-based coverage.
704 As was noted, Chairman Eshoo, the Supreme Court made the
705 expansion voluntary with States and not all States have taken
706 up that really important option. In January 2014, when the
707 coverage became effective from the ACA, we had 24 States that
708 had expanded Medicaid.
709 Today 36 States do so. Two additional States are poised
710 to start coverage in July, leaving 12 States without
711 expansion and over four million people without insurance as a
712 result.
713 After years of implementation, there is now a
714 significant body of evidence on the success and impact of
715 expansion. Pre-COVID the expansion covered about 12 million
716 newly eligible people. Un-insurance rates dropped in all
717 States, but the decline was particularly steep in the
718 expansion States, 69 percent un-insurance rates in those

719 states compared to 11.1 percent in the non-expansion States
720 in 2019.
721 But of course, it is not just about insurance. It is
722 about the care, and studies have shown that people have
723 gotten cancer treatments, preventive care, care management
724 for chronic conditions.
725 It has also helped people retain and gain jobs, and in
726 the recession, it has really helped significantly cushion the
727 blow for million of workers who have lost their job.
728 And notably, it has also reduced racial disparities in
729 all States and then particularly, again, in the expansion
730 States compared to the non-expansion States.
731 It has also helped the safety net. Rural hospitals, for
732 example, have seen their uncompensated care costs drop by 43
733 percent in expansion States compared to 16 percent for rural
734 hospitals in non-expansion States, and it has done most of
735 this with little cost to States because of the generous match
736 rate and offsetting savings.
737 But the job is not done. In my minute or so remaining,
738 let me just review a few ways in which Medicaid coverage can
739 be strengthened.
740 First of all, closing the coverage gap remains, of
741 course, key unfinished business. The added support for
742 expansion in the Recovery Plan is welcome and so timely,
743 given the public health emergency.

744 I do not know if you have all seen the news, but just
745 last night an expansion bill passed in the House in the State
746 of Wyoming.
747 Doing a better job addressing racially driven inequities
748 in coverage must also be front and center as we move forward,
749 and again, the Recovery Plan took a really important step
750 forward by extending the postpartum period of coverage for
751 pregnant women.
752 The U.S., of course, is an outlier in terms of our share
753 of Black women who are dying during or after giving birth,
754 and postpartum coverage extension is a critically important
755 advance.
756 Equity issues, of course, are not just limited to
757 discrete issues. They must be looked at in every part of our
758 delivery system and payment system. We have a bill
759 introduced by members of this committee which would create
760 parity in payment rates for primary care between Medicaid and
761 Medicare, and that would help quite a bit.
762 Other reforms would also significantly improve coverage
763 and care, including 12 months' continuous coverage for adults
764 and for children.
765 And lastly, I want to note how important it is to give
766 consideration to long-term services and support, like those
767 that are so important for Ms. Hatcher's son, who is going to
768 testify in a few minutes, her son Simon. Nearly a third of

769 Medicaid expenditures are for home and community-based
770 services or nursing home care. Medicaid is the default
771 payer, and we need a number of reforms in that area.
772 We need to reimagine long-term care so that it provides
773 safe and quality care for all who need it, preferably at home
774 and in the community, and provides a living wage for those
775 who provide the services.
776 Serving more than 75 million people, nearly half of whom
777 are children, Medicaid plays a central role in the healthcare
778 system and in our communities. It deserves and it requires
779 our support and attention.
780 Thank you for allowing me to present testimony today,
781 and I look forward to your questions.
782 [The prepared statement of Ms. Mann follows:]
783
784 **********COMMITTEE INSERT**********
785

786 *Ms. Eshoo. Thank you, Ms. Mann.
787 Next, we have Ms. Carey who is recognized for five
788 minutes for your testimony.
789 Please unmute and know again how grateful we are for you
790 to be with us today in your terrific work.
791

792 STATEMENT OF MARNI JAMESON CAREY

793

794 *Ms. Jameson Carey. Thank you, Chairman Eshoo and
795 Ranking Member Guthrie and members of the Subcommittee on
796 Health, for the invitation to address you. It is truly a
797 pleasure to be here on the anniversary of the Affordable Care
798 Act.

799 My name is Marni Jameson Carey. I am the Executive
800 Director of the Association of Independent Doctors, a
801 national nonprofit trade association with members in 44
802 States. At AID, we work to educate lawmakers, employers,
803 patients, and taxpayers about why preserving independent
804 doctors is so essential to lowering the cost of healthcare,
805 improving access, and restoring the doctor-patient
806 relationship.

807 Since AID was established, its mission has not changed.
808 We strive to achieve systemwide price transparency, which
809 would introduce competition into our price-opaque healthcare
810 system.

811 We aim to achieve site-neutral payments so the same
812 medical service costs the same regardless of whether it is
813 performed in an independent doctor's office or an out-patient
814 hospital setting.

815 And we work to stop the consolidation in healthcare,
816 specifically the employment of physicians by hospitals and

817 private equity groups which drives up costs.

818 I see the bills before this committee today as attempts
819 to expand coverage and protect the vulnerable, which are such
820 certainly worthy causes. However, I would like to address a
821 root problem, a fundamental reason so many Americans still
822 lack coverage and access.

823 Healthcare costs are too much. At nearly 18 percent of
824 our Nation's gross national product, Americans spend nearly
825 one out of every $5 they earn to pay for healthcare.

826 The system we have is driving prices higher. Since the
827 ACA went into effect, national spending has gone from $2.6
828 trillion to over $3.7 trillion. Our lack of coverage and the
829 issues surrounding coverage are a direct byproduct of the
830 high cost of healthcare.

831 If healthcare were affordable, coverage would begin to
832 take care of itself, and the cost matter, regardless of who
833 is paying, regardless if it is the patient or the taxpayer or
834 the government or the employer or the insurer, we can lower
835 prices by achieving price transparency, realizing site-
836 neutral payments, and stopping consolidation.

837 Before I became Executive Director for AID, I worked as
838 a health reporter, writing for the Los Angeles Times and the
839 Orlando Sentinel. As the ACA rolled out, media reports were
840 full of statistics about how many Americans would gain or
841 lose coverage as a result of insurance exchanges, mandates,

842 and Medicaid expansion.

843 In fact, that remains much of the talk here today.
844 Covered lines became the story largely because hospitals and
845 insurers did a great job of turning the public's attention
846 toward the issue of coverage and away from the matter of
847 cost.

848 Sadly to some, cutting cost is less appealing than
849 guaranteeing revenue streams. Lowering cost is what I would
850 like the subcommittee to focus on today. The path forward
851 begins with systemwide healthcare price transparency.

852 For too long hospitals and insurance companies have
853 profited excessively from keeping their patients and prices
854 in the dark. Most patients have no idea when they get their
855 care what the price will be until they get their bill.

856 This matters especially with those who have high
857 deductible plans. However, if consumers could see the price
858 of their care beforehand and shop and compare prices, more
859 would choose lower priced providers. Price competition would
860 enter the market, and prices would come down.

861 Patients would see the wide price variations. For
862 instance, the price of having a C-section at one hospital in
863 California could cost $6,000 or $60,000, depending on their
864 insurance.

865 Price transparency would also expose facility fees,
866 which hospitals pack onto their employee doctor services that

867 adds zero value, but that can drive up costs three to five
868 times.
869 As long as these prices are hidden, hospitals get away
870 with these extra charges. When they no longer can, they will
871 lose much of their financial incentive for hiring doctors,
872 and when they do, we can show, if not unwind, the
873 consolidation trend in healthcare, which economists agree is
874 a leading driver behind skyrocketing healthcare costs.
875 Sorry. Am I still going here?
876 We have made progress. In January, the Department of
877 Health and Human Services' hospital price transparency rule
878 went into effect, requiring hospitals to show all their
879 prices online. Only hospitals are not complying.
880 Just yesterday the Wall Street Journal published an
881 article stating that their investigators visited over 3,000
882 hospital Websites and found most had imbedded codes that
883 worked to block access to their newly posted prices.
884 This is a golden moment for the Biden administration and
885 for this Congress to build on the price transparency
886 initiative, which has its roots in the Affordable Care Act
887 and which puts consumers in charge of their healthcare
888 spending.
889 A recent National Merit survey found that 91 percent of
890 Americans believe that hospitals should be legally required
891 to post all of their prices online and in an easy to access

892 format.

893 Price transparency is not a red or blue issue. It is an
894 American issue. It is a unifying issue, and it would cost
895 taxpayers nothing.

896 As we acknowledge the anniversary of the Affordable Care
897 Act and a new era in Washington, I urge the subcommittee to
898 work to enact legislation that would reinforce systemwide
899 price transparency, encourage competition, and discourage
900 healthcare consolidation, all of which would drive down the
901 cost of healthcare and make coverage truly accessible and
902 affordable for all Americans.

903 Thank you again for this opportunity and for your
904 service to our country.

905 [The prepared statement of Ms. Jameson Carey follows:]

906

907 **********COMMITTEE INSERT**********

908

909 *Ms. Eshoo. Thank you.

910 And last but not least, Ms. Hatcher, you are recognized
911 for five minutes, and please remember to unmute. Wonderful
912 to have you with us.
913

914 STATEMENT OF LAURA LeBRUN HATCHER

915

916 *Ms. LeBrun Hatcher. Thank you so much.

917 Greetings, Chairwoman Eshoo and Chairman Pallone,
918 Ranking Members Rodgers and Guthrie, and members of the
919 committee. Thank you for inviting me here today to share my
920 family's story with you.

921 My son Simon has the best laugh you have ever heard. He
922 loves to watch the Muppets and play the drums, sometimes at
923 the same time.

924 Simon was born in 2006 before the Affordable Care Act
925 became law. He had a brain bleed in utero and when he was
926 just two weeks old and in need of emergency brain surgery, I
927 learned about the limitations of our private health
928 insurance, about lifetime caps on care, and the danger of
929 losing coverage because of preexisting conditions my child
930 was born with.

931 Through Simon's early years, his diagnoses piled up:
932 hydrocephalus, cerebral palsy, epilepsy, autism, a genetic
933 disorder, and so did our medical bills with each ride in an
934 ambulance and each stay in the pediatric intensive care unit.

935 My anxiety increased. I was afraid for my son, and I
936 was afraid of losing his health insurance. I was terrified
937 of reaching his rapidly approaching lifetime cap on care, and
938 I had no idea what we would do when we hit it.

939 So it felt like a miracle when the Affordable Care Act
940 passed. I no longer had to worry about his health insurance
941 dropping him because he needed a high level of care, and for
942 the next seven years as Simon grew up, I grew more confident
943 in my ability to care for my medically complex child, to get
944 him what he needed to survive and to thrive.
945 Then in 2017 that confidence was shattered when the
946 Republican-led House of Representatives voted to repeal the
947 healthcare protection that my child's life depended on.
948 At first, I was devastated, and then I found other
949 families like mine. We are called the Little Lobbyists, name
950 after an article about a 6-year-old boy called Timmy who came
951 to Capitol Hill to ask Congress to save his healthcare.
952 Simon and I joined Timmy, Xiomara, Abby, Emma, Joe,
953 Teddy, Claire, and so many other amazing kids with complex
954 medical needs and disabilities and their families, and
955 together we advocate for the healthcare, education, inclusion
956 our families need to survive and thrive.
957 And that is why I am here today. Though there is still
958 a case in the Supreme Court threatening the ACA, it seems
959 that for now ACA protections which we worked so hard to save
960 have survived.
961 As our country begins to recover from this deadly
962 pandemic and the horrific disproportionate toll it has taken
963 on marginalized communities, especially disabled Black, Brown

964 and indigenous peoples, it is time for us to work together to
965 help all of our families thrive.
966 So let me tell you a little bit more about my family.
967 In 2019, after being on a waiting list for nine years, Simon
968 qualified for a Medicaid waiver, thanks to Medicaid expansion
969 in my State. We finally have coverage for the things that
970 our insurance would not fully cover, like medication to
971 prevent Simon's seizures, a pulse oximeter he needs to sleep
972 safely, and a walker that he uses to get around.
973 Simon also has access to home and community-based
974 services. At 14, with the help of a direct support
975 professional, he was able to get his first taste of
976 independence.
977 In addition to being Simon's mom, I am a self-employed
978 graphic designer. My husband Brian is also a designer.
979 Recently Brian lost his job and with it our employer-
980 sponsored health insurance. But thanks to the Affordable
981 Care Act and a navigator, who helped us avoid treacherous
982 junk insurance plans, we were able to purchase quality health
983 coverage for our family through the exchanges.
984 We have been able to turn an unforeseen hardship into an
985 opportunity for Brian to join me in building our family
986 business.
987 But COVID has been tough on our business. Projects have
988 been canceled or postponed, and it has also been tough on

989 Simon. Online school has been hard, but he cannot safely
990 return to the classroom until he has access to a vaccine.
991 He also lost his direct support professional because
992 there was not enough funding for Medicaid services for the
993 PPE and support that his staff needed. Fortunately, Congress
994 offered us a lifeline with the American Rescue Plan, and I
995 want to personally thank you for that.
996 You voted to support funding for Medicaid home and
997 community services that people with disabilities like my son
998 need to stay in their communities and out of deadly
999 institutions.
1000 You voted to encourage States that have not yet expanded
1001 Medicaid to do so so more people like Simon can access the
1002 lifesaving care that they need.
1003 In addition to support for small businesses like mine,
1004 Congress built on the ACA. By expanding subsidies to
1005 eliminate the cliff that my family fell off of, I am able to
1006 think about the future with the confidence of knowing that we
1007 will not pay more than 8.7 percent of our income on our
1008 health coverage, even if our business grows, as I really hope
1009 it does.
1010 I am asking you to make these provisions permanent. My
1011 family and so many others need the security that comes with
1012 affordable, quality healthcare. Thanks to the ACA and to the
1013 American Rescue Plan, I am able to sleep a little better and

1014 continue dreaming my American dream where my family succeeds
1015 with a small business and my son with complex medical needs
1016 and disabilities survives and thrives in his community, in
1017 this country where we all belong.
1018 Thank you.
1019 [The prepared statement of Ms. LeBrun Hatcher follows:]
1020
1021 **********COMMITTEE INSERT**********
1022

1023 *Ms. Eshoo. Thank you very much. And thank you for all
1024 of the advocacy. It is really something to behold, and I
1025 think if someone had said to you in the beginning this is
1026 what you will be a part of and that the organization would
1027 grow and be as effective, you would have said, "No, we are
1028 not, will never be able to do that.''
1029 But you have, and it has been so important for so many.
1030 I will now move to member questions, and the chair
1031 recognizes herself for five minutes for questions.
1032 You know, there has been a reference legitimately to the
1033 American Rescue Plan and its subsidies, how they are going to
1034 benefit millions of people. I think that we have an issue
1035 here because the CBO estimates that only ten percent of those
1036 uninsured and eligible for the new subsidies are going to
1037 enroll and only 20 percent of those currently insured but
1038 unsubsidized will sign up for the new benefits because of a
1039 lack of awareness.
1040 So I think whoever would like to take this, probably
1041 Cindy Mann or Katie Keith or both. What do you advise us and
1042 the administration to do?
1043 If people do not know, they are not going to take
1044 advantage of what we are working so hard to give them, you
1045 know, in terms of this coverage.
1046 My goal, the goal of so many, our North Star has been
1047 universal healthcare, and what we have in the American Rescue

1048 Plan, in my view, advances that, but people have to know.
1049 My other question is to Mr. Cameron. You are obviously
1050 a fan of the plans that you have spoken about, but you know,
1051 for these short-term plans what really bothers me is that
1052 many of them are the kind of surprise medical billing.
1053 The Congress addressed that, thank goodness, on a
1054 bipartisan basis, but they imposed burdensome post claims,
1055 review processes to avoid paying for surgeries, for emergency
1056 room visits, for cancer treatments. They used the fine print
1057 of their coverage restrictions or enrollee's medical history
1058 to deny claims.
1059 So there are problems with some of these short-term
1060 plans, and it is not to pick on anyone. It is to see what is
1061 wrong to be made right.
1062 And we had a hell of a time addressing surprise billing,
1063 and we did. It is costly and, I think, really wrong.
1064 So first to Cindy Mann and to Katie Keith. What do you
1065 recommend that we do so that people will, in fact, take
1066 advantage of what we are working so hard to provide them?
1067 And, Mr. Cameron, maybe you want to comment on what I
1068 just outlined, and that H.R. 1875 closes the loophole that
1069 allows these short-term plans to avoid the ACA rules, to
1070 finally put an end to preexisting condition discrimination.
1071 You are talking about ones that you like and do some of
1072 the good things, but that is not the case across the board.

1073 So let's start. I have a minute and 38 seconds for
1074 three people to answer my questions.
1075 *Ms. Mann. This is Cindy Mann. I will jump in but also
1076 be really quick.
1077 It is a really important point you have brought up.
1078 People have to know what the benefits are. People have to
1079 know what the rules are. People also need help applying, and
1080 we have learned in the past, there were robust navigation and
1081 outreach efforts, but they have dried up a lot over the last
1082 four years.
1083 *Ms. Eshoo. I did not hear you. They what?
1084 *Ms. Mann. I said they dried up. They were cut
1085 substantially, and so this is the time, particularly because
1086 of the pandemic, where we need to increase that outreach and
1087 navigation.
1088 You are covered in California. The marketplace in
1089 California had documented how important that marketing is to
1090 make sure people understand these rules and what has changed.
1091 Also it is going to be really important to try and make
1092 those changes permanent so people will have confidence that
1093 they will still be there.
1094 *Ms. Eshoo. Mr. Cameron, do you want to comment?
1095 *Mr. Cameron. I thought you had one other person in
1096 front of me, but to your question --
1097 *Ms. Eshoo. Well, I only have 26 seconds now. So that

1098 is why I am shifting.

1099 *Mr. Cameron. First of all, I am a fan of choice. I am
1100 not necessarily a fan of all STP plans, and I will tell you
1101 that many States have adopted regulations that are trying to
1102 address the issues with the bad actors. Like in everything,
1103 there are bad actors and there are good actors, and we have
1104 addressed those.

1105 We have limited preexisting condition clauses for all of
1106 the plans. They have in some cases the same approach or
1107 clauses as the ACA plan. We go after them in the fine print,
1108 and we help consumers to be able to get the coverage that
1109 they need.

1110 I would also just quickly say that many of those that
1111 will not take advantage of the subsidy that you mentioned are
1112 those that are healthy and the plans are still too expensive.

1113 *Ms. Eshoo. All right. My time is expired.

1114 I now will recognize the ranking member of our
1115 subcommittee, Mr. Guthrie, for his five minutes of questions.

1116 *Mr. Guthrie. Thanks. I appreciate that very much.

1117 Ms. Carey, I guess we are talking about where the
1118 Affordable Care Act has not been successful is in controlling
1119 cost of healthcare. As you mentioned, over a trillion
1120 dollars have increased in healthcare spending since the
1121 Affordable Care Act was passed 11 years ago.

1122 And testimony has been given today that the ACA and we

1123 hear the American Rescue Plan have made coverage affordable
1124 by subsidizing ever increasing costs, and this continued
1125 increasing subsidies to chase ever increasing costs is just
1126 not sustainable, and particularly those who are just above
1127 the threshold to get any kind of subsidies continue to get
1128 squeezed by the ever-increasing cost.
1129 So my point is that we have failed at controlling
1130 healthcare costs or getting a handle on healthcare costs, and
1131 we need to focus on healthcare costs or the system is going
1132 to implode.
1133 And so your research, Ms. Carey, has been on the Federal
1134 Government and its role in driving healthcare costs,
1135 particularly structural regulations of Medicare. Could you
1136 explain further?
1137 I know you did in your opening statement, but could you
1138 explain further how we can deal with healthcare costs, which
1139 would hopefully make insurance -- if we deal with the costs,
1140 it makes insurance more affordable. We are going to make
1141 insurances unaffordable for everybody if we do not deal with
1142 costs.
1143 *Ms. Jameson Carey. That is right. We all pay for
1144 healthcare whether we are paying as the patient or paying as
1145 the taxpayer or paying through premiums. So we have to bring
1146 down the whole burden across the board.
1147 And there are many systems in place right now that are

1148 working to drive up the cost, and hospitals when they
1149 purchase medical groups, they are able to layer in facility
1150 fees that independent doctors do not charge, and that
1151 compounds.

1152 So if you have a primary care doctor who refers you to
1153 an orthopedist who refers you to an MRI or refers you to an
1154 out-patient surgical center, all of them layer in facility
1155 fees, which drive up the cost of care five times or more.

1156 So we need to unwind that and bring those costs down and
1157 expose them to price transparency. When patients begin to
1158 see the huge variance in price and that you can get a
1159 colonoscopy for $750 and across the street for $4,000, and
1160 you look for the quality and you get the best value.
1161 Competition will enter the system, and the costs will come
1162 down, and that will [inaudible] take care of itself.

1163 *Mr. Guthrie. Thank you for that.

1164 And, Ms. Mann, in GAO's report on express lane
1165 eligibility, ELE, GAO found that CMS has issued guidance on
1166 how to determine ELE errors and calculate such payments if
1167 those errors occur.

1168 If the ELE option is continued, it will be particularly
1169 important that CMS issue such guidance as questions have been
1170 raised by States and others regarding how ELE errors should
1171 be defined.

1172 Has CMS issued such guidance?

1173 *Ms. Mann. There is a lot of guidance around error
1174 rates and how those are calculated. Some of that guidance
1175 would pertain to the express lane eligibility that you speak
1176 of.
1177 There are only a couple handful of States, about nine
1178 States that do express lane eligibility, and both the GAO and
1179 OIG found that it has been an effective program, albeit a
1180 limited scope program to be able to promote enrollment.
1181 But certainly CMS can continue to look at questions
1182 around it and issue guidance as needed.
1183 *Mr. Guthrie. So more guidance is needed it appears?
1184 *Ms. Mann. Well, the findings from the OIG and from the
1185 GAO, the GAO did suggest that there be more guidance. OIG
1186 indicated that it did not see any particular evidence of
1187 erroneous determinations.
1188 So that was a while ago. Those reports were several
1189 years ago. So it is always good for CMS to continue to look
1190 at all facets of the program and identify whether any
1191 particular [inaudible] is needed to assure program integrity.
1192 *Mr. Guthrie. Hey, thank you very much for that.
1193 And, Mr. Cameron, I know Idaho is one of 27 States with
1194 short-term plans, and short-term plans are not for everyone.
1195 They typically are a gap when people need coverage and they
1196 need affordability.
1197 So would you talk in the 40 seconds left about States'

1198 ability to regulate these plans and who these plans are a
1199 value for, if they have value for certain groups of people?
1200 *Mr. Cameron. Absolutely. Certainly they have value
1201 for those that are in between jobs or those that are forced
1202 out until the next open enrollment period. Many States have
1203 also started regulating these plans a little more intently.
1204 Some States, five States, have banned them. Twenty
1205 States have limited what these plans can have in them,
1206 limited their length-off time, and even those that allowed,
1207 like Idaho, allowed them to exist longer than six months have
1208 instituted requirements on preexisting conditions and on
1209 essential health benefits.
1210 We are really trying to attract the young and the
1211 healthy back into the marketplace so that it will help hold
1212 down cost for everyone, including those that are buying
1213 coverage through the ACA.
1214 *Mr. Guthrie. Thank you.
1215 My time has expired, and I yield back. Thank you, Madam
1216 Chair.
1217 *Ms. Eshoo. The gentleman yields back.
1218 It is a pleasure to recognize the chairman of the full
1219 committee, Mr. Pallone for your five minutes of questions.
1220 *The Chairman. Thank you, Chairwoman Eshoo.
1221 You know, it bothers me because we keep hearing about
1222 this idea of choice, and of course, you do not have to choose

1223 the Affordable Care Act. You do not even have to have health
1224 insurance at all if you do not want to. So you ultimately
1225 have a choice of what you want to do.
1226 But I think that what bothers me is, you know, you say
1227 you have a choice, but when you buy these junk plans, people
1228 do not realize that they do not cover things.
1229 And so, you know, I use the extreme example which was
1230 sold before the ACA. I do not know if it is sold anymore,
1231 where people would buy plans that did not have
1232 hospitalization. They go to the hospital, and then they are
1233 shocked to find out it does not cover hospitalization because
1234 they cannot believe a plan is sold that does not cover
1235 hospitalization.
1236 Nobody believes that when they buy a plan it is not
1237 going to, you know, cover mental health. It is not going to
1238 cover maternal health. They just assume it does.
1239 And you can say, well, they are stupid and that is their
1240 own problem, but you know, this is the reality that you
1241 cannot have these false choices.
1242 The same thing is with innovation. Of course, we are
1243 all for innovation and we want to encourage innovation, but
1244 everybody wants the new thing. They want the new machine.
1245 They want the new way of diagnostic care.
1246 Well, a lot of times those things drive up the cost, but
1247 everybody wants them, and so I kind of want to debunk this

1248 thing that you can squeeze a lot more out of this system and
1249 still do more. I do not really think that is true.
1250 If you squeeze the system, often what happens is you do
1251 not have benefits. You do not have new techniques. You are
1252 not covered, and you know, it may be that you can squeeze a
1253 little more out of the system and save money, but that is
1254 often not the case.
1255 So with that I really want to go to Ms. Keith. I want
1256 to ask you about these short-term or junk plans with the
1257 three minutes we have left.
1258 These junk plans often exclude coverage for prescription
1259 drugs, mental health, substance use disorders, and in some
1260 cases basic preventative services; is that correct?
1261 *Ms. Keith. That is correct, yes.
1262 *The Chairman. And I understand that these junk plans
1263 impose annual and lifetime limits; is that correct?
1264 *Ms. Keith. That is correct.
1265 *The Chairman. And is it correct that these junk plans
1266 also deny coverage altogether for individuals sometimes with
1267 preexisting conditions?
1268 *Ms. Keith. That is correct, yes.
1269 *The Chairman. So my Republican colleagues claim that
1270 these short-term or junk plans provide Americans with choice.
1271 That is what I mentioned, but is this choice to buy bare
1272 bones coverage beneficial for consumers?

1273 Can you describe why an individual who is healthy when
1274 they sign up for one of these plans can still be subject to
1275 hundreds of thousands in medical bills?
1276 *Ms. Keith. Thank you for that question.
1277 So there are many reasons why someone who might be
1278 healthy enrolled and then comes to need health care. They
1279 might have an accident. They might be injured. They might
1280 get pregnant. They might be diagnosed with something.
1281 And when you happen to be enrolled in one of these
1282 short-term plans or other non-comprehensive options, you end
1283 up with high medical bills because of the significant gaps in
1284 these products. They simply do not cover the benefit
1285 categories that you just mentioned that most people expect to
1286 be covered. Prescription drugs is a huge one.
1287 They often have very high out-of-pocket costs, so up to
1288 $30,000. That is compared to about $8,000 with Affordable
1289 Care Act plans, and many exclude coverage for preexisting
1290 conditions, in addition to the other benefits and services
1291 that they often exclude.
1292 Those are just some of the ways that I think enrollees
1293 in short-term plans can be very surprised and end up with
1294 devastating medical bills as a result.
1295 *The Chairman. And, Ms. Keith, our committee did an
1296 investigation, and they found that these short-term or junk
1297 plans subject consumers to engage in some burdensome process

1298 to avoid paying for medical, and consumers are denied
1299 coverage for lifesaving and necessary treatments and left
1300 with thousands of dollars in medical bills.
1301 You see, the problem is you can talk about choice and
1302 you can say, oh, everybody should have a choice, but
1303 unfortunately, a lot of people just do not understand when
1304 they sign up for these things.
1305 You know, no one would ever believe that they have
1306 health insurance that does not cover hospitalization. Most
1307 people would never believe that they have health insurance
1308 that does not cover maternal health care, right?
1309 I mean, who would think that you would sell that kind of
1310 a plan?
1311 And this is my experience, and this is what happens, and
1312 this is what the committee found. And then what happens is
1313 the plans try to get around all of this, and people end up
1314 bankrupt.
1315 You know, I just want to stress that because I think it
1316 is so important, you know. I know you can always say, look,
1317 it does not matter. You know, buyer beware, but they do not
1318 read the fine print when they sign that. They are just not
1319 aware.
1320 So thank you, again. I appreciate it.
1321 And with that, Madam Chair, I yield back.
1322 *Ms. Eshoo. The gentleman yields back.

1323 The chair recognizes the ranking member of the full
1324 committee, Mrs. Rodgers, for your five minutes of questions.
1325 *Mrs. Rodgers. Thank you, Madam Chair.
1326 Thank you to all of the witnesses for being here.
1327 You know, across the country States run their own
1328 exchanges, and we have seen in those State-run exchanges an
1329 enrollment increase for the most part, although Washington
1330 State has actually seen a decline both in 2019 and 2020.
1331 And it highlights the need for more affordable options.
1332 So Mr. Cameron, my neighbor, my district actually borders
1333 Idaho. I was excited to learn about the innovative model
1334 that you have come up with in Idaho.
1335 And you have clearly worked very hard to try to find the
1336 options that people need so that they have health insurance
1337 and they have access to that healthcare when they need it.
1338 I would like to start out by just asking what advice do
1339 you have for us, as we are continuing to try to make
1340 healthcare affordable.
1341 And in your opinion, is there anything stopping
1342 Washington from implementing a plan like yours?
1343 *Mr. Cameron. Well, thank you, Congresswoman, and thank
1344 you for the compliment, and I am glad to be here.
1345 First of all, our plan, our approach could be adopted by
1346 other States, providing some of the bills that are introduced
1347 today do not pass, which really cut the legs out of anybody

1348 buying a plan, regardless of whether it is a good plan or a
1349 bad plan if it is outside of the ACA.
1350 You know, the implication that you are somehow better
1351 without coverage than you would be with coverage that is
1352 inferior, I just do not agree with that.
1353 And we have worked long and hard in Idaho and many other
1354 States to try and put appropriate standards and guidelines
1355 around what should be short-term plans and to avoid the fine
1356 print.
1357 *Mrs. Rodgers. Okay. Thank you.
1358 *Mr. Cameron. Sorry.
1359 *Mrs. Rodgers. Thank you. I want to move on to a
1360 couple other questions, too.
1361 Do any of the bills before the committee today, in your
1362 opinion, lower the cost of healthcare?
1363 *Mr. Cameron. You know, the only bill I think that is
1364 in front of the committee that has even a remote chance is
1365 the one that funds reinsurance pools, but then only if it is
1366 modified and adjusted to do high risk reinsurance pools that
1367 are invisible reinsurance pools.
1368 *Mrs. Rodgers. Okay. Thank you.
1369 Ms. Carey, do you believe any of these bills before the
1370 committee will help lower the cost of healthcare?
1371 *Ms. Jameson Carey. I did not see any evidence of that.
1372 *Mrs. Rodgers. Okay. You know, I really think that

1373 this hearing is a missed opportunity to build on our work
1374 together to actually try to lower the cost of healthcare, not
1375 to shift those costs to the taxpayer.
1376 I am excited about the potential of transparency to
1377 lower cost, but I would also like to hear about how it would
1378 help patients.
1379 Ms. Carey, can you give us some examples of how
1380 transparency within healthcare would help patients pay less
1381 for their healthcare?
1382 *Ms. Jameson Carey. It would help in so many ways.
1383 First of all, it would put the power in the patient's hands
1384 and not into the insurer's hands and into the government's
1385 hands. It would help them drive as consumers and improve
1386 every market when they have price competition and price
1387 transparency.
1388 Markets complete. Quality gets better, and prices come
1389 down. We have seen it in retail. We have seen it in
1390 airlines. And if consumers can get on their phone an app
1391 that compares what it is like to have a hernia surgery or how
1392 much it costs across systems system-wide and they pick the
1393 high value, low-cost provider, others are going to have to
1394 compete, and that is going to empower patients, bring costs
1395 down, and really make healthcare affordable and accessible.
1396 *Mrs. Rodgers. So as a follow-up, what advice would you
1397 have for a patient needing to get an MRI, for an example,

1398 that has a high deductible?

1399 *Ms. Jameson Carey. I would go to anyplace that posts
1400 their prices. Green Imaging has price transparency, has an
1401 imaging center across the country. Go to a surgical center,
1402 like Oklahoma Surgery Center, and look up what they charge
1403 for a knee replacement, for example. It is $15,500 where the
1404 average cost for a total knee replacement is $57,000 in this
1405 country.

1406 And you go to your hospital and you say, "Look. I can
1407 get an MRI for $350 over here. I can get my knee replaced
1408 for 15,500 over here. Can you match that?''

1409 That is what I would tell the American consumer, to hold
1410 the hospitals accountable to the price that you should be
1411 paying, not to the prices that they want to charge you.

1412 *Mrs. Rodgers. Would you speak to the concern about
1413 quality, as you are making that decision?

1414 *Ms. Jameson Carey. Quality of care also takes care of
1415 itself when patients have transparency to the marketplace. A
1416 great example is Lasix surgery, which has only come down in
1417 price because these ophthalmologists are competing, and the
1418 quality is being reported online in real time.

1419 The same is with the plastic surgeons who typically do
1420 not get involved with insurance. They get private pay, and
1421 their prices come down, and their quality has gone up.

1422 It works in the market, and it can work systemwide.

1423 *Mrs. Rodgers. Thank you. I appreciate you being with
1424 us today.
1425 *Ms. Jameson Carey. My pleasure.
1426 *Mrs. Rodgers. I yield back, Madam Chair.
1427 *Ms. Eshoo. The gentlewoman yields back.
1428 A pleasure to recognize the gentleman from North
1429 Carolina, Mr. Butterfield.
1430 *Mr. Butterfield. Thank you very much, Madam Chair. It
1431 is good to see all of you this morning. Actually it is
1432 afternoon now.
1433 But it is also good to see the witnesses, and thank you
1434 for your testimony.
1435 Let me spend my few minutes with Cindy Mann, if I may.
1436 Ms. Mann, just 12 States, including my home State of
1437 North Carolina, have failed to expand Medicaid. We have
1438 talked about this now for 11 years. They have failed to
1439 expand Medicaid despite the Federal Government picking up the
1440 majority of the cost.
1441 The American Rescue Plan included a robust financial
1442 incentive for these States. States that expand under this
1443 new incentive can use those funds to combat the pandemic.
1444 They can expand coverage. They can bolster their programs.
1445 For example, it would cost North Carolina $490 million
1446 to expand the Medicaid Program, but North Carolina would
1447 receive $1.7 billion in new Federal funding if it expanded

1448 under the American Rescue Plan.

1449 Do the math. North Carolina could reinvest the
1450 remaining $1.2 billion of new Federal funds in critical State
1451 programs and in communities like I represent.

1452 The question, Ms. Mann, if you believe that States like
1453 my State should expand Medicaid because it is the right thing
1454 to do. I believe that 600,000 North Carolinians who would
1455 gain coverage and access to quality healthcare under
1456 expansion are reasons enough.

1457 But Republicans who control our State legislature have
1458 thus far disagreed with me. Given that, can you discuss the
1459 economic benefits of Medicaid expansion with States and
1460 communities?

1461 We have heard it before, but we need to hear it again.

1462 *Ms. Mann. I would be glad to. Thank you for the
1463 question and thank you for your support for getting expansion
1464 in place in North Carolina.

1465 It represents about ten percent of all the people in
1466 this country that are in the coverage gap, your residents in
1467 North Carolina.

1468 You are absolutely right, Congressman. It is a real
1469 value to the States. There has been an increase in Medicaid
1470 expenditures as a result of the expansion, but it has been
1471 because we have been covering more people, and the vast
1472 majority of those additional costs have been borne by the

1473 Federal Government.

1474 States have enjoyed generous match rates, and they have
1475 also been able to offset other costs that they have been
1476 spending with State-only dollars with the value of having
1477 Medicaid matching apply.

1478 So it has been enormously helpful to States. I need to
1479 remind everybody, of course, that we have Medicaid expansion
1480 in 36 States. There are States with Republican legislators
1481 and Democratic legislatures, Republican governors and
1482 Democratic governors.

1483 No State that has adopted an expansion has decided to
1484 drop it, and that is, of course, in part because the State is
1485 providing care for their residents. It is providing
1486 reduction in uncompensated care for providers who serve them,
1487 but also because it has been a real benefit fiscally for
1488 States to be able to provide that care in bringing Federal
1489 dollars to share in the cost.

1490 *Mr. Butterfield. It is all about these expansion
1491 States and how they have benefitted. Can you give me just a
1492 very simple, plain example of how expansion can benefit the
1493 State, other than providing care to the patient and improving
1494 the economy?

1495 Are there some other collateral benefits?

1496 *Ms. Mann. Sure. So a couple, let me mention a couple.
1497 One is virtually every State right now, expansion or non-

1498 expansion, spends some of their now dollars whether it is on
1499 mental health services, substance abuse disorder services.
1500 They are spending State-only dollars.
1501 And yet with the Medicaid expansion funding, a much
1502 broader group of beneficiaries who can now enroll in the
1503 Medicaid program, that brings in Federal dollars where the
1504 State has been shouldering those expenses with State-only
1505 dollars.
1506 Medicaid has been an incredibly strong factor in terms
1507 of addressing the opioid crisis, for example, bringing down
1508 deaths and destruction in communities across the country.
1509 The other way in which Medicaid provides fiscal benefits
1510 to States is because the Federal dollars coming in provide
1511 additional economic activity in the State, and so there is a
1512 boon in that way as well.
1513 And for some States where they have imposed fees on
1514 health providers and health plans, often those fees are based
1515 on how many lives are covered. So to the extent that plans
1516 or hospitals are serving more people, they may be paying more
1517 revenues into the State.
1518 *Mr. Butterfield. Thank you. Thank you, Ms. Mann, and
1519 I pray that we see the day very soon when these 12 States
1520 will expand Medicaid.
1521 *Ms. Mann. I am hopeful. It is a very exciting
1522 incentive that you all have made available.

1523 *Mr. Butterfield. Thank you.

1524 I yield back, Madam Chair.

1525 *Ms. Eshoo. The gentleman yields back.

1526 There is hope on the horizon. I mean two deeply red
1527 States, Wyoming and Alabama, are considering expansion. So
1528 there is hope out there. There is some movement.

1529 The chair now recognizes Dr. Burgess. Are you there,
1530 Dr. Burgess? I do not see you.

1531 Not there. We will circle back to him.

1532 And I will recognize the gentleman from Virginia, Mr.
1533 Griffith, for his five minutes of questions.

1534 *Mr. Griffith. Thank you very much, Madam Chair.

1535 A note to Ms. Jameson. I instinctively like what you
1536 are saying about transparency, but there are hospitals who
1537 say that they would have a hard time being able to stay open
1538 in rural areas if the transparency that you propose is
1539 mandated.

1540 What is your response to that argument?

1541 *Ms. Jameson Carey. We need hospitals, and we need them
1542 to stay open, but we do not need them owning all of the
1543 physicians in a community and all of the imaging centers, and
1544 we need them to unwind themselves of some of the
1545 consolidation and focus on their internal hospitalization
1546 needs.

1547 So I find a lot of hospitals spending a lot of money

1548 that they are not paying in property taxes, for instance,
1549 because 62 percent of our hospitals are not-for-profit or
1550 they pay no taxes.
1551 These are monies that are supposed to get plowed back
1552 into the community in the way of charitable patient care, but
1553 instead they are turning it into infrastructure.
1554 So I would like to see a little realignment of the
1555 funds, have them spending less money on acquiring things,
1556 less money on building things, and more on giving back to the
1557 patient and getting their costs truly in line with delivering
1558 patient care.
1559 *Mr. Griffith. I look forward to figuring out how we
1560 get that balance down because I am worried about our rural
1561 hospitals as well. But I want people to know that you can
1562 lower costs on things like eye surgery.
1563 You mentioned Lasik, and when I was in the State
1564 legislature, I worked with a group that was working on
1565 cataract, a stand-alone surgical center for cataracts and
1566 glaucoma. As soon as they got the permission to open, the
1567 prices in the community dropped substantially, all providers
1568 including the hospital.
1569 All right. Mr. Cameron, does Idaho have network
1570 adequacy standards to ensure health plans in your State
1571 provide sufficient in-network access to primary and specialty
1572 providers?

1573 *Mr. Cameron. Yes, we do. We have six carriers in our
1574 exchange, which most other States cannot brag of that, and we
1575 do have network adequacy standards that we require that they
1576 meet.

1577 *Mr. Griffith. And how do you balance network adequacy
1578 with the insurer's ability to negotiate lower cost or exclude
1579 lower caliber providers?

1580 *Mr. Cameron. Well, obviously, they have the ability to
1581 establish those contracts. As seen, at times it required
1582 negotiation and conversation with our department and the
1583 provider or our department and the insurance carrier to make
1584 sure that it has taken place.

1585 *Mr. Griffith. Do you think folks at CMS in Baltimore
1586 or Washington, D.C. would understand the nuances of Idaho's
1587 health insurance market to be able to write rules addressing
1588 your network adequacy standards?

1589 *Mr. Cameron. Absolutely not.

1590 *Mr. Griffith. And how about your rate review
1591 determinations? And explain if you can.

1592 *Mr. Cameron. Yes. We have a very extensive process in
1593 which the carriers are required to submit their rates. We
1594 review every policy, every wording of every policy, and we
1595 review how they calculated the rates.

1596 We have actuaries on staff that review them, and we push
1597 back at times. We have a high-risk reinsurance pool that

1598 helps us, and we argue that rates should be lower because of
1599 that, and so we have done a pretty good job over the last
1600 four years of trying to control those rates in spite that
1601 their costs, particularly for five years, were really
1602 exorbitant.
1603 *Mr. Griffith. What do you think the confusion caused
1604 by perhaps having folks at CMS in Baltimore and Washington
1605 trying to make all of these rules and decision; what do you
1606 think that confusion would do to competition?
1607 And would it encourage or discourage insurance carriers
1608 to offer plans in Idaho?
1609 *Mr. Cameron. We think it would discourage them. We
1610 think it would create, you know -- I do not know what the
1611 right word is -- a vacuum where carriers would not be able to
1612 offer and meet those demands.
1613 We think consumers would be less protected and would not
1614 know who to turn to. So when we hear about folks that have
1615 bought plans that are not appropriate, we hear those on ACA
1616 plans. We get complaints all the time on folks that have
1617 bought ACA plans and they've thought something was covered
1618 and it was not.
1619 And if they had to report to Washington, that would be
1620 devastating to them.
1621 *Mr. Griffith. If Medicare for All that was introduced
1622 last week were to pass, the bill would eliminate Medicaid as

1623 well as the private market. Approximately how many people in
1624 your State would lose their current insurance plans? Do you
1625 know?
1626 *Mr. Cameron. It would be about 1.4 million which would
1627 lose their coverage, which is about what we have covered. We
1628 have 1.8 million, is our population.
1629 *Mr. Griffith. All right. Thank you very much.
1630 I yield back, Madam Chair.
1631 *Ms. Eshoo. The gentleman yields back.
1632 It is a pleasure to recognize the gentlewoman from
1633 California, Ms. Matsui.
1634 *Ms. Matsui. Thank you very much.
1635 *Ms. Eshoo. Nice to see you.
1636 *Ms. Matsui. Thank you. You, too. Thank you very
1637 much, Madam Chair, for calling this very important hearing,
1638 and happy anniversary, too, for ACA.
1639 From the young and uninsured to the middle income off-
1640 exchange couple, an estimated 25 million Americans stand to
1641 benefit from the health coverage expansion in the American
1642 Rescue Plan.
1643 However, as the chairwoman outlined, the Congressional
1644 Budget Office estimates that only a small percentage of the
1645 uninsured or unsubsidized will sign up for the new benefits.
1646 Ms. Keith, Covered California is encouraging its 11 health
1647 carriers to invest in marketing and outreach to find off-

1648 exchange consumers to let them know that they are now
1649 eligible for financial help.
1650 Is this something that the Biden administration could do
1651 as well?
1652 *Ms. Keith. Thank you, Congresswoman, for that
1653 question.
1654 So I would first say that I think the CBO's estimates
1655 are low on this point, in part, because the enhancements are
1656 only temporary. So if and when those enhancements were made
1657 permanent, I think we would see those numbers increase
1658 significantly. So I do want to make that point.
1659 In terms of what Covered California is doing, I think
1660 Covered California has really led the way in investments in
1661 marketing and outreach. They have put together entire
1662 reports about how that has helped keep premiums down in our
1663 State and really brought in healthier and younger people.
1664 So far, the Biden administration has allocated about $50
1665 million to advertise the current special enrollment period
1666 that's running through Healthcare.gov.
1667 I think an even greater investment is needed, and
1668 certainly I think to undo some of the harm that we have seen
1669 over the past four years. Many uninsured people are unaware
1670 of the Affordable Care Act.
1671 I think the same is going to be true of this new
1672 financial help that is available, and I think it is on all of

1673 us to make sure that people understand their options.

1674 *Ms. Matsui. Well, thank you very much.

1675 And in California we really build up the plan to

1676 maximize enrollment and based upon marketing principles. So

1677 we hope to encourage the administration to do the same, too.

1678 From PPE and testing to treatment and vaccinations,

1679 inequitable access has been really a defining characteristic

1680 of the COVID-19 pandemic, an enduring problem in this

1681 healthcare system.

1682 The ACA's Medicaid expansion helped reduce longstanding

1683 racial disparities in health coverage, but we know that

1684 coverage alone is not enough to eliminate these disparities.

1685 This is one reason why the American Rescue Plan injects new

1686 resources to States, localities, and directly to families.

1687 Ms. Mann, can you provide an example of how some States

1688 are working to address social determinants through their

1689 Medicaid programs?

1690 *Ms. Mann. Certainly, and thank you for that question.

1691 Let me start with your home State, which is the State of

1692 California, which has been operating under a Medicaid waiver

1693 and has had something in place, pilots around the States

1694 called Whole Person Pilots.

1695 *Ms. Matsui. Yes.

1696 *Ms. Mann. Whole Person Care Pilots that have invested

1697 in social determinants of care, has addressed homelessness,

1698 has addressed housing insecurity issues, has addressed hunger
1699 and violence, and other needs that people have.
1700 And they are now looking, the State of California is now
1701 looking to make that program statewide and make sure that
1702 whole care is provide, meaning that we do not release people
1703 from a hospital if they are homeless. That is not good care.
1704 That is not smart care. That is not cost-effective care.
1705 So increasingly we are seeing States do that. North
1706 Carolina is a State that is just about to embark on major
1707 system transportation in its Medicaid Program where buying
1708 health is the mantra, and that is health needs with excellent
1709 medical care, but also really thinking about those health-
1710 related issues that can drive bad health and health care
1711 costs.
1712 So we have seen an enormous number of States really move
1713 ahead, particularly in COVID times, realizing the link
1714 between social barriers of health and delivery of healthcare
1715 is so important if we are going to get good results.
1716 *Ms. Matsui. So you would recommend that Congress
1717 support these types of programs moving forward?
1718 *Ms. Mann. I think that it is really important to
1719 support it, and there are a number of ways it can be
1720 supported. Part of it is in our healthcare system itself,
1721 making sure that payers, Medicaid, Medicare, commercial
1722 payers, recognize some of these services.

1723 But also, we need other investments. We need more
1724 affordable housing.
1725 *Ms. Matsui. Right.
1726 *Ms. Mann. We need investments that increase SNAP
1727 benefits. They are all important ingredients to really
1728 making sure that the whole person is cared for and that
1729 people actually can get healthier as they move through the
1730 system.
1731 *Ms. Matsui. Well, thank you very much, and I agree
1732 with you.
1733 And I yield back.
1734 *Ms. Mann. Thank you.
1735 *Ms. Eshoo. The gentlewoman yields back.
1736 It is a pleasure to recognize the gentleman from
1737 Florida, Mr. Bilirakis, for your five minutes of questions.
1738 *Mr. Bilirakis. Thank you, Madam Chair. I appreciate
1739 it very much. Thanks for holding this hearing.
1740 The first question is for Mr. Cameron.
1741 One of the major promises of the ACA was affordable
1742 insurance for every American. The law even went so far as to
1743 penalize those who did not enroll.
1744 However, in the decade since its enactment, insurance
1745 costs continue to rise. Why is that?
1746 *Mr. Cameron. Well, I think it is a number of reasons.
1747 Thank you for the question.

1748 It is because those that are healthy are pushed out.
1749 Those that do not qualify for a subsidy are forced out. So
1750 if you are schoolteacher and your employer offers you
1751 coverage, but it does not pay for the coverage on your spouse
1752 and your kids, you do not get a subsidy.
1753 If you are a rancher or a farmer, you do not qualify for
1754 a subsidy because your incomes are too unpredictable. All of
1755 those things, that family glitch and the unpredictable
1756 nature, have forced the young and healthy out while costs
1757 have continued to rise.
1758 And so what you have in our marketplace, what we have
1759 essentially is those people who absolutely need coverage or
1760 who are subsidized. About 85 percent of our folks, maybe
1761 even 90 percent of our folks receive a subsidy, and it has to
1762 be a significant subsidy. If it is just a $50 subsidy on a
1763 $1,000 premium, it does not get people to buy.
1764 *Mr. Bilirakis. Thank you.
1765 A second question for you, sir. CMS released a report
1766 in August of 2019 on individual insurance market enrollment
1767 trends. Data show that between the years 2016 and 2018,
1768 unsubsidized enrollment declined by approximately 40 percent.
1769 If the ACA has fulfilled its promise to provide
1770 affordable health coverage to all, why has this decline
1771 occurred?
1772 And is it an absolute affordability issue? And if so,

1773 how has Idaho, your State of Idaho, responded to increased
1774 enrollment and its risk pool?
1775 *Mr. Cameron. Yes, thank you very much for the
1776 question.
1777 First of all, it absolutely has happened. We have seen
1778 it happen in our State, and essentially people are being
1779 forced out of the marketplace. They are unable to afford
1780 those prices.
1781 And so if you are not getting a subsidy, you do not have
1782 any choice. Your choices are going without coverage or going
1783 to a Health Sharing Ministry Plan or going to a short-term
1784 plan.
1785 And so what we did in Idaho is we said, okay, if this is
1786 where people are being driven, how do we improve the
1787 marketplace?
1788 How do we help the ACA plans?
1789 And so we said, okay, if you are going to offer long-
1790 range, short-term plans, you have to meet the conditions of
1791 the ACA. You have to have all of the essential health
1792 benefits. You have to not have preexisting condition clauses
1793 if you are selling at the same time on the exchange, and you
1794 have to be part of the same risk pool.
1795 So we tie the rates together. So if the rate increases
1796 occur to one, it occurs to both of them. So they are all
1797 sharing the same risk pool.

1798 And in my mind that is what the ACA was intended to do,
1799 was to do that, but then the rule and subsequent decisions
1800 forced individuals out and have made prices higher. So if
1801 you are not getting the subsidy, if you are in the family
1802 glitch, we are not getting the benefit of you being in the
1803 risk pool.

1804 *Mr. Bilirakis. Thank you very much.

1805 The next question is for Ms. Carey.

1806 How are hospitals complying with the price transparency
1807 rule issued by the previous administration? I think you
1808 addressed that.

1809 Where do the biggest issues persist in achieving true
1810 transparency, and how can Congress address this?

1811 *Ms. Jameson Carey. Thank you, Congressman, for the
1812 question.

1813 Congress can address this by putting a law in place that
1814 further reinforces the rule and going further in requiring
1815 hospitals to show not only their discounted cash prices, but
1816 all of their secret negotiated rates with all of their
1817 contracted payers.

1818 And insurance companies are supposed to follow a rule
1819 that lands January 1, 2022. We need Congress to make sure
1820 and HHS to make sure these rules get put in place and get
1821 recognized and are enforced.

1822 Hospitals are not complying with the rule as it stands.

1823 We see a lot of good investigative media coverage exposing
1824 that. They really need to be held accountable. We really
1825 need machine readable formats so data innovators can
1826 aggregate the data so we can start to shop for prices the way
1827 we shop for airline tickets, and the competition will kick
1828 in, and the prices will come down.

1829 *Mr. Bilirakis. Thank you.

1830 And, Madam Chair, in the interest of time, I will go
1831 ahead and yield back the rest of my time.

1832 *Ms. Eshoo. The gentleman yields back.

1833 It is a pleasure to recognize the gentlewoman from
1834 Florida, Ms. Castor, for your five minutes of questions.

1835 *Ms. Castor. Well, thank you, Madam Chair. Thanks for
1836 having this very important hearing on how we expand coverage
1837 and lower healthcare costs, including two of my bills.

1838 But first, happy 11th year anniversary to the Affordable
1839 Care Act. It has provided affordable coverage and health
1840 coverage for families, and on behalf of the over two million
1841 Floridians who go shopping on the healthcare marketplace, and
1842 that is where they get their affordable coverage, thank you,
1843 thank you.

1844 On behalf of the seniors in Florida who have stronger
1845 Medicare, thanks.

1846 On behalf of all of the young people who have been able
1847 to stay on their parents' insurance.

1848 And, by the way, when you are talking about choice, here
1849 in the Tampa Bay area if you got shopping in the ACA
1850 marketplace, there are over 100 private plans that you have
1851 to choose from. So I think that highlights the importance of
1852 navigators.
1853 But now, thanks, colleagues and the American Rescue
1854 Plan, we have made ACA coverage even more affordable. One
1855 estimate in the Sunshine State is we have over 300,000
1856 families that are newly eligible for expanded tax credits.
1857 So that is going to make a real difference.
1858 And of course, we still have the issue of expanding
1859 Medicaid in Florida. If we were to do that, not only would
1860 we bring billions of dollars of our tax money back to the
1861 State and expand economic activity, as Cindy Mann has said,
1862 but this would make a real difference in the lives of so many
1863 Floridians.
1864 So hopefully they will hear what Congressman Butterfield
1865 said. Do the math. This is a benefit.
1866 And I want to thank Representative Veasey who has worked
1867 on this with me and his terrific Incentivizing Medicaid
1868 Expansion Act, and Representative Schrier, Dr. Schrier, thank
1869 you for your work on the KIDS Act. That is the primary care
1870 that will boost the Medicaid reimbursement rates as well.
1871 But I want to spend my time on navigators and the
1872 outrageous junk plans. One of my bills is the Expand

1873 Navigators' Resources for Outreach, Learning, and Longevity
1874 Act, or the ENROLL Act. It will provide continuity for
1875 families and navigators.
1876 And I would like to ask Ms. Hatcher first of all. You
1877 said that you used the navigator to help you shop for
1878 coverage in the ACA marketplace. How did the navigator help
1879 you find coverage that was right for your family?
1880 *Ms. LeBrun Hatcher. Thank you for the question.
1881 The navigator was actually quite indispensable. You
1882 know, shopping for healthcare is overwhelming under the best
1883 circumstances. There are lots of different options, and
1884 trying to figure out what will be the right fit for your
1885 family is a challenge, especially when you do not have the
1886 backing of an HR department.
1887 So the navigator kind of functions as your own HR
1888 professional. She or he lets you know what your options are.
1889 You can talk through different plans. They help you
1890 determine what your subsidies may or may not be.
1891 So it has been truly indispensable, and they also help
1892 you be sure that the coverage that you think you are getting
1893 is what you are getting.
1894 What we learned through the ACA is that we were actually
1895 able to purchase better insurance than what had been offered
1896 through my husband's employer-sponsored care. We had more
1897 options. We were able to choose a plan with a company that

1898 we trusted, and it was actually a very, very good experience,
1899 very positive.
1900 *Ms. Castor. Thank you.
1901 Now on junk plans, Ms. Keith, thank you for your
1902 outstanding testimony. I am so concerned about these junk
1903 plans and the fact that so many of these companies take
1904 advantage of our neighbors.
1905 In fact, I just got word this morning when I was asking
1906 for that update on how many plans were in this local area.
1907 They shared a story that just last week a couple was dropped
1908 without notice. They had one of these junk plans and was
1909 dropped without notice. They did not find out about this
1910 until they went for a CAT scan.
1911 They did not have coverage because this short-term plan,
1912 they hightailed it out of there, and they had to pay out of
1913 pocket for the CAT scan.
1914 And we just cannot have folks suffering like this
1915 anymore. We know that a lot of these plans have these
1916 fraudulent marketing tactics, too, but talk to us, too, about
1917 some of the backend tactics that these plans engage in to
1918 avoid paying medical bills.
1919 *Ms. Keith. Thank you for that very important question.
1920 So some of the backend tactics, many of these companies
1921 engage in what we call rescission. So as soon as someone
1922 actually needs healthcare and maybe this applies to the

1923 couple that you are talking about in Florida, as soon as they
1924 need healthcare, the insurance company will pull their
1925 application, will ask for medical records going back three,
1926 five, seven years, and comb through all of that information
1927 looking for a reason to tie the healthcare that they need
1928 either to a preexisting condition or some reason why they
1929 should not have issued the policy in the first place.

1930 That gives the company grounds to pull back, to rescind,
1931 to cancel the policy, leaving the person without any type of
1932 coverage at all, and fully responsible for their medical
1933 bill. It is one of the biggest abuses that we have seen.

1934 *Ms. Eshoo. Your time has expired. Thank you, Ms.
1935 Castor.

1936 The chair is pleased to recognize the gentleman from
1937 Missouri, Mr. Long, for your five minutes of questions. It
1938 is good to see you.

1939 *Mr. Long. Thank you, Madam Chair.

1940 And I hate to go over plowed ground, but whenever the
1941 ACA was about to come into effect, we had discussions about
1942 the navigator, and if memory serves, you could not be a
1943 navigator if you knew anything about insurance. If you had
1944 any nexus to insurance, you were disqualified from being a
1945 navigator.

1946 So to me that was kind of like if your car needed
1947 repair, you can take it to someone, anyone but an automobile

1948 mechanic.

1949 So with that being said, Director Cameron, here is my
1950 question for you. You talk about the importance of getting
1951 people into the marketplace to stabilize and lower premiums.
1952 The ACA Navigator Program has consistently underperformed in
1953 its enrollment goal.

1954 In 2017 and 2018, navigators enrolled only one percent
1955 of total enrollees and had comparable outcomes for 2018 and
1956 2019. Agents and brokers, which are licensed and trained to
1957 educate the people on insurance, can be much more effective
1958 and cost efficient in assisting people obtaining coverage.

1959 CMS noted that in 2018 agents and brokers were
1960 responsible for 42 percent of enrollees at an average cost of
1961 $2.40 per enrollee.

1962 Can you discuss how effective the Navigator Program has
1963 been, and do you think we should be providing an additional
1964 $100 million to the program collected from exchange user
1965 fees?

1966 *Mr. Cameron. Thank you, Congressman, for that
1967 question.

1968 No, I do not. In our State, we have used some
1969 navigators, but the bulk, about 80 percent of our folks that
1970 are enrolled use an agent who actually is, as you said,
1971 licensed and trained.

1972 They have to go through an extra training program to

1973 work through our State-based exchange so that we make sure
1974 that they are covering all of the facets appropriately.
1975 And that is how the majority of Idaho citizens obtain
1976 their individual coverage, and frankly, that is the safest.
1977 That is the safest way. They are responsible for what they
1978 helped individual purchase.
1979 And so we think rather than spend that money that way,
1980 that it would be better to more embrace the agent community
1981 and the agent population.
1982 *Mr. Long. Do you think navigators should be able to
1983 consider short-term, limited-duration plans when assisting a
1984 potential enrollee?
1985 *Mr. Cameron. I do not believe a navigator would have
1986 the expertise to be able to distinguish between a good short-
1987 term plan and one that maybe is not as good.
1988 So I would have some heartburn with that. Obviously, if
1989 they became licensed and were trained, even though they are
1990 operating as a navigator, but if they are licensed and have
1991 all the same or similar training as an agent, then perhaps
1992 they could.
1993 *Mr. Long. What are some the headwinds and challenges
1994 that agents and brokers in your State face helping people
1995 obtain coverage in the ACA marketplace.
1996 *Mr. Cameron. Yes. Perhaps the most difficult one is
1997 ones that I have already mentioned. They have folks that

1998 want coverage, that know the importance of coverage, like the
1999 63 and 62-year-old from Twin Falls, Idaho, who wants
2000 coverage, but prices got too high, $1,500 a month. So they
2001 are forced out of coverage.
2002 They actually went to the traditional style short-term
2003 plans, which are not the better ones, and they are hopping
2004 from one company to another company until they turn 65. And
2005 in the meantime, that is hurting the overall risk pool.
2006 Or we have individuals that because they are, you know,
2007 like I said, a spouse or schoolteacher, they cannot afford
2008 the dependent coverage on the school district's plan, and so
2009 they are forced to go without coverage, and if they are
2010 basically healthy, then they are choosing to take that risk
2011 on themselves.
2012 We believe that the appropriate use of short-term plans
2013 as in-between coverages is appropriate. It saves lives. It
2014 saves with early diagnosis and early treatment of conditions,
2015 and they have the opportunity then at the open enrollment
2016 then to move over to an ACA plan.
2017 *Mr. Long. Well, I know that since 2013, premiums in
2018 individual markets have tripled just since 2013 here in
2019 Missouri. So we are going to have to figure out some kind of
2020 way to consider lowering premiums for the Affordable Care Act
2021 plans beyond just throwing more money at this problem.
2022 And my wife's car is having some issues, and so I am

2023 going to head out now and yield back because I need to head
2024 over here to the dry cleaners and see if they can fix her
2025 car.
2026 I yield back.
2027 *Ms. Eshoo. I am sorry. I did not follow my own rules
2028 about unmuting.
2029 The chair now, let's see, recognizes Mr. Schrader of
2030 Oregon for your five minutes of questions.
2031 *Mr. Schrader. Thank you, Madam Chair.
2032 The Affordable Care Act has been an unqualified success
2033 for millions and millions of Americans. Having said that,
2034 there are still a few that unfortunately do not have access,
2035 those in those States that decided not to do the Medicare
2036 expansion, which I find unbelievable.
2037 When I was budget chair in Oregon, it was a no-brainer.
2038 If the Feds. are going to, you know, pay 95 or 90 percent of
2039 the bill paid on healthcare, it would save my State money in
2040 the long run.
2041 So hopefully, listening to the testimony States are
2042 gradually figuring out that they really need to do that.
2043 The other problem that was not anticipated in the
2044 Affordable Care Act is the problems with upper middle-class
2045 individuals that do not qualify for subsidies, and Mr.
2046 Cameron has talked about that. Actually you all have at
2047 that.

2048 And I guess one of the cost containment options that you
2049 did think was reasonable, Mr. Cameron, was the reinsurance or
2050 risk pools. Could you comment on that?
2051 I mean, there is evidence that it can reduce premiums by
2052 almost 17 percent. Could you comment on that briefly?
2053 *Mr. Cameron. Thank you, Congressman, for the question.
2054 In Idaho, we have a high-risk invisible re-insurance
2055 pool. So what happens, we actually take some of our premium
2056 tax dollars as well as some other funds that we were able to
2057 cobble together. Carriers, insurance carriers, buy the
2058 reinsurance. So they have to determine whether they are
2059 going to seed the risk, and we help cover those most
2060 expensive treatment items with about 50 percent coinsurance,
2061 if you will, to the insurance company.
2062 The consumer does not know that their condition is being
2063 reinsured. So they are protected. At the same time it has
2064 helped lower cost over time.
2065 We have not seen quite the level that you mentioned,
2066 although we are a small State with a small pool of money, and
2067 so we are only covering those high-risk items for which we
2068 can afford.
2069 The larger the pool, the more we could afford to cover,
2070 but I think that has --
2071 *Mr. Schrader. Very good.
2072 *Mr. Cameron. I think the bill would need some

2073 amending.

2074 *Mr. Schrader. Very good, very good. But I have heard
2075 both Democrats and Republicans talk about risk pools,
2076 reinsurance program. So there seems like an area of
2077 commonality.

2078 You also talk a little bit about the short-term plans.
2079 On one hand, some can be taking advantage. We have heard
2080 about the bad actors, but there are some good actors. It has
2081 a role. I actually like what you say about bridging
2082 insurance, longer term insurance.

2083 And you commented that in Idaho they had to meet at
2084 least the essential benefits that were in the Affordable Care
2085 Act; is that correct?

2086 *Mr. Cameron. Yes, that is correct. We actually went
2087 and drafted a bill, worked with the legislature, and allowed
2088 us to devise what we are calling the enhanced short-term
2089 plans. We would prefer not to call them short-term plans,
2090 but that was the opportunity we could move forward with.

2091 *Mr. Schrader. Well, it would seem to me the goal of
2092 the Affordable Care Act was to make sure that you could not
2093 short-change. All of the comments we have heard here today,
2094 you know, individuals who are not reading the fine print, and
2095 as long as you had the essential healthcare benefits in
2096 either short-term plan or an association plan.

2097 I mean, you know, if we had association plans that were

2098 required and you had essential benefits that were similar to
2099 the ACA, I think that would also be an area of commonality.
2100 Another point that my colleagues on the other side of
2101 the aisle bring up all the time are health savings accounts
2102 and flexible savings accounts. Is there a role for that, Mr.
2103 Cameron, in helping people that do not get the subsidies for
2104 healthcare?
2105 *Mr. Cameron. Absolutely. We are big fans of using the
2106 health savings account, particularly amongst those that are
2107 healthy. Those are some of the ideas that need to be
2108 discussed as we bring or draw back the healthy of all ages
2109 back into the marketplace.
2110 People do not like buying insurance if they do not feel
2111 like they are going to need it or utilize it, and so then
2112 they end up with a situation where they are going bare and
2113 all of a sudden find out they do not have coverage.
2114 So we think that there ought to be some options and
2115 choices within the ACA that would openly allow health savings
2116 accounts so that those that are healthy can buy less
2117 expensive coverage and set other money aside in their health
2118 savings account.
2119 *Mr. Schrader. Well, it seems to me there is a marriage
2120 here between making sure low-income folks get the cost
2121 sharing subsidies they need, get the Medicaid coverage or
2122 subsidies in the Affordable Care Act, and then there is, you

2123 know, an opportunity at the higher end of the income spectrum
2124 to make sure they also can afford healthcare.
2125 That really is our goal here, making sure everyone has
2126 affordable healthcare.
2127 So I appreciate everyone's testimony. It has been very
2128 helpful, and I think this is an area we can get together and
2129 work on.
2130 And I yield back, Madam Chair.
2131 *Ms. Eshoo. The gentleman yields back.
2132 The chair recognizes the gentleman from Florida, Mr.
2133 Dunn, for your five minutes of questions.
2134 *Mr. Dunn. Thank you very much, Madam Chair.
2135 Let me start by associating myself with Representative
2136 Schrader's remarks.
2137 I am pleased to be discussing ideas to lower healthcare
2138 costs for the American people. As we all know, healthcare
2139 coverage does not always equal access to affordable, quality
2140 healthcare. We are not better off if more people technically
2141 have coverage by insurance, but still face sky high
2142 deductibles and exorbitant prices.
2143 I believe that price transparency throughout the
2144 healthcare system will empower patients to choose their care
2145 and ultimately lead to lower cost.
2146 Patients should be able to know how much a visit will
2147 cost before they show up, and they should know how that cost

2148 might vary at other hospitals, clinics, and offices.

2149 The physician-patient relationship also needs to be
2150 preserved. It is the pillar of a patient's trust in the
2151 healthcare system. Medical choices should be made by
2152 patients, doctors, and families, not bureaucrats. Physicians
2153 have the knowledge and the best interest of their patients at
2154 heart.

2155 And we should be wary of any actions by insurance plans
2156 to restrict choices and insert themselves into what should be
2157 doctor-patient decisions.

2158 As we think about transparency, preserving the doctor-
2159 patient relationship, and lowering cost, we must focus on
2160 policy that drives value in the healthcare system. We can do
2161 this with policy incentives that encourage efficient,
2162 evidence-based, integrated care that considers the whole
2163 patient.

2164 We can and we must modernize our healthcare. We think
2165 we can improve healthcare outcomes while we lower healthcare
2166 costs.

2167 So Ms. Jameson Carey, you are a proponent of healthcare
2168 price transparency to lower healthcare costs. What is the
2169 role of the physician when helping patients navigate the
2170 system?

2171 And how can physicians increase price transparency?

2172 Ms. Carey?

2173 *Ms. Jameson Carey. Thank you for the question,
2174 Congressman.
2175 Doctors want to show their prices. Doctors are on
2176 patients' sides. They are not on the side of insurance
2177 companies necessarily. They want to know prices. They want
2178 to be able to tell their patients how much things cost, and
2179 sometimes they do not even know.
2180 Doctors come to me all the time saying, "I just want to
2181 restore the doctor-patient relationship and get the hospital
2182 administrators, the government, and the insurance companies
2183 out of the exam room. But I spend the first ten minutes of
2184 my visit with the patient answering questions to qualify for
2185 certain reimbursements or certain coverages, and it is a
2186 waste of time, and I need to get back to helping out my
2187 patient.''
2188 Unfortunately, doctors are very nervous about posting
2189 their prices because there are two upper questions for them.
2190 They all want their prices out there, but they are afraid if
2191 they put their cash prices out there that insurance plans
2192 will cancel them because their cash prices will look so much
2193 better than their contracted rates with insurers.
2194 I have also talked to doctors who put their prices up
2195 and the hospital tells them to take the prices down or they
2196 will lose their privileges because it's threatening to the
2197 hospital who charges four times more.

2198 So we need this to be open. We need to shine some
2199 sunshine on this situation. We need doctors to be free to
2200 post their prices and not to get the reprimands and return
2201 the relationship between the doctor and the patient as you so
2202 eloquently pointed out.

2203 *Mr. Dunn. So I agree. I mean, in my practice we
2204 actually were forbidden from revealing prices publicly
2205 because that was equivalent, in the insurance company's view,
2206 of sharing, price fixing with other physicians across town.
2207 It was a crazy situation.

2208 And the same is true, by the way, of other services.
2209 Radiology stands out in my mind. I was a patient this past
2210 year.

2211 And I want to talk to you, by the way, offline about
2212 this later, Ms. Carey.

2213 So do doctors in your association, Ms. Carey, have
2214 adequate access to price information across the system?

2215 It is funny. You alluded to many who do not know the
2216 cost of the very services that they order, you know, for
2217 their patients. So is there something that we can do to help
2218 them know that?

2219 *Ms. Jameson Carey. Well, I think if you made it easier
2220 for everyone to have their prices transparent, they would
2221 really appreciate that because they refer a patient to a MRI,
2222 and they do not always know how much that is going to cost

2223 them, and they would like to be good stewards of their
2224 patients' finances, and they do not have enough access to
2225 prices themselves. They almost have the same access the rest
2226 of us have.

2227 So they are operating in the dark. So if we get more
2228 sunshine and more transparency, they are going to be able to
2229 steer their patients to the best value providers.

2230 Also, if they remain independent, they are not required
2231 to forward all of their patients into the health system where
2232 costs are the highest. So employee physicians must refer
2233 into --

2234 *Mr. Dunn. We are running out of time, but I want to
2235 talk to you later, your association later, and I cannot agree
2236 with you more.

2237 We were literally forced to turn patients back into a
2238 system that outrageously overcharges them, and I have great
2239 examples of that.

2240 Thank you, Madam Chair. I yield back.

2241 *Ms. Eshoo. Thank you. The gentleman yields back.

2242 It is a pleasure to recognize the gentleman from
2243 California, Dr. Ruiz, for your five minutes of questions.

2244 *Mr. Ruiz. Thank you, Madam Chair.

2245 Today we celebrate 11 years since the Affordable Care
2246 Act became the law of the land. This historic, lifesaving
2247 piece of legislation has helped millions of Americans access

2248 healthcare, and as this past year has made clearer than ever,
2249 having an affordable option that is not tied to employment is
2250 critical to the millions of families that rely on the
2251 marketplace or Medicaid for their healthcare.
2252 Of course, there is still more that needs to be done,
2253 which is why we are having this hearing today and why it was
2254 so important that the American Rescue Plan was just signed
2255 into law to expand coverage and reduce the cost of healthcare
2256 for millions of Americans.
2257 As I have been on the ground administering vaccines to
2258 underserved communities in my district, I can say
2259 unequivocally that now, during this public health emergency,
2260 is precisely the time to expand healthcare.
2261 Access to healthcare is a human right, not a privilege
2262 for just a select segment of the population. Whether or not
2263 someone has access to affordable healthcare should not depend
2264 on their zip code or how much money they make or how healthy
2265 they are, which is why we must keep working to reduce gross
2266 health disparities, achieve health equity, and create an
2267 America where every person has access to quality, affordable
2268 healthcare.
2269 And on the topic of health equity, today I would like to
2270 focus on an area of health equity that does not get as much
2271 attention as it should, the Indian Health Service.
2272 Today we are considering my bill, H.R. 1888, the

2273 Increasing Access to Indian Health Service Act, which extends
2274 100 percent Federal Medical Assistance Percentage, the FMAP,
2275 to urban Indian organizations and allows tribal health
2276 programs to receive reimbursements for services provided
2277 outside of the four walls of their clinic.
2278 IHS provides healthcare to 2.2 million American Indian
2279 and Alaskan Natives every year. Across the United States, 41
2280 urban Indian Health Program provided medical services to over
2281 65,000 people per year.
2282 Even though they are a vital part of the Indian Health
2283 Service provider network, they only receive about one percent
2284 of the annual IHS budget.
2285 Furthermore, urban Indian health programs are the only
2286 IHS facilities that do not receive 100 percent FMAP for
2287 Medicaid services. Under the American Rescue Plan, I
2288 successfully advocated for the next two years urban Indian
2289 health programs will receive 100 percent FMAP, but this is
2290 merely a temporary policy.
2291 We need a permanent fix. Ms. Mann, what is the current
2292 FMAP for the urban Indian health programs?
2293 *Ms. Mann. The services that are provided through the
2294 Medicaid program would be at the State's regular Medicaid
2295 match, Congressman. So in California, that would be 50
2296 percent, and so a very significant difference from what the
2297 American Rescue Plan was provided and what your bill would

2298 provide on a more permanent basis.

2299 And you are absolutely right. It is the one portion of
2300 that delivery system which is left out of the 100 percent
2301 match and really important --

2302 *Mr. Ruiz. And is there any policy basis for this
2303 disparity in how the Federal Government funds services
2304 received for different Indian health providers?

2305 *Ms. Mann. I believe it is, like the Medicaid
2306 expansion, it is sort of an accident of history, right, in
2307 terms of who [inaudible]. So I would defer to you to have a
2308 better sense of that.

2309 *Mr. Ruiz. A 100 percent FMAP --

2310 *Ms. Mann. But there is no sound policy basis that I
2311 know of, Congressman.

2312 *Mr. Ruiz. Thank you. Thank you.

2313 A 100 percent FMAP for UIOs means the Federal Government
2314 would over a greater portion of Medicaid care. Is it fair to
2315 assume that this could help incentivize States to increase a
2316 pay raise to these financially strained providers?

2317 *Ms. Mann. I think it can. I think it can help them
2318 increase pay for staff. It can help them provide their
2319 navigation help. It can help them address things like
2320 emotional determinants. It can really provide a more robust
2321 platform of providing care and assistance to people.

2322 *Mr. Ruiz. Thank you.

2323 It is critical that we pass my legislation to ensure
2324 this long overdue policy is implemented permanently.
2325 Finally, Ms. Mann, I would like to ask you about the
2326 other provisions of H.R. 1888 that would permanently allow
2327 IHS clinics to receive Medicaid reimbursement for services
2328 provided outside of their clinic.
2329 The administration recently extended a grace period that
2330 allows for this type of reimbursement through the end of
2331 fiscal year 2021. My understanding is that there is nothing
2332 in statutes or regulations that guarantees that this ability
2333 to bill Medicaid for these services will extend beyond that
2334 date.
2335 Ms. Mann, would it be beneficial to ensure that tribal
2336 healthcare providers can maintain this reimbursement for care
2337 outside of the four walls of their clinic beyond 2021?
2338 *Ms. Mann. Absolutely, and there have been steps taken
2339 under the Obama administration that were taken to be able to
2340 extend that 100 percent FMAP for contracted providers, but it
2341 has not been as even-handedly provided for as your
2342 legislation would do.
2343 And I think there has been a lot of temporary
2344 flexibilities that have been granted during the pandemic that
2345 States and the Federal Government and healthcare providers
2346 need to look carefully at and determine which ones ought to
2347 be made permanent.

2348 *Mr. Ruiz. Thank you. I yield back.
2349 *Ms. Eshoo. The gentleman's time has expired.
2350 The chair is pleased to recognize the gentleman from
2351 Utah, Mr. Curtis, for your five minutes of questions.
2352 *Mr. Curtis. Thank you, Madam Chair.
2353 I am so grateful for all of our witnesses today. I am
2354 finding myself wishing I had an hour with each one of them.
2355 Thank you for your thoughtful testimonies.
2356 A quick thought, not a question, Ms. Jameson Carey. I
2357 actually had four surgeries last year, and I can speak
2358 firsthand to the confusion of pricing.
2359 And one of the points that I do not think was made but I
2360 would like to throw in here is this confusion and the
2361 multiple bills that come after surgery make it very, very
2362 difficult for the average consumer to get insurance
2363 reimbursement.
2364 And I would just like to kind of throw that in to
2365 validate your point, in addition to what you have said.
2366 Mr. Cameron, we have a couple of connections. We share
2367 a border. I am from Utah. I noticed in your bio you are
2368 third generation insurance agent.
2369 My father was an independent insurance agent, and his
2370 father was an independent insurance agent, and I broke that
2371 third-generation link. In hindsight maybe I should have gone
2372 into insurance.

2373 But I remember my father taught me a couple of lessons
2374 when I was very young about insurance that I feel like we
2375 have forgotten in today's world.
2376 The first was that you only buy insurance for things
2377 that you cannot afford to pay for, and I feel like in today's
2378 world we want insurance to cover dollar one, and we could
2379 reduce the cost of insurance, I think, if we could remember
2380 that.
2381 The second thing he taught me was to never get a traffic
2382 ticket because it makes your insurance go up, and it is a
2383 very simple example, but I think we also forget sometimes
2384 what we do that causes the cost of insurance to go up.
2385 Now, a question for you, Mr. Cameron. In the last
2386 Congress I had a bill. It was called the American Health
2387 Share Plans Act, and in essence what it did is it would
2388 permit member companies -- Costco is maybe a good example
2389 that would come to mind for everybody or similar companies
2390 like that with membership -- to sponsor healthcare plans,
2391 particularly across straight lines. In Costco's case, they
2392 have 84,000 members.
2393 Have you heard of that plan?
2394 And do you see how plans like that, large and small,
2395 might be able to help us reduce the cost of health insurance?
2396 *Mr. Cameron. Certainly, and thank you for the
2397 question, and thank you for being a good neighbor.

2398 First, we have worked very carefully with association
2399 plans. We have also worked with our legislature on a bill
2400 for selling across State lines. It can be done.
2401 The biggest fear about selling across State lines is
2402 where does the consumer go when they have bought a plan that
2403 is not licensed in Idaho? Where do they go?
2404 And so we were able to address that with collaboration
2405 of other States that are struggling. That is with Utah,
2406 Oregon, Washington, Nevada, Wyoming, et cetera. And so we
2407 have been able to address that.
2408 We have been working also with association health plans.
2409 The biggest dilemma there is in many cases some of the
2410 associations want to just carve out special niches and insure
2411 those.
2412 And we pushed back on that and said, look, you have got
2413 to take everybody who is a member of that association.
2414 *Mr. Curtis. Yes.
2415 *Mr. Cameron. If you are a Chamber, you have got to
2416 pick everybody who is a Chamber.
2417 *Mr. Curtis. And you will excuse me for jumping in, but
2418 we have got such limited time.
2419 I would like to just reiterate something that you just
2420 said in your opening remarks about the States being
2421 laboratories. And I think you have brought many good
2422 examples today.

2423 I wish we could bring all 50 State Commissioners to the
2424 hearing to learn individually what they have learned about
2425 all of their different ways to approach things.
2426 Quickly, Ms. Mann, we have heard a lot of emphasis today
2427 on why not all of the States are jumping into Medicaid
2428 expansion, and I have a theory on that, and that is that we
2429 want this one size fits all from Washington, D.C., without
2430 letting them have any flexibility.
2431 Bipartisan healthcare solutions and the Medicaid Program
2432 include 12-month continuous coverage in addition to promoting
2433 greater fiscal responsibility with the waiver program.
2434 Utah was previously approved for waiver that included
2435 work requirements. That is important in our States, but the
2436 Biden administration recently notified the State that its
2437 waiver did not promote the objectives of the Medicaid
2438 Program.
2439 Do you believe we could get more participation from
2440 States and have better policy if we did not have this one
2441 size fits all Medicaid approach?
2442 *Ms. Mann. Congressman, that is a really important
2443 question.
2444 And I would say that, first, I will get to the work
2445 requirements issue in a second, but first, there is an
2446 enormous amount of flexibility in the Medicaid Program, and
2447 you know, there is the common phrase which I think is

2448 accurate, which if you have seen one State's Medicaid
2449 Program, you have seen one State's Medicaid program.
2450 States decide on their delivery systems and their
2451 payment rates.
2452 *Mr. Curtis. Ms. Mann, we are going to run out of time.
2453 I would love to let you go because you have so many important
2454 things to say.
2455 Let me say in the last few seconds I have got just a
2456 real plea for the individual needs of States, realizing that
2457 we do not have all of the answers at the Federal level.
2458 I wish we had more time. I am sorry. I am out of time.
2459 *Ms. Mann. I could not agree more.
2460 *Mr. Curtis. Thank you.
2461 *Ms. Eshoo. The gentleman yields back. Thank you, Mr.
2462 Curtis.
2463 A good exchange. We learn so much in hearings. I love
2464 hearings. They are long, but they are highly instructive.
2465 It is a pleasure to recognize the gentleman from
2466 Maryland, Mr. Sarbanes, for his five minutes of questions.
2467 *Mr. Sarbanes. Thanks very much, Madam Chair.
2468 I am very honored to have Ms. Hatcher on this panel as
2469 one of my constituents today, and I want to thank her for her
2470 very important perspective.
2471 Ms. Hatcher, thank you for sharing your family's story.
2472 I wondered if you could describe a little bit more the

2473 challenges caused by the COVID-19 pandemic in terms of the
2474 impact on your family and how you were able to access the ACA
2475 marketplaces for coverage, in view of that, and just
2476 generally share your perspective on why that kind of coverage
2477 opportunity is so critical.
2478 *Ms. LeBrun Hatcher. Thank you so much for your
2479 question. It is a pleasure to be here as well.
2480 First, I just want to recognize that so many people,
2481 particularly communities of color who we know have been very
2482 hard hit by this pandemic, have had it more difficult than I
2483 have. I am grateful for my ability to work from home, and I
2484 am grateful for my resources like computers that I have been
2485 able to take advantage of.
2486 But having said that, the COVID pandemic has been very
2487 hard on my family, as it has been for many others. My
2488 daughter, who is a senior in high school, she has missed
2489 pretty much every milestone.
2490 For my son, online learning has been really hard. He
2491 has got cognitive disabilities, and remote therapy and remote
2492 classes, you know, I am very worried about the regression
2493 that this may have caused him.
2494 It has also been really hard to juggle supporting Simon
2495 in those ways and, you know, try to work full time in this
2496 current economic environment.
2497 Losing Simon's DSP, losing those kinds of supports, that

2498 has been a real blow. We were really focused on working
2499 towards his independence, and not being able to have those
2500 resources has made it even more challenging in an already
2501 challenging time.

2502 Being able to access the ACA has been one of the bright
2503 spots. It has allowed us to have the security of knowing
2504 that we have health coverage, especially when, you know, we
2505 are in a global pandemic, and it is pretty scary out there
2506 when it comes to one's ability to maintain one's health.

2507 Having the ability to choose what program we went with,
2508 having the ability to have the Medicaid support for Simon has
2509 been enormously beneficial.

2510 *Mr. Sarbanes. Thank you very much. I appreciate that.

2511 You know, one of the things that the American Rescue
2512 Plan did was it built, as we know, on the Affordable Care Act
2513 in significant ways, potentially transformative ways on
2514 making it possible for more Americans to access in an
2515 affordable way healthcare coverage at a time when they were
2516 struggling financially.

2517 It expands the ACA's tax subsidies, including for the
2518 first time for Americans above 400 percent of the Federal
2519 poverty line. And we know that this has been a real issue
2520 for families across the country. So the ARP was a meaningful
2521 response to that challenge.

2522 Ms. Keith, can you talk briefly about how many

2523 individuals are expected to see their monthly premiums
2524 decrease as a result of the American Rescue Plan, sort of
2525 what we built onto the ACA, improved it, and how many
2526 uninsured individuals will qualify for these expanded
2527 subsidies?
2528 *Ms. Keith. Thank you for that question.
2529 So the current nine million subsidized enrollees are
2530 going to see their premiums go down. They can return to
2531 Healthcare.gov or their State-based marketplaces in most
2532 States beginning on April 1 and start to see savings on
2533 average of about $50 per month per person. So big savings,
2534 money back in people's pockets.
2535 That is in addition to the 14.9 million uninsured people
2536 who will be eligible for these subsidies, including the 3.6
2537 million uninsured families who are above that 400 percent
2538 poverty line threshold that you mentioned who have never been
2539 eligible before.
2540 And I think this is really going to close the gap for
2541 some of the people that have enrolled in the short-term plans
2542 and the Healthcare Sharing Ministries and have really been
2543 cut off from access. I think it is going to be
2544 transformative for these families.
2545 *Mr. Sarbanes. I appreciate that very much.
2546 You know, for a long time, we talked about how we could
2547 build on the foundation of the ACA, strengthen it, expand it

2548 with, lift it higher.

2549 For years we had to be in a kind of defensive posture
2550 against the repeal efforts, and that made it hard for us to
2551 do that. The American Rescue Plan has shown that there
2552 really is a path forward to expand coverage and to view the
2553 ACA as that bedrock.

2554 And I think we can learn from that, Madam Chair, and
2555 continue to offer great ideas to strengthen and improve
2556 coverage for all Americans.

2557 And I yield back.

2558 *Ms. Eshoo. The gentleman yields back.

2559 It is a pleasure to recognize our colleague from
2560 Georgia, the ever moving around in his car every time we have
2561 a hearing, Mr. Carter.

2562 How are you?

2563 *Mr. Carter. I am good, and thank you, Madam Chair. I
2564 appreciate it. I am trying to figure out how to do the
2565 background so you will not know I am in a car, but
2566 nevertheless, I want to truly thank you for this hearing and
2567 thank the panelists.

2568 This is a great hearing, a much needed hearing,
2569 certainly something that we in the State of Georgia -- this
2570 is important because I will tell you that we have been
2571 working for the last two years to try to figure out why
2572 almost a million Georgians that are uninsured and are

2573 eligible for subsidies under Obamacare have not enrolled in
2574 the exchange.
2575 And about a little bit over 150,000 of these that are
2576 eligible for the Bronze Plans would have zero- or single-
2577 digit premiums per month, and we found that there are really
2578 two issues.
2579 First of all, we need to get to the people where they
2580 buy their insurance.
2581 And, secondly, the insurance is still far too costly.
2582 On the first issue, and that is about getting the people
2583 to the insurance, Georgia has proposed not using
2584 Healthcare.gov and instead using a network of private Web
2585 browsers, such as -- or Web brokers, I should say -- such as
2586 HealthSherpa or GetInsured and other health insurance
2587 carriers to find people where they are.
2588 And what I wanted to ask you, Mr. Cameron, is have you
2589 found that brokers in your experience are more successful
2590 enrolling people than federal trained navigators?
2591 *Mr. Cameron. Absolutely, Congressman. I will tell you
2592 that Idaho has its own State-based exchange, and we did it
2593 for some of the same reasons you have talked about. We are
2594 the only Republican State that has a State-based exchange.
2595 We would welcome others to join us because we think it can be
2596 less expensive and be able to reach more people.
2597 *Mr. Carter. So not using Healthcare.gov has not

2598 hindered enrollment in Idaho?

2599 *Mr. Cameron. Not at all. That is not our issues. Our
2600 issues are affordability and those folks who do not believe
2601 they need the coverage.

2602 *Mr. Carter. Okay. So that is the first problem that
2603 we had. The second problem that we have had, or the second
2604 issue, Georgia's 1332 waiver is also planning a reinsurance
2605 model so that we can lower premiums up to 25 percent in some
2606 rural areas where there is less competition.

2607 And listen. There are two Georgias. There is Atlanta,
2608 and there is everywhere else. And in South Georgia, it is a
2609 problem, a big problem. We do not have as much competition
2610 as we should.

2611 But if we were to do this, Mr. Cameron, can you talk
2612 about how reinsurance in Idaho and how it has helped to lower
2613 premiums?

2614 *Mr. Cameron. You bet. First of all, we did not use
2615 the 1332 waiver. We attempted to, frankly, found that the
2616 1332 waiver process was too cumbersome and too difficult for
2617 what we were going to gain from it.

2618 So we just adopted our own program, and we looked
2619 prospectively. We have one-quarter of our premium tax
2620 looking prospectively. It is deposited into our account. We
2621 set up the reinsurance process with a board that I appoint
2622 that is made up of both consumer advocates as well as

2623 insurance carriers.

2624 And the insurance carriers have to pay a premium in
2625 order to buy the reinsurance. Plus they can be assessed if
2626 we ever get upside down.

2627 But we are not. We are operating in the black with
2628 several million dollars carrying over from year to year, and
2629 it does help reduce rates, and we hope it would reduce rates
2630 more significantly down the road as our pot continues to
2631 grow.

2632 *Mr. Carter. Well, you know, we may reach out to you to
2633 find out exactly how you were able to do it.

2634 We are trying to do the 1332 waiver in the State of
2635 Georgia, and I hope that this administration does not think
2636 it knows better than what we know in Georgia what we need,
2637 and I hope that the flexibility that the 1332 waiver offers
2638 is absolutely crucial to getting more Georgians access to
2639 quality, affordable health insurance.

2640 So we will be monitoring this and, Mr. Cameron, we may
2641 be in touch with you to find out how you could help.

2642 But my message is simple, and that is we do not need to
2643 be relitigating this 1332 waiver. This is something that is
2644 extremely important to the State of Georgia, and I hope that
2645 we will be successful in this.

2646 And with that, Madam Chair, I will yield you back 30
2647 more seconds.

2648 *Ms. Eshoo. Well, we thank the gentleman who yields
2649 back, and drive safely. I think someone else is driving,
2650 right?
2651 *Mr. Carter. Oh, yeah.
2652 *Ms. Eshoo. It is a pleasure to recognize the gentleman
2653 from California, Mr. Cardenas, for your five minutes of
2654 questions.
2655 Great to see you.
2656 *Mr. Cardenas. Great to see you, Madam Chairwoman, and
2657 all of my colleagues, and thank you so much to all of the
2658 witnesses who are giving us some insight and expertise about
2659 what's going on out there in America when it comes to
2660 healthcare.
2661 And also, I would like to thank the Ranking Member
2662 Guthrie as well for having this hearing.
2663 The Affordable Care Act, the ACA, significantly reduced
2664 racial and ethnic disparities in health coverage for
2665 children, including by reducing the coverage gap between
2666 Latino children and all, up to three points in 2016.
2667 Nevertheless, according to recent research, the
2668 Georgetown Center for Children and Families, the gap between
2669 coverage rates for Latino children and all children widened
2670 in 2018 for the first time in a decade, threatening to undo
2671 the progress of the ACA and placing Latino children in a more
2672 vulnerable situation in the years prior to the pandemic.

2673 Ms. Keith, what can Congress do not only to reverse the
2674 trend and restore the gains of the ACA for Latino children,
2675 but fully close racial and ethnic coverage gaps for all
2676 children?
2677 *Ms. Keith. Thank you for that question, and I would
2678 also welcome Ms. Mann's comments on this as well since she
2679 focuses on this issue.
2680 I think there are many things that can be done,
2681 including extending coverage as you all just did under the
2682 American Rescue Plan to parents and making sure that parents
2683 have access to affordable coverage because that translates to
2684 children's coverage gains.
2685 There have already been steps to roll back the public
2686 charge rule, which was disincentivizing enrollment, and
2687 again, I think having navigators' outreach in a moment making
2688 folks aware that these options are available is going to be
2689 critically important, including in Spanish language and with
2690 trusted partners out in the community doing this very
2691 important work.
2692 Much to be done. Many gains that could be made.
2693 *Mr. Cardenas. Thank you.
2694 And, Ms. Mann, if you can answer that with an additional
2695 question that I have for you.
2696 Thank you so much, Katie.
2697 The ACA helped provide coverage to at least four million

2698 Latino adults and 600,000 Latino children once the ACA became
2699 law, but many of the law's benefits remain inaccessible to
2700 millions due to their immigration status, including those
2701 with deferred action for childhood arrivals, otherwise known
2702 as DACA.
2703 Latinos continue to have one of the highest uninsured
2704 rates in the country, at nearly 19 percent when last checked
2705 in 2019, and noncitizen Latinos have higher uninsured rates
2706 than all other noncitizen groups, regardless of income or
2707 work status.
2708 Ms. Mann, as Congress considers how to build upon the
2709 ACA and expand coverage, what can it do to better integrate
2710 individuals otherwise left out due to their immigration
2711 status?
2712 *Ms. Mann. Thank you, and it is a really important
2713 question.
2714 So as Katie had noted, the public charge rule certainly
2715 chilled people's ability to get care and to sign up for
2716 coverage even when they were eligible.
2717 So that rule has now been repealed, rescinded, but it
2718 will take a lot more than recission to be able to really
2719 restore trust among families that they can go and apply for
2720 the kind of coverage that they are, in fact, eligible for.
2721 Many mixed households, immigration households of citizens'
2722 children were refraining from looking for coverage and

2723 seeking care, and that is very unfortunate on all levels.
2724 So we need to really be aggressive now about getting the
2725 word out and making sure people do feel comfortable when they
2726 are eligible.
2727 Then there are some people that simply are not eligible.
2728 There is still a five-year bar from any lawfully present
2729 individuals to be able to access Medicaid coverage and CHIP
2730 coverage, and that can be addressed.
2731 And there are several groups of people who are lawfully
2732 in the United States, including the DACA people, who do not
2733 qualify and could be brought into coverage program through
2734 Federal action.
2735 *Mr. Cardenas. Thank you, Ms. Mann.
2736 I have a question for you, Laura, Ms. Hatcher. Are you
2737 aware, Ms. Hatcher, that Congress tried to end the ACA more
2738 than once?
2739 *Ms. LeBrun Hatcher. Thank you for your question.
2740 Yes, I am aware of that.
2741 *Mr. Cardenas. How did you and your family feel when
2742 you witnessed that over and over and over?
2743 Did it seem like no big deal or was it something that
2744 actually you felt afraid if the ACA were to end?
2745 *Ms. LeBrun Hatcher. When Congress initially began the
2746 attempt to repeal the ACA, I felt frightened and powerless,
2747 and then when I watched adults with disabilities lining --

2748 *Mr. Cardenas. We have ten seconds, Laura. Let me ask
2749 this one question.
2750 Did it feel like life and death for your family perhaps
2751 if the ACA were repealed?
2752 *Ms. LeBrun Hatcher. It is life and death for my
2753 family.
2754 *Mr. Cardenas. It is life and death.
2755 Ladies and gentlemen, millions of families are in the
2756 same situation. Let's make the ACA better and stronger for
2757 every family in America.
2758 I yield back.
2759 *Ms. Eshoo. The gentleman yields back.
2760 A pleasure to recognize Dr. Joyce of Pennsylvania for
2761 your five minutes of questions.
2762 *Mr. Joyce. Thank you for yielding, and thank you,
2763 Madam Chair Eshoo and Ranking Member Guthrie for holding this
2764 hearing.
2765 And thanks to all of the panel for appearing with us
2766 here today.
2767 Mr. Cameron, you mentioned in your testimony that the
2768 1332 waiver process was too burdensome and difficult, and you
2769 were able to implement a reinsurance program without it.
2770 Congress had debated increasing flexibility in 1332, and
2771 the Trump administration's guidance provided as much
2772 flexibility as it could within the law.

2773 Do you think, Mr. Cameron, that Congress should look to
2774 build on the Trump guidance and increase the aforementioned
2775 flexibility?

2776 *Mr. Cameron. Well, thank you for that question,
2777 Congressman, and that is a tough one.

2778 I think that Congress should look even further, and I am
2779 not going to suggest we build on anybody's foundation. I
2780 think you should look further to allow States to be the
2781 laboratories of innovation, laboratories of creativity.

2782 Some of the provisions in law did not even allow or we
2783 were trying to get the 1332 under the Trump administration
2784 and, frankly, could not and you would have thought we would
2785 have been able to but could not because of some of the
2786 barriers and strict interpretation of the law.

2787 Things like the demand that it be cost neutral, and yet
2788 they would define what we could measure in order to make it
2789 cost neutral. We could show where we were reducing costs for
2790 the ACA members as well as others, but it still was not
2791 allowed.

2792 So it is sort of a sore spot in our journey.

2793 *Mr. Joyce. Mr. Cameron, let's continue along the line
2794 on State innovation. H.R. 1796 before us today provides
2795 grants for State innovation. Yet the Biden administration
2796 has suggested it may repeal the Trump 1332 guidance.

2797 Do you recommend that Congress increase the 1332

2798 flexibility to get the best use of the proposed State
2799 innovation dollars should this proposal move through
2800 committee?

2801 *Mr. Cameron. Absolutely. To throw additional grant
2802 money at it does not help unless you are going to expand that
2803 ability for States to do things.

2804 I would strongly encourage to allow that. Every State
2805 is different. Although we have commonalities, every State
2806 has their unique challenges, and we should allow States to
2807 innovate and hopefully find solutions to lowering cost.

2808 *Mr. Joyce. You suggest in your testimony going from a
2809 three to one age ratio to five to one. Is this something
2810 currently permitted under 1332 today, or is that a
2811 flexibility that we should be exploring and providing to
2812 States?

2813 *Mr. Cameron. Absolutely, it is a flexibility that you
2814 should be employing. You should at least have the GAO or
2815 some private enterprise study it, but we think that
2816 flexibility should be there to States.

2817 We did our own actuarial analysis using a private firm,
2818 and by expanding from one to five, it would lower cost for
2819 everyone, not just the young, but for everyone. So even the
2820 seniors would be able to take advantage if you went to a one
2821 to five instead of a one to three. But it is not permitted
2822 under the current statute, at least according to CMS.

2823 *Mr. Joyce. I am certainly encouraged by lowering the
2824 cost, lowering the cost to seniors, to individuals all ages,
2825 and to State innovation, the point that you have made
2826 repeatedly and that is so important for us to understand that
2827 each State is individual.
2828 So if this committee chooses to move forward with H.R.
2829 1796, what are your specific recommendations in terms of how
2830 those funds should be structured and how those funds should
2831 be used?
2832 *Mr. Cameron. Well, thank you, and I do not know that I
2833 will give you as specific of an answer as I would like to.
2834 First, I would use those funds to allow for that
2835 innovation, that creativity, to allow for systems like what
2836 Idaho has done where we are trying to attract the young and
2837 the healthy.
2838 If you do not figure out how to attract the young and
2839 the healthy back into the ACA, the ACA will continue to
2840 spiral out of control, and even families like Ms. Hatcher
2841 will be eventually forced out of coverage unless they are on
2842 Medicaid.
2843 And to me, I think we have got to figure out ways to
2844 attract the health of all ages and the young back into the
2845 marketplace.
2846 The Congress in the American Rescue Plan addressed those
2847 above 400 percent of poverty. As we look at it, you could go

2848 forward with addressing those in the family glitch.

2849 *Mr. Joyce. I thank you for your comments.

2850 I see my time has expired, and thank you, Madam Chair

2851 Eshoo, and I yield.

2852 *Ms. Eshoo. Good questions, Mr. Joyce.

2853 I am going to have to step out for a short period of

2854 time, and our colleague, Mr. Sarbanes is going to step into

2855 the chair.

2856 First of all, thank you, and I believe the next member

2857 for you to recognize is the gentlewoman from Michigan, Mrs.

2858 Dingell.

2859 So thank you. I shall return.

2860 *Mrs. Dingell. Thank you, Chairman Eshoo and Ranking

2861 Member Guthrie, for convening today's hearing discussing a

2862 number of reforms and doing it to strengthen Medicaid and the

2863 Affordable Care Act on the 11th anniversary.

2864 I cannot help but think of John today and all that he

2865 did for healthcare for many years, and he would say to

2866 Republicans and Democrats gathered, you need to work

2867 together.

2868 But I am also reminded of his father who was one of the

2869 authors of Social Security, and some of the things I hear

2870 today were said 80 years ago, and it is such a part of our

2871 fabric now that I hope we can all work together so that every

2872 American gets access to healthcare.

2873 I appreciate the inclusion of my legislation to make
2874 permanent the Money Follows the Person Rebalancing
2875 Demonstration Act. Since it was authorized, the Money
2876 Follows the Person Rebalancing Demonstration has helped many
2877 Americans transition from institutional care to their homes
2878 and the community.
2879 Money Follows the Person has led to positive health
2880 outcomes for the beneficiaries. It has improved quality of
2881 life, and it has generated savings for Medicaid and Medicare.
2882 Despite these benefits, someone not being
2883 institutionalized, being a home care setting, and not costing
2884 as much money because they are at home and not in an
2885 institutional setting, it does not have permanent
2886 authorization or funding.
2887 Instead Congress has passed five short-term extensions
2888 to ensure program continuity. This uncertainty in funding as
2889 well as lapses in funding has caused some States to walk away
2890 from the program and has led to declines in efforts to
2891 transition individuals from the institutional setting to the
2892 community over the years.
2893 Ms. Mann, evidence has clearly demonstrated that funding
2894 uncertainty has had a damaging effect on Money Follows the
2895 Person Programs. Can you specifically describe the short-
2896 and long-term impacts this has had on beneficiaries?
2897 *Ms. Mann. Absolutely. And I applaud the introduction

2898 of that legislation, Congresswoman. As you say, it is a
2899 strongly supported, bipartisan supported program both in
2900 Congress and in States across the country.
2901 I was at CMS at one point when Money Follows the Person
2902 was expiring, and it really caused a great deal of havoc and
2903 concern among both the individuals who were getting
2904 assistance from that among the States that had been funding
2905 programs to do, as you described, to help people transition
2906 from nursing homes into the community, to help people stay in
2907 the community and avoid institutional care when they needed
2908 long-term services and supports.
2909 It is just an incredibly important bridge that provides
2910 a lot of flexibility in the way that people have been talking
2911 about, and when there is not certainty about the long-term
2912 funding for a program like that, then there is a lot of worry
2913 in the community.
2914 And also it impairs States' abilities and communities'
2915 abilities to plan programs and really try and invest and make
2916 sure that the program is as effective as possible.
2917 So having that stability after how long it has been in
2918 place will be really a value-added for everybody.
2919 *Mrs. Dingell. So let me ask you another question that
2920 I think is really important. When MFP participants
2921 transition from receiving care in nursing homes to community-
2922 based settings, do Medicaid Programs experience cost savings

2923 as a result?

2924 *Ms. Mann. On a per person basis it is overall much
2925 less expensive to care for people in the home. It is not
2926 cheap, but it is far less expensive than in the nursing home.

2927 And it is people's choice as well to stay in their homes
2928 or back in their homes in their communities.

2929 *Mrs. Dingell. One last one. I have got one minute
2930 left.

2931 Do you think that a consistent, reliable funding stream
2932 for Money Follows the Person would help to revitalize
2933 programs that have struggled over this past year and
2934 encourage States that wound down their programs to reinstate
2935 them?

2936 *Ms. Mann. Absolutely, absolutely. States are loath to
2937 jump in and set up new structures and fund services through
2938 it if they are not certain that the money will continue to be
2939 available.

2940 *Mrs. Dingell. And in 30 seconds, how would making this
2941 a permanent part of the Medicaid Program benefit
2942 institutionalized beneficiaries seeking transition to the
2943 community?

2944 *Ms. Mann. Well, often the idea of you are in a nursing
2945 home and the idea of leaving that institution to go into the
2946 community is just very difficult for people to think about
2947 how to do that.

2948 So help finding affordable housing, help paying for that
2949 transition, providing ramps and retrofitting apartments or
2950 housing to be able to make it doable for people to be able to
2951 then also arrange for the care that they might need at home.
2952 It is all those components that can be very scary steps
2953 for a lot of people, but one that they are eager to do if
2954 they have the support.
2955 *Mrs. Dingell. Thank you.
2956 Thank you, Mr. Chairman. I yield back.
2957 *Mr. Sarbanes. [Presiding.] Thank you, Congresswoman.
2958 I believe now, Congressman Crenshaw, you are recognized
2959 for five minutes.
2960 *Mr. Crenshaw. Thank you, Mr. Chairman.
2961 Thank you, everybody, for being here on such an
2962 important topic.
2963 Look. I will start philosophical and then get into my
2964 passion on direct primary care, which I am new to this
2965 committee, but you will hear a lot out of me on direct
2966 primary care over this session.
2967 But starting at the 30,000-foot level, I do not want to
2968 keep funding things that are proven to work well. We should
2969 be creative and flexible about how we deliver care.
2970 If we agree on that fact, and I think we actually do,
2971 that that Americans need access to good healthcare, the
2972 question is how we do it.

2973 And when we are looking at a program like Medicaid that
2974 we continue to fund endlessly and unsustainably, and yet it
2975 does not have a co-relation with improved outcomes. Study
2976 after study shows this.
2977 Nobody is saying that Medicaid causes bad outcomes, but
2978 if there is no correlation between Medicaid and good
2979 outcomes, we should at least have some questions in mind and
2980 be looking for more innovative solutions besides just
2981 increasing it endlessly.
2982 Yesterday we heard about how important primary care is.
2983 It is the gateway to healthcare. This is why direct primary
2984 care is such an important focus of mine, and I think that we
2985 can have some bipartisan agreement on it.
2986 I have heard in this committee hearing that there is
2987 already bipartisan agreement on the success of reinsurance
2988 program as a way to solve the tail end of the problem, where
2989 cost gets so overwhelming that insurance companies cannot
2990 cover them without raising premiums to extraordinary levels,
2991 and so an invisible reinsurance program works well for that.
2992 But we have to focus on the beginning of this, too. In
2993 Texas, we have had really interesting success with self-
2994 funded programs where a company will contract with a direct
2995 primary care physician. This does a few things. It
2996 immediately has an outcome of a direct relationship between
2997 the doctor and the patient, now with no extra costs or

2998 copays.

2999 It also reduces their premiums on the backend as they
3000 renegotiate with their insurance companies. It benefits all
3001 around.

3002 So how do we expand this model is going to be a question
3003 of mine. I have a bill that does that.

3004 My first question to Ms. Carey. You lead an association
3005 of doctors who want to remain independent, and are the
3006 doctors you work with participating in the direct primary
3007 care model?

3008 *Ms. Jameson Carey. Yes. Thank you for the question.
3009 It is such an important topic.

3010 In fact, last year we surveyed our members, and I asked
3011 them how many of them had a direct primary care practice or I
3012 like to call it direct care because I do think there are
3013 specialists, pediatricians and obstetricians and
3014 gastroenterologists even that would like to practice direct
3015 care.

3016 And I asked how many were already doing this. It turned
3017 out 30 percent of my members already were in a direct care
3018 model or had a hybrid, and 30 percent wanted to move in that
3019 direction. Another 30 percent felt that they just could not.
3020 They are radiation oncologists and feel very wedded to the
3021 insurance plans.

3022 But for those who can move in that direction, they are

3023 experiencing far more freedom, far less regulations, and
3024 their patients and employment populations are enjoying
3025 greatly reduced prices. It is an excellent way to go.
3026 *Mr. Crenshaw. It is and correct me if I am wrong. On
3027 average I am told it is about $75 a month. So we are talking
3028 a gym membership basically.
3029 Now, I realize that it is not insurance, but this is a
3030 long list of services that you get a quarterback. You get a
3031 quarterback for your healthcare, and nobody has that in
3032 America right now. Well, not nobody, but a lot of people do
3033 not, and that is really frustrating, I think.
3034 *Ms. Jameson Carey. I think that if employers could put
3035 that money, that $85, $75 per employee or $125 for a family
3036 and allow for those employees to get primary care, their
3037 labs, their well care, their radiology, all of that included,
3038 the rest of it can start to take care of itself with the
3039 self-insured employers that cover some of those costs, and it
3040 would save.
3041 The studies I have seen, the employees are extremely
3042 happy with the quality of care, the access, and the employers
3043 are saving 60 to 70 percent.
3044 *Mr. Crenshaw. And the next question people have, of
3045 course, is, well, not everybody can even afford $75 a month.
3046 So my bill would allow for 1115 waivers to provide direct
3047 primary care to low-income patients and more flexibility

3048 through Medicaid.

3049 So, Mr. Cameron, do you think -- that is something we
3050 are looking at in Texas. It obviously takes a waiver at the
3051 Federal level and then cooperation at the State level. Would
3052 something like that work in Idaho as well for increased
3053 flexibility?

3054 *Mr. Cameron. Absolutely. We have attempted to promote
3055 direct primary care as well. One of the problems is that the
3056 ACA has primary care loaded into the price, and so you really
3057 in some ways ended up paying twice for that service.

3058 So we would welcome 1115 waivers or whatever waiver is
3059 necessary to allow that experimentation at any State.

3060 *Mr. Crenshaw. Thank you, and I yield back.

3061 *Mr. Sarbanes. Thank you very much.

3062 I believe Congresswoman Kuster is next. You are
3063 recognized for five minutes.

3064 *Ms. Kuster. Thank you very much, Mr. Chairman, and
3065 thank you, again, to the chair for having this important
3066 hearing.

3067 We need to repeat the fact the ACA has resulted in more
3068 than 20 million Americans gaining health coverage, and its
3069 consumer protections have ensured that millions will no
3070 longer face discrimination for preexisting conditions.

3071 There are over 52 million Americans and over 200,000
3072 right here in the Granite State who live with preexisting

3073 conditions every single day and could have been denied access
3074 to healthcare prior to the ACA.
3075 The ACA required insurance companies to comply with
3076 comprehensive consumer protections, but we all know that junk
3077 plans are exempt from them. A committee investigation found
3078 that these short-term, limited duration plans offered bare
3079 bones coverage and subject consumers to an invasive review
3080 process on the back end in order to avoid paying for medical
3081 plans.
3082 These junk plans require consumers to provide up to five
3083 years of medical and prescription drug history.
3084 Ms. Keith, I will start with you. I understand that it
3085 is common for junk plans to refuse to pay for medical claims
3086 if they determine that it was due to a preexisting condition
3087 or resulted from a preexisting condition; is that correct?
3088 *Ms. Keith. That is, yes.
3089 *Ms. Kuster. And can you describe why Americans with
3090 these junk plans are left with thousands of dollars in unpaid
3091 medical bills despite having insurance and paying premiums?
3092 *Ms. Keith. Yes. Thank you for that question.
3093 So the reason that patients get left with bills is
3094 because the coverage that they are in simply does not cover
3095 much. There are huge benefit gaps, as we have heard, not
3096 covering prescription drugs, not covering mental health care,
3097 not covering substance use disorder service, services that we

3098 have heard many members talk about being very important, very
3099 high out-of-pocket costs, and then the practice of rescission
3100 which we have discussed.
3101 *Ms. Kuster. And another policy that surprised me, I
3102 understand that junk plans rescind the underlying policy, a
3103 practice that is banned by the ACA; is that also correct?
3104 *Ms. Keith. It is correct that the ACA banned
3105 rescissions except in the most narrow of circumstances like
3106 fraud.
3107 *Ms. Kuster. Thank you.
3108 And, yes, these junk plans rescind the coverage from
3109 patients if they decide that the consumer should have
3110 disclosed certain risk factors on their application. The
3111 committee investigation found that a patient was billed
3112 $190,000 for a treatment related to a heart condition, and
3113 the company rescinded the coverage because the patient failed
3114 to disclose he was previously diagnosed with diabetes.
3115 Junk plans also rescind coverage of cancer patients and
3116 deny claims related to cancer treatment.
3117 Simply put, these plans are a backdoor way to deny
3118 coverage for Americans with preexisting conditions and bog
3119 them down with red tape paper trail requirements. They put
3120 vulnerable Americans at risk and leave families with massive
3121 supply bills.
3122 Ms. Castor's bill to subject these junk plans to the

3123 ACA's comprehensive consumer protections is important, and I
3124 am very pleased today to be reintroducing my legislation
3125 entitled Protecting Americans with Preexisting Conditions, to
3126 ensure the consumer protections from the ACA cannot be
3127 undermined.
3128 And with that, Mr. Chairman, I will yield back or I
3129 could yield my time to anyone else that needs it.
3130 [No response.]
3131 *Mr. Sarbanes. Seeing none, we will take your time
3132 back, and I believe now, Congresswoman Kelly, you are
3133 recognized for five minutes.
3134 *Ms. Kelly. Thank you, Mr. Chair.
3135 Professor Keith, in your testimony you mentioned that
3136 Black and Hispanic individuals have seen the highest gains
3137 under the ACA which has afforded them less cost related to
3138 prohibitions to care and greater access to primary care.
3139 Can you tell us a bit about how the American Rescue Plan
3140 will help address inequities not only in the Medicaid
3141 population but as well as the population who do not qualify
3142 for Medicaid but are still low income and subject to
3143 inequities in healthcare coverage?
3144 *Ms. Keith. Yes, thank you for that very important
3145 question.
3146 So Black and Latino communities, in particular, have
3147 seen the largest coverage gains under the Affordable Care

3148 Act, and the American Rescue Plan is going to even further
3149 those coverage gains and the process that needs to be made.
3150 So hundreds of thousands of people of color will be
3151 newly eligible for subsidies because their income was too
3152 high and will be able to enroll in finding affordable
3153 coverage option now.
3154 You mentioned this, but the data does show that when
3155 folks have access to high quality coverage, it helps get them
3156 access to care.
3157 There is more work to be done and certainly around
3158 disparities, but I think this is a very strong start and
3159 continues to build on the process that has already been made.
3160 *Ms. Kelly. Thank you.
3161 Ms. Mann, in your testimony you discuss how Medicaid
3162 expansion was significantly associated with the reduction in
3163 maternal deaths, with positive effects concentrated among
3164 non-Hispanic Black women.
3165 As you may know, I am an ardent advocate for maternal
3166 health. In fact, part of my legislation, the Helping MOMS
3167 Act, was included in the American Rescue Plan, which expanded
3168 Medicaid coverage to postpartum mothers from 60 days to one
3169 year after birth.
3170 Can you possibly talk about how the expansion of
3171 Medicaid and making CHIP permanent in conjunction with the
3172 extended coverage of postpartum mothers work together to not

3173 only reduce maternal mortality in the U.S. but also have a
3174 positive impact on Black mothers who die at a higher rate
3175 than their peers?

3176 *Ms. Mann. It would be a pleasure to respond to that,
3177 and thank you and thank you for your advocacy on this
3178 incredibly important issue.

3179 As I am sure you know, the 60-day postpartum coverage
3180 period that has been part of the Medicaid Program was not
3181 based on clients. It was a number that was picked and it
3182 provided some postpartum coverage for people, but
3183 increasingly, as we have seen the mortality rates and the
3184 morbidity rates increase, particularly among women of color
3185 and Black women in particular, more work has been done and
3186 investigation has gone on and more consideration about how
3187 those problem arise.

3188 And many arise in the postpartum period. So we have
3189 seen just strong agreement across health professionals,
3190 around women's organizations and others that the extension to
3191 12 months postpartum is consistent with the science, and it
3192 will be incredibly important as a way to reduce those
3193 disparities.

3194 The permanent authorization of CHIP will also contribute
3195 to reducing those disparities and help around prenatal care
3196 and postpartum coverage as well. As you know, CHIP has an
3197 option to cover pregnant women. It is mostly for children,

3198 but it also has a pregnant women option, and so expanding
3199 that option for CHIP and then making CHIP a permanent program
3200 will ensure that the benefits of those policies will reach a
3201 lot more women.

3202 *Ms. Kelly. If I can just go back again to maternal
3203 mortality, there is concern that making optional the
3204 provision in the American Rescue Plan that extends the
3205 postpartum coverage means a number of States that have not
3206 chosen to expand Medicaid will also choose not to extend
3207 Medicaid coverage to postpartum moms, such as Texas, Alabama,
3208 Mississippi.

3209 Do you think any of the bills discussed here today,
3210 especially the increased FMAP under H.R. 340, the
3211 Incentivizing Medicaid Expansion Act, would entice States
3212 that we suspect would not extend the coverage to postpartum
3213 moms to extend it?

3214 I am very, very concerned about that.

3215 *Ms. Mann. Absolutely. There is discussion in some
3216 non-expansion States on the postpartum coverage. There was
3217 some proposal to do that in South Carolina, but by and large,
3218 it is a proposal that is considered in the context of a
3219 broader Medicaid Program.

3220 I do not know if you were here when we talked earlier in
3221 the hearing about just last night Wyoming passed a bill in
3222 the house to expand Medicaid thanks to the incentives in the

3223 American Rescue Plan.

3224 Alabama is considering is, a State obviously with very
3225 significant disparities in health driven by race and
3226 ethnicity.

3227 So I think what you have done in combination has really
3228 opened eyes and provided some really very significant
3229 investments for States to reconsider whether they do the
3230 expansion and incorporate also to extend the postpartum
3231 coverage period.

3232 *Ms. Kelly. Thank you.

3233 And I yield back time I do not have. Thank you.

3234 *Mr. Sarbanes. Thank you, Congresswoman.

3235 Congresswoman Barragan, you are now recognized for five
3236 minutes.

3237 *Ms. Barragan. Thank you, Mr. Chairman.

3238 Today is a great day to celebrate the ACA and what the
3239 Affordable Care Act has been able to do for expanding access
3240 to healthcare to many underserved, to many low-income
3241 families and communities, and the impact that it has had has
3242 been enormous.

3243 Today we also discussed bills that build on the
3244 Affordable Care Act to sort coverage gains, and I want to
3245 star with the CHIP Program, and, Ms. Mann, this is going to
3246 be for you.

3247 The Children's Health Insurance Program is one of our

3248 Nation's most important healthcare programs by providing
3249 health coverage to 9.6 million low-income children, including
3250 nearly 1.3 million children in California.
3251 Despite being so vital, CHIP is currently the only
3252 Federal health insurance program that requires its funding to
3253 be reauthorized periodically. This dangerous precedent leads
3254 to programs vulnerable to potential lapses in funding.
3255 This occurred in 2017, when CHIP temporarily expired for
3256 over four months, putting States at risk of running out of
3257 money for the program and threatening the coverage of
3258 children who rely on CHIP to get the care they require.
3259 This should never happen again. My bill, the Children's
3260 Health Insurance Program Permanency Act, will ensure that
3261 funding for this program will no longer be held hostage
3262 during partisan budget battles. Our goal should be to make
3263 sure every child in this country has access to the medical
3264 care she or he needs when they need it.
3265 I want to thank my committee colleagues, Congressman
3266 Cardenas, Congressman Rush, and Congresswoman Schrier for
3267 cosponsoring this important legislation.
3268 Ms. Mann, can you please discuss CHIP's importance for
3269 children and how periodic reauthorization battles threaten
3270 the program?
3271 *Ms. Mann. Absolutely. Thank you for the question,
3272 Congresswomen.

3273 CHIP has been a really valuable impetus for reform for
3274 coverage for children. I was around and working on
3275 children's coverage issues in 1997 when the Congress passed
3276 CHIP, and no one knew exactly how many children would be
3277 covered and how many States would pick it up.
3278 Every State picked it up by 2000 so just in the three
3279 short years, and it has been such a popular program, helping
3280 to allow States to expand their Medicaid Programs to cover
3281 more children in Medicaid, as well as to set up separate
3282 children's insurance programs. It has really been a
3283 lifeline.
3284 I have also been around long enough to see what happens
3285 when the reauthorization did not occur. We saw the first
3286 time that that happened. We saw some States stop taking new
3287 applications. They did not know if the money was going to be
3288 there. It was not reauthorized. They had to stop taking
3289 applications. They put children on waiting lists to get the
3290 care that they need.
3291 We have seen that reoccur in different times when
3292 reauthorization has arisen. It is an enormously popular
3293 program going almost to its 25th year, and it is time to make
3294 it a permanent authorization in terms of the funding.
3295 *Ms. Barragan. Well, thank you, Ms. Mann. It is a
3296 shame that our children would be used as pawns in a political
3297 battle, and they would not have coverage for any period of

3298 time.

3299 Ms. Mann, can you talk about actions that States had to
3300 take after CHIP expired in 2017, including having to send
3301 letters to parents warning that their children may lose
3302 coverage?

3303 *Ms. Mann. Absolutely. And this happened also earlier
3304 in 2015, and I was at CMS at the time, and on one hand,
3305 States juggle with not wanting to give people those notices
3306 because they hoped that reauthorization would happen, and
3307 they knew how much those notices would cause alarm in those
3308 families.

3309 And yet at some point when that reauthorization did not
3310 come through, they had an obligation. They had a legal
3311 obligation. They had a moral obligation to let families know
3312 what was happening.

3313 And then, of course, that caused great consternation in
3314 families wondering how their child would get the care that
3315 they need the next week and the next month. So it caused
3316 great hardships all around the country and unnecessarily so.

3317 Because of the popularity of the program in a bipartisan
3318 way, we need to set it on a path where that never happens
3319 again.

3320 *Ms. Barragan. Well, thank you.

3321 I just want to close by mentioning another program that
3322 I think is really great, the home and community-based

3323 services that allow people to receive care in their own homes
3324 rather than having to go into an institution, to a nursing
3325 home.
3326 We have seen because of COVID how that has been even
3327 more important, and so we just want to continue to work on
3328 efforts to expand that and to make sure we provide
3329 protections.
3330 And with that, Mr. Chairman, I yield back.
3331 *Mr. Sarbanes. Thanks very much.
3332 Congresswoman Rochester, you are recognized for five
3333 minutes.
3334 *Ms. Rochester. Thank you, Mr. Chairman.
3335 And I would also like to thank the witnesses for joining
3336 us and especially Ms. Hatcher. To have you represent the
3337 Little Lobbyists on the 11th anniversary of the Affordable
3338 Care Act is just an incredible moment.
3339 Access to affordable comprehensive coverage has never
3340 been more critical. However, the Trump administration
3341 slashed funding by 90 percent for advertising and outreach
3342 for the Affordable Care Act's marketplace options and refused
3343 to establish a broad open enrollment during the COVID-19
3344 pandemic.
3345 As a result, enrollment of new consumers in the ACA
3346 marketplace dropped 50 percent in 2021 compared to 2016.
3347 According to a survey by the Commonwealth Fund, over 40

3348 percent of uninsured Americans are unaware of the ACA
3349 marketplaces or available subsidies to help pay for coverage.
3350 Another survey by the Kaiser Family Foundation found
3351 that over half of uninsured consumers were not aware that the
3352 ACA marketplace has an actual annual open enrollment.
3353 Ms. Keith, can you discuss in more detail how butting
3354 the ACA's advertising budget under the previous
3355 administration has impacted enrollment and how investing in
3356 outreach efforts and setting enrollment targets impacts new
3357 enrollment?
3358 *Ms. Keith. Thank you so much, Congressman, for that
3359 question.
3360 So enrollment through Healthcare.gov has been stagnant
3361 until this year when there was a huge increase in demand
3362 because of the pandemic. So enrollment actually declined
3363 year over year.
3364 You know, it works well for the folks who are already in
3365 it, but as you mentioned, the number of new consumers coming
3366 in every year and getting the coverage that they need
3367 declined significantly.
3368 And that is really where your outreach and marketing and
3369 the investments in those funds make a difference. Many
3370 studies have shown that bringing in new people, which often
3371 tend to be younger and healthier, helps keep a stable
3372 marketplace.

3373 And I think we lost a lot of opportunities to bring
3374 those people in in the past few years.
3375 *Ms. Rochester. Thank you.
3376 It is almost like you anticipated my next question,
3377 which was to help us to understand how advertising and
3378 enrollment efforts that help younger and healthier
3379 individuals enroll really does have an impact on the cost of
3380 care for all Americans and access to affordable coverage.
3381 Could you talk a little bit about that?
3382 *Ms. Keith. Yes, absolutely. I think that is a core
3383 part of doing the outreach in enrollment, is to make sure
3384 that, you know, especially younger and healthier consumers
3385 know that these coverage options are available and that it is
3386 affordable.
3387 I do not think it is hard to understand that older
3388 people or maybe people with health conditions, you know, know
3389 that they need to go and get health insurance. It is where
3390 folks are younger or healthier, maybe think they do not need
3391 coverage or assume that it is too expensive. They are the
3392 ones who need the extra push, and that is who marketing and
3393 outreach really helps.
3394 Once folks learn the prices, once they learn that they
3395 can get good quality coverage, they want that health
3396 insurance. It is just a matter of reaching them.
3397 *Ms. Rochester. And the American Rescue Plan extended

3398 the ACA subsidies to more Americans, including for the first
3399 time to individuals with incomes above 400 percent of the
3400 Federal poverty line. Millions of families will experience
3401 lower premiums and out-of-pocket costs.
3402 Ms. Keith, how many uninsured individuals are likely to
3403 be eligible for the subsidies under the American Rescue Plan?
3404 *Ms. Keith. The estimates I have seen are that 14.9
3405 million uninsured people qualify, and that includes 3.6
3406 million uninsured people who were above that 400 percent
3407 poverty line, so 3.6 million more middle income families.
3408 *Ms. Rochester. Great. And I understand that uninsured
3409 Americans are less likely to be aware of the deadlines and
3410 the availability of the coverage, and that this assistance is
3411 available; is that correct?
3412 *Ms. Keith. That is correct.
3413 *Ms. Rochester. Thank you, Ms. Keith.
3414 And the American Rescue Plan expanded coverage to
3415 millions of Americans. However, many consumers still lack
3416 basic information about their coverage options.
3417 I am proud to have introduced H.R. 1872, the More Health
3418 Education Act, to invest $100 million annually for outreach
3419 and enrollment efforts. My bill will help lower healthcare
3420 costs and expand coverage to more Americans, and I urge my
3421 colleagues to support it as well as we move forward through
3422 this process.

3423 Thank you, and I yield back, Mr. Chairman.

3424 *Mr. Sarbanes. Thank you very much.

3425 I believe the next member to be recognized for five
3426 minutes is Congresswoman Schrier.

3427 *Ms. Schrier. Thank you, Mr. Chairman.

3428 And thank you to all of our witnesses today.

3429 On this 11th anniversary of the ACA, I speak as both a
3430 pediatrician and a lawmaker when I say follow the data.
3431 Affordable coverage leads to better access to care, which
3432 leads to better health outcomes and lower costs, by the way.

3433 So I am thrilled to have my bill, Kids' Access to
3434 Primary Care, included in this hearing. In my State of
3435 Washington, more than 800,000 children access care through
3436 Apple Health, our State Medicaid Program.

3437 And across the country, we know that the provider
3438 network for Medicaid patients is really strained. These
3439 patients have trouble finding providers who will see them.
3440 Physicians cite low reimbursement as the primary reason they
3441 are unable to accept additional Medicaid patients.

3442 So shoring up this absence to care by raising Medicaid
3443 reimbursement to match Medicare reimbursement rates will help
3444 kids grow up healthier and should play a vital role in
3445 reducing the health disparities by reaching underserved
3446 populations.

3447 So I want to turn to Ms. Mann. In your testimony you

3448 noted that Medicaid access translates into addressing needed
3449 care. Can you briefly talk about the importance of access to
3450 care and what this means for kids and their future health
3451 outcomes?

3452 And to address some of my colleagues' concerns about
3453 cost of care, what early care for children means for long-
3454 term costs to our healthcare system.

3455 *Ms. Mann. I would be glad to. Thank you for the
3456 question, Congresswoman.

3457 So access to care in Medicaid is generally very strong
3458 in some areas of the country and for some services. There
3459 can be access issues. And in many instances that can be
3460 traced back to the payment rates, and particularly for
3461 primary care and for primary pediatric care. Unfortunately,
3462 the rates can be far too low to be able to sustain on the
3463 services that children need.

3464 Just as important to bring in more physicians, I would
3465 say also the adequacy of that payment level can help provide
3466 that platform for a nonperforming pediatric primary care
3467 system, one that does not take 15 minutes to check out a
3468 child, but that really explores the developmental development
3469 for the child, works with the parent and the child to
3470 understand what is going on at home, whether there are hunger
3471 issues and other problems that might impair the individual's
3472 health.

3473 So in many different ways primarily care is a strong
3474 platform for being able to care for kids, and as I'm sure you
3475 know, it is so important, particularly for young children.
3476 Those investments in care for young children, there is really
3477 lots of evidence showing that it will support that child
3478 throughout her childhood as well as when she becomes an
3479 adult.
3480 And that will, in fact, save dollars, and there is
3481 certainly lots of evidence about that. It saves healthcare
3482 dollars, education dollars, juvenile justice dollars, lots of
3483 different parts of the system.
3484 *Ms. Schrier. Thank you.
3485 *Ms. Mann. It is strengthening our systems of care.
3486 *Ms. Schrier. Thank you.
3487 I want to quickly turn my attention to something my
3488 colleague just asked about, which is that access is not
3489 really access if you cannot afford premiums or deductibles.
3490 And the middle class has really been left out of so many of
3491 the subsidies that expanded care to others, many priced out
3492 of the marketplace, and that is why the American Rescue Plan
3493 offered tax credits and subsidies to cut premiums for nearly
3494 all Americans.
3495 In fact, 75 percent of people on the exchange in
3496 Washington State will be helped by this, and an additional
3497 25,000 will gain coverage now because they can afford it.

3498 And, in fact, an average family of four in my district
3499 will see their premiums drop from about $14,000 a year to
3500 $8,500 a year, which is a significant 40 percent drop.
3501 In fact, one of my own patients' families looked at
3502 their $17,000 premiums compared to the $1,400 they would have
3503 spent just paying cash, and they just went without coverage.
3504 And so, Dr. Keith, could you talk about how the
3505 provisions for middle class families will make healthcare
3506 more affordable and how that might also translate to lower
3507 costs overall for young families?
3508 *Ms. Keith. Yes, thank you. And it is exciting to hear
3509 that data out of Washington State.
3510 So the way that the subsidies will extend for middle
3511 income families is no one who is purchasing their own private
3512 health insurance will have to spend more than eight and a
3513 half percent of their income towards premiums. It is going
3514 to really reduce those costs, as you just suggested, and make
3515 coverage much more affordable for people.
3516 *Ms. Schrier. Thank you very much.
3517 I yield back.
3518 *Mr. Sarbanes. Thank you.
3519 Congresswoman Trahan, you are now recognized for five
3520 minutes.
3521 *Mrs. Trahan. Well, thank you, Mr. Chairman.
3522 And my thanks to each of the witnesses.

3523 So many of the questions have, you know, been answered,
3524 but I just wanted to sort of say, you know, four years before
3525 the Affordable Care Act became the law of the land, it was
3526 the Commonwealth of Massachusetts that blazed the trail of
3527 nearly universal coverage. Our healthcare coverage expansion
3528 served as a model for the ACA.
3529 Today the uninsured rate in Massachusetts is about three
3530 percent, one of the lowest rates in the country. But not
3531 only is its healthcare accessible and affordable in
3532 Massachusetts. We also consistently rank among the best in
3533 the Nation for the quality of care that is delivered.
3534 And I think it is also worth noting that the expansion
3535 of coverage in my State occurred in a bipartisan basis, with
3536 a Republican governor and State legislature controlled by
3537 Democrats. In other words, Democrats and Republicans can, in
3538 fact, work together to enact healthcare programs that
3539 maintain quality while expanding coverage.
3540 Ms. Keith, like so many members on this committee, I am
3541 deeply concerned about the inequities in healthcare
3542 accessibility and affordability. Fortunately, the American
3543 Rescue Plan enhanced the ACA subsidies and significantly
3544 lowered premiums for Americans.
3545 And the American Rescue Plan also significantly reduces
3546 premiums for individuals already eligible for coverage and
3547 extends the ACA subsidies to Americans who are currently

3548 uninsured.

3549 Can you briefly discuss how these enhanced subsidies
3550 help make coverage even more affordable and accessible?

3551 *Ms. Keith. Thank you for that terrific question.

3552 So the enhanced subsidies are going to not only save
3553 people monthly premiums in what they would otherwise be
3554 paying.

3555 I do want to emphasize that many folks will have the
3556 opportunity to buy an even more comprehensive plan with a
3557 lower deductible and lower out-of-pocket cost. So the
3558 subsidies are focused on the premiums, but it is actually
3559 going to give people even more buying power to go and get the
3560 even more significant financial protection that they need.

3561 And you are exactly right. That extends up and down the
3562 entire income scale. I really cannot emphasize enough how
3563 transformative this is going to be for millions of people.

3564 *Mrs. Trahan. Terrific, and we are excited about
3565 expanding upon that as well.

3566 You know, Dr. Schrier, she touched upon the Medicaid
3567 expansion and how that is going to benefit our children. So
3568 with the remaining time that I have, I would like to turn to
3569 another important issue, which is the expansion of coverage
3570 to treat substance and opioid use disorder.

3571 And many of the States that have been hardest hit by the
3572 opioid epidemic have not expanded Medicaid. So, Ms. Mann,

3573 you briefly touched on this earlier in this hearing. Could
3574 you explain how the expansion of Medicaid increases access to
3575 treatment and care for those suffering from opioid use
3576 disorder?
3577 *Ms. Mann. If you think about a State that has not
3578 covered any of their childless adults, right, not done the
3579 expansion, and for whom even parents are at very, very low-
3580 income levels. The medium stage of non-expansion States is
3581 at 40 percent of the poverty line, and when you earn anything
3582 above that amount you become ineligible for coverage.
3583 So with that extent of a coverage gap, what it means is
3584 that the only way people can get services and care if they
3585 have a substance abuse disorder is through charity care,
3586 through uncompensated care, or maybe if the State has some
3587 community treatments that it is paying for with its own
3588 dollars, which will generally mean it is quite limited.
3589 As States have expanded Medicaid coverage, they have
3590 brought in millions of people into coverage, and that allows
3591 them access to all the care they need, whether it is primary
3592 care, whether it is cancer screenings or whether it is
3593 substance use disorder treatments.
3594 And we have seen the States that have expanded coverage
3595 really do the most in terms of providing those services.
3596 *Mrs. Trahan. Great. Well, I want to thank you for
3597 your thoughtful answers to these questions. I think it is

3598 clear from the testimony that Medicaid expansion offers
3599 tremendous benefits, and it is cost effective and provides
3600 quality, affordable care to those in most need.
3601 I am proud that my State made this decision early on to
3602 expand Medicaid coverage, and I hope the remaining States
3603 will make that same decision.
3604 Thank you, Mr. Chairman. I yield back.
3605 *Mr. Sarbanes. Thank you.
3606 Madam Chair, I am going to yield the virtual gavel back
3607 to you. I believe Congressman Burgess is next in line, but I
3608 will leave it to you.
3609 Thank you.
3610 *Ms. Eshoo. [Presiding.] Thank you. Thank you very
3611 much, John. I appreciate it.
3612 I was gone a little longer than I anticipated, but that
3613 is what happens when there are many members of Congress that
3614 are part of a meeting. It gets stretched out.
3615 It is a pleasure to recognize Dr. Burgess of Texas for
3616 your five minutes of questions.
3617 *Mr. Burgess. Thank you for the recognition, and I also
3618 apologize to our panel. There are three different hearings
3619 that I am part of this morning. So it has been a little
3620 difficult to balance between Health, Budget, and the Rules
3621 Committee, but this is important.
3622 And I would like to ask Dean Cameron. You noted in your

3623 written testimony, while it is not necessarily right for
3624 everyone, short-term plans can be a helpful alternative for
3625 individuals in certain situations.
3626 You know, I am reminded there is a Fox News Bureau down
3627 in Dallas that I will sometimes be tasked with going down and
3628 giving an interview with a fellow there that controls the
3629 microphones and gets you seated and makes sure the shot is
3630 right.
3631 He asked me after one of my interviews that was about
3632 healthcare. He said, "I hope you are going to do something
3633 about this.''
3634 This was before the individual mandate was zeroed out.
3635 He said, "I have got to pay a fine, and then I go and I am
3636 able to buy a noncompliant insurance policy that actually
3637 covers what I need.''
3638 And I could not help but think, you know, we have not
3639 really done this individual any great favor by fining him and
3640 then turning him loose to buy the actual coverage that he
3641 needs.
3642 So, Mr. Cameron, I wonder if you could expand upon and
3643 kind of walk us through what additional benefit we might see
3644 from keeping the short-term, limited-duration plans.
3645 *Mr. Cameron. Well, thank you for the question.
3646 First and foremost I think you give choice, choices to
3647 consumers who cannot afford the ACA plans, and in spite of

3648 the adjustments that have been made in APTC here recently,
3649 there is still a large segment of the population in Idaho who
3650 will not qualify, particularly those who are younger.
3651 I looked the other day. We run studies of those that
3652 would get the enhanced APTC, and they are 50-year-olds and
3653 families of four. Whereas if you are 25, married to a 25-
3654 year-old, you do not get anything.
3655 And so those individuals, those healthy individuals
3656 really need someplace to go, and so from our approach, I
3657 think it is a legitimate question as to what benefit short-
3658 term plans should have and what are the requirements. That
3659 is a legitimate debate and question and one that I think many
3660 State insurance commissioners are addressing and working with
3661 their legislators on, and I commend them for their efforts.
3662 I think individuals who do not have choice end up going
3663 without coverage. There are conditions that come up, end up
3664 going undiagnosed and untreated, and so then they wait and
3665 come onto the ACA plan when they have got a condition. They
3666 wait until that case, and then that makes it more expensive.
3667 If you think about it, and I know it is an overused
3668 axiom, but if everybody waited to buy homeowner's insurance
3669 to when their house was on fire, it would be tremendously
3670 expensive.
3671 So we have got to figure out ways to get everybody
3672 involved, the young and the healthy in the same risk pool.

3673 That is what we have done here in Idaho, is trying to get
3674 even those that are on those enhanced short-term plans that
3675 are in the same risk pool with the ACA, which it will help us
3676 hold costs down to those that are purchasing on the exchange.
3677 *Mr. Burgess. That is a terribly intriguing concept and
3678 one that I hope this committee will spend some time studying.
3679 Let me just ask you, Mr. Cameron. Section 1332 waivers,
3680 they are actually part of the Affordable Care Act. The Trump
3681 administration was criticized for using 1332 waivers, but
3682 1332 waivers were actually written into law. As the labor
3683 law was written, they were delayed so that they would not go
3684 into effect until January of 2017, for reasons that I do not
3685 completely understand.
3686 But have you had any thoughts about the 1332 waivers?
3687 *Mr. Cameron. Yes, thank you, Congressman.
3688 We do have very strong opinions about the 1332 waivers.
3689 We think they ought to be there, but we think they ought to
3690 be allowed to use States to become sort of the laboratories
3691 of innovation and creativity.
3692 In our experience, even under both administrations, the
3693 provisions of the 1332 made it very difficult, particularly
3694 for rural, small States, to participate and to utilize.
3695 Larger States could get the 1332 waivers. We actually
3696 even applied for 1115 and a 1332 combined. We called them
3697 the dual waiver approach, which was going to help reduce cost

3698 both to the Federal Government and to the State, reduce
3699 premiums by 25 percent, and yet we could not quite get that
3700 across the finish line because of the strict interpretation.
3701 So we encourage additional flexibility and 1332 waivers.
3702 *Mr. Burgess. I think that is an excellent point and
3703 one that we should look to.
3704 So you only pay for what you need. What an interesting
3705 concept.
3706 I thank the chair. I will yield back.
3707 *Ms. Eshoo. The gentleman yields back.
3708 I now will recognize the gentlewoman from Minnesota,
3709 Angie Craig.
3710 [No response.]
3711 *Ms. Eshoo. Are you there?
3712 Oh, I am sorry. All right. The gentlewoman from Texas,
3713 Mrs. Fletcher. Lovely to see you. Thank you for your
3714 patience.
3715 *Mrs. Fletcher. Lovely to see you. Thank you so much,
3716 Chairwoman Eshoo. Thank you for recognizing me now and for
3717 holding this hearing. It has been incredibly helpful to me
3718 listening.
3719 And of course, we focus on so many important provisions
3720 and achievements that we have been able to make because of
3721 the important provisions of the ACA on this anniversary and
3722 also identified some of the areas of improvement certainly

3723 that are needed. And so it has been an incredibly helpful
3724 hearing.
3725 I am also glad that we focused on the American Rescue
3726 Plan and a provision, a really important provision, that was
3727 actually from my bill, H.R. 871, the Expand Medicaid Now Act,
3728 to provide generous new financial incentives to States to
3729 expand Medicaid, and I am so glad to see that States are
3730 seriously looking at expansion, as Ms. Mann noted in her
3731 opening statement and again with questions.
3732 In my home State of Texas, this provision would result
3733 in billions of Federal dollars going to our State, and it is
3734 the state with the highest uninsured rate in the country, and
3735 we know that so many Texans are living in this coverage gap,
3736 that there is real and meaningful coverage expansion that we
3737 desperately need here in Texas.
3738 So while I hope that the bill that is included in the
3739 Rescue Plan will provide the incentive to the remaining
3740 States, the non-extension States, I am somewhat worried other
3741 States will continue and my own State, hopefully not, but
3742 will continue to refuse to expand.
3743 And so for that reason I wonder about the other options
3744 that exist to expand access, and I wanted to focus my
3745 questions on those.
3746 I understand that from 2007 to 2010 for select counties
3747 and then further expanded in 2010 to all counties, California

3748 allowed counties to expand Medicaid coverage through a
3749 Section 1115 demonstration project. These individuals were
3750 later transitioned into the statewide expansion established
3751 under the ACA.
3752 Similarly, from 2012 to 2014, a county in Illinois also
3753 had an 1115 demonstration project creating Medicaid expansion
3754 for county residents who were then moved into the statewide
3755 program.
3756 My county that I live in Harris County, is the third
3757 largest county in the United States, after Los Angeles County
3758 and Cook County, and so you know, a similar extension project
3759 is, of course, of interest.
3760 To me conceptually as we are thinking about this, there
3761 was a similar demonstration project, I understand, in
3762 Cuyahoga County, Ohio, and so those kinds of projects could
3763 provide a model for new county demonstration projects in
3764 States like Florida and Texas and elsewhere.
3765 So I want to direct my questions on this topic to Ms.
3766 Mann. First of all, can you talk a little bit about how
3767 county extension projects might complement the additional
3768 expansion incidents we included in the American Rescue Plan?
3769 And then just because I talked for a while, I just want
3770 you in your comments to also talk a little bit about the
3771 expansion in the American Rescue Plan.
3772 I think some people may think that the five percentage

3773 point increase is not a large number. So in the context of
3774 your discussion can you also explain why that is a good deal
3775 for States as you share your thoughts with us on expansion
3776 and these potential other avenues for expansion?
3777 *Ms. Mann. Absolutely, and I am glad to be back on this
3778 one and thank you for your question.
3779 The American Rescue Plan has provided a really strong
3780 incentive for States to reconsider that have not yet expanded
3781 coverage to say now may be the time. Now may be the time
3782 because so many people are uninsured and so many people are
3783 having health issues because of the pandemic.
3784 But now is the time in Texas because there are so many
3785 individuals who just do not have insurance, but percentage-
3786 wise and number-wise, it is the largest in the country.
3787 And because of that, you know, because the Family
3788 Foundation has estimated that the 12 States together will get
3789 about $9.6 billion should they all go forward and expand
3790 coverage, and Texas will get the lion's share of those
3791 dollars because of the size of the uninsured population and
3792 the extent and their program.
3793 The five percent is a large amount of money because it
3794 is not for the expansion group. The five percent is for all
3795 expenditures in your Medicaid Program, and so the base upon
3796 which it applies is a much larger base. For Texas it
3797 includes the coverage they are providing for people with

3798 disabilities and elderly. So it is a very large amount of
3799 money.

3800 In terms of thinking about counties moving forward, you
3801 are absolutely right. There have been instances in the past.
3802 They were all pre-ACA or at least the effective date of the
3803 ACA, but they really did provide coverage and they really did
3804 help get States and communities ready for full statewide
3805 Medicaid expansion.

3806 I am, you know, heartened that everybody in Texas is
3807 continuing or many people in Texas are continuing to think
3808 about the ways in which coverage expansion in Medicaid can
3809 come to the Lone Star State. Hopefully, the American Rescue
3810 Plan incentive will do the job.

3811 But it is really good to hear that people are thinking
3812 about lots of different options.

3813 *Mrs. Fletcher. Well, thank you so much for that. I
3814 appreciate your testimony and the testimony of all of our
3815 witnesses today.

3816 I have exceeded my time. Chairwoman Eshoo, thank you so
3817 much, and I will yield back.

3818 *Ms. Eshoo. Thank you for your patience.

3819 I do not see any Republicans to call on. So I will go
3820 next and recognize the gentlewoman from Minnesota, Angie
3821 Craig. Is Angie there?

3822 [No response.]

3823 *Ms. Eshoo. No. Not seeing Ms. Craig, we will now go
3824 to members that are members of the full committee, not
3825 members of the subcommittee, but we welcome them and they are
3826 waiving on.
3827 And I will recognize the gentleman from Illinois, Mr.
3828 Rush for five minutes of questions.
3829 *Mr. Rush. I want to thank you, Madam Chair. Thank you
3830 for allowing me to participate in today's hearing on the ACA.
3831 *Ms. Eshoo. You are always welcome. You are always
3832 welcome.
3833 *Mr. Rush. Thank you so much, especially on this
3834 occasion of the 11th anniversary.
3835 I was proud, as you were, to vote for the ACA in 2010,
3836 which has since become a lifeline for millions of Americans.
3837 I also was pleased last month to vote for the American
3838 Rescue Plan, which delivered on a Democrat promise extending
3839 the ACA and making healthcare more affordable for all
3840 Americans.
3841 The improvements included in the American Rescue Plan
3842 and in the legislation that we are considering today are long
3843 overdue and cannot come soon enough.
3844 In 2020, it was estimated that 846,000 Illinoisian lost
3845 employer-sponsored insurance. During a global pandemic, it
3846 is critical that we ensure everyone has access to high
3847 quality, affordable healthcare.

3848 COVID-19 has revealed a bright light on healthcare
3849 disparities which are too common for Black and Brown
3850 Americans in my district and around this Nation. It is our
3851 duty to ensure that we conduct outreach to African Americans,
3852 to Latinos, to Asians, those who are more likely to have
3853 negative health outcomes from COVID-19.
3854 A Gallup survey conducted last year found that non-White
3855 adults were more than two times as likely to defer seeking
3856 treatment for COVID-19-like systems known to them than known
3857 to White Americans.
3858 Access to affordable healthcare insurance would reduce
3859 this disparity. Fortunately, the American Rescue Plan
3860 temporarily extends the marketplace premium tax credit to
3861 more individuals for 2021 and 2022.
3862 That said, Ms. Keith, are these increased subsidies
3863 available now for 2021?
3864 Are those already enrolled in the plan for 2021 through
3865 Healthcare.gov, what action, if any, is needed for these
3866 consumers to receive the subsidy for which they now qualify
3867 for?
3868 *Ms. Keith. Thank you so much, Congressman, and thank
3869 you for your leadership on all of these issues.
3870 So the subsidies that you are talking about will be
3871 available through Healthcare.gov beginning on April 1st, and
3872 Federal officials are encouraging everyone who already has

3873 coverage or needs coverage to go back into the system and
3874 make sure that you say, yes, I want to take advantage of
3875 these credits.
3876 It is also the moment though to see if you want to
3877 change plans and maybe lower your deductible or lower your
3878 out-of-pocket cost. It is really a moment to shop around and
3879 get the best deal for you and take care of your healthcare.
3880 And I have not said this yet, so I will emphasize.
3881 Anyone who is uninsured or needs healthcare or health
3882 coverage can enroll through Healthcare.gov through May 15th.
3883 It is really, really important to get the word out.
3884 Thank you.
3885 *Mr. Rush. All right. Ensuring affordability of high-
3886 quality healthcare, as I said before, is a top priority, and
3887 since the announcement [inaudible] afforded a short-term
3888 limited-duration insurance. These junk plans often are sold
3889 to patients by insurance sales representatives, but they do
3890 not disclose the coverage which will leave patients on the
3891 hook for literally thousands of dollars.
3892 Ms. Keith, are there any demographic breakdowns based on
3893 race for short-term, limited-duration plan enrollment?
3894 *Ms. Keith. None that I am aware of, no, sir. The best
3895 data that we have really comes from the committees, your own
3896 investigation of these practices for these products.
3897 *Mr. Rush. [Inaudible.] My time is running out, and I

3898 yield back the balance of my time.

3899 And thank you again for your consideration and for your
3900 grace and mercy.

3901 *Ms. Eshoo. You are wonderful. You are always welcome.
3902 I think it is an eloquent statement about our subcommittee,
3903 that we always have members that want to waive on. So each
3904 one of you is always welcome.

3905 It is a pleasure to recognize Ms. Schakowsky of
3906 Illinois, waiving on for five minutes of questions. And your
3907 patience as well because you have been onboard since before
3908 we began this morning. So you have had the benefit of
3909 hearing all of the questions and all of the answers.
3910 Welcome.

3911 *Ms. Schakowsky. Well, thank you, Madam Chair, and I
3912 also am just grateful for the opportunity to waive on and
3913 happy 11th anniversary to the Affordable Care Act.

3914 I was so proud to help craft it as a member of this
3915 subcommittee, the Health Subcommittee, and to be a member of
3916 the Energy and Commerce Committee, to actually get this done.

3917 And I have heard many wonderful, life-changing stories
3918 that people have experienced because of the ACA, and I want
3919 to just acknowledge the words of Laura Hatcher and thank you
3920 so much for your words and sharing your experience, but also
3921 for the Little Lobbyists we have seen at the Capitol for a
3922 long time, and it has just been priceless, the influence that

3923 they have.

3924 But still, we can definitely make improvements. In
3925 Illinois, we had a problem with network adequacy actually for
3926 a while. It is better now, but for a while many Affordable
3927 Care Act plans did not include any of the major hospital or
3928 affiliated doctors in the Chicago area, while the law
3929 absolutely says that they must have inclusive adequacy
3930 networks and access to specialists. It did not happen.

3931 And so, Professor Keith, I wanted to ask you. Can you
3932 speak to the importance of network standards to ensure that
3933 patients are able to have a good number of choices and have
3934 the doctors and the providers that are really needed for them
3935 particularly?

3936 *Ms. Keith. Thank you for that very important question.

3937 So you are right. The Affordable Care Act included
3938 network adequacy standards. I think many people have started
3939 encouraging what we call quantitative network adequacy
3940 standards, which really say that a patient should be able to
3941 find a primary care physician or a specialist or a hospital
3942 within a certain distance from their home or where they work.

3943 And this is the idea that folks should have good access
3944 to actual providers in their neighborhood or close to them.
3945 An example would be being able to find a primary care
3946 physician within ten miles or 15 minutes, and those standards
3947 would change based on rural or suburban areas, things like

3948 that. So really a way to include access to actual healthcare
3949 providers.

3950 *Ms. Schakowsky. So the key word is "quantitative,''
3951 and let's hope that we can get there.

3952 I want to also mention to you that some States actually
3953 have the authority to lower premiums if they are felt to be
3954 exorbitant. Illinois is not one of those States. We can
3955 oversee, but we cannot do anything actually to change that.
3956 We can review these numbers.

3957 And so I wanted to ask you. Can we require, when we
3958 improve this Act, to make sure that all States are able to
3959 look at and review these rates and make adjustments to the
3960 rates?

3961 *Ms. Keith. Certainly. So the Affordable Care Act
3962 included what we call rate review standards, but you are
3963 exactly right. Not every State has what we call prior
3964 approval authority, meaning they can actually deny the rate
3965 that an insurance company wants to use before it goes
3966 forward.

3967 I think there has been a lot of focus today on
3968 healthcare costs. I think rate review is one way that State
3969 regulators and Federal regulators could really leverage and
3970 put pressure on insurance companies to help bring down
3971 healthcare costs.

3972 The whole goal here is to make sure that costs are fully

3973 justified and that consumers are not paying more than they
3974 should be paying. I think it is a huge consumer protection.
3975 *Ms. Schakowsky. Absolutely. So I just wanted to say
3976 that my bill that is in this packet, H.R. 1890, the Health
3977 Care Consumer Protection Act, has two things that I was just
3978 really talking about, to set network adequacy in the way that
3979 you describe, to make sure that everyone has access, and to
3980 make it standard, to set network adequacy standards, and I
3981 guess that my bill says that CMS would do that.
3982 And, secondly, to permit all States to be able to
3983 address the excessive rates by actually requiring a reduction
3984 in those rates. I know that there are many times that it
3985 would have been very helpful to us in Illinois not to just
3986 comment on it, not just to be reviewing it, but to have some
3987 actual power.
3988 So I am almost out of time, and I want to thank all of
3989 the wonderful panelists for being here, and it has been an
3990 honor to be able to waive onto your committee, Madam Chair.
3991 And I yield back.
3992 *Ms. Eshoo. Well, we thank you.
3993 I see that the gentlewoman from Minnesota is back on the
3994 screen and with us. So I recognize the gentlewoman from
3995 Minnesota, Ms. Craig, for your five minutes, and thanks for
3996 your patience.
3997 And I also note that Mr. Veasey has joined us and will

3998 waive on. So I just want you to know that I see you there,
3999 and you will be coming up after Ms. Craig.
4000 So away we go with Minnesota.
4001 *Ms. Craig. Thank you so much, Chairwoman Eshoo, for
4002 yielding, and thank you to the witnesses for your resilience
4003 here during this testimony today.
4004 The ACA in my mind led to historic coverage gains and
4005 put in place important and meaningful consumer protections.
4006 Over 100,000 Minnesotans enrolled in health coverage through
4007 the ACA marketplaces in 2020, and 59,000 Minnesotans received
4008 tax subsidies to make their healthcare more affordable.
4009 Those Minnesotans include hardworking small business
4010 owners like Ali Hatoum, owner of Morning Glory Bakery in
4011 Rosemount. The ACA enabled Ali to secure affordable coverage
4012 for himself and his family and to put the resulting savings
4013 back into his business.
4014 Today we are building on that work to further lower
4015 healthcare costs and expand coverage for my constituents and
4016 all Americans.
4017 So I want to start with Ms. Keith here this afternoon.
4018 The ACA, as you mentioned in your testimony, established a
4019 temporary reinsurance program. Can you talk a little bit
4020 more about how that program helps to reduce premiums and the
4021 benefits of such a program in our State?
4022 *Ms. Keith. Thank you for that question.

4023 So the temporary reinsurance program for the ACA was in
4024 place from 2014 to 2016, and while it varied year by year,
4025 that program was responsible for reducing premiums anywhere
4026 from 4 to 14 percent.
4027 I would also add that we have seen 15 States use Section
4028 1332 waivers that have been discussed today to do their own
4029 State-based reinsurance programs, and as of 2020, the 12
4030 States that had those programs in place have reduced premiums
4031 by about 18 percent.
4032 So these programs do allow for significant premium
4033 savings.
4034 *Ms. Craig. Thank you so much.
4035 I know that reinsurance helps to pay for the cost of
4036 those most high-risk patients in the pool, those with serious
4037 medical conditions, thereby reducing the premiums for all
4038 individuals.
4039 But can you talk just a little bit more about how
4040 reinsurance works?
4041 This is something that I want to make sure that my
4042 colleagues on the committee understand, as well as my
4043 constituents.
4044 And then maybe just more broadly, what other measures
4045 would be effective in lowering premiums and out-of-pocket
4046 costs?
4047 *Ms. Keith. Certainly. So reinsurance can be designed

4048 in a number of ways, but at its core, it is about providing
4049 funding to help offset high claims, as you have mentioned.
4050 This is really a way of giving insurance companies stability
4051 so that they are not all raising premiums and pricing,
4052 expecting to get the people with the highest, most costly
4053 preexisting conditions.

4054 Once insurance companies know that they will have some
4055 of those claims offset, they can drop premiums for everyone
4056 so that they are not all pricing like they are going to get
4057 someone who is really, really sick.

4058 It just provides that market stability that insurance
4059 companies are looking for.

4060 And I will say it is reinsurance programs and other
4061 programs as well, Medicare Part D, for instance; it is a
4062 noncontroversial program in our other Federal coverage
4063 programs.

4064 *Ms. Craig. Yes, thank you for adding that. I often
4065 say that flood insurance, crop insurance, other types of
4066 insurance also have reinsurance as part of those policies and
4067 often cannot understand how they get involved in sort of
4068 political debate since that is just a normal,
4069 noncontroversial part of an insurance plan.

4070 Can you also just talk a little bit more perhaps about
4071 some of the other measures that you think would lower
4072 premiums for folks in the individual marketplace, in

4073 particular, and what else we could be doing to lower out-of-
4074 pocket costs for our constituents.
4075 *Ms. Keith. Certainly. So this is an area where I am
4076 very excited about State experimentation. We have heard a
4077 lot about State labs as innovation, and I think providing
4078 States with additional Federal funding to lower healthcare
4079 costs, to lower patient out-of-pocket costs, to experiment in
4080 ways in advanced health equity, I think is the direction we
4081 should be going in.
4082 We have seen a number of States, California,
4083 Massachusetts, Vermont, New Jersey -- I am probably missing
4084 some -- who have actually decided to sort of directly help
4085 subsidize patient costs and building upon those programs.
4086 I think there is a whole range of options, and it would
4087 be great to really unleash States and see what they could do
4088 building off of the Affordable Care Act as a framework.
4089 *Ms. Craig. Thank you so much, Ms. Keith.
4090 It will not surprise you to learn that the reinsurance
4091 proposal is my bill that I am carrying here in the U.S. House
4092 of Representatives, and again, I see this as super common
4093 sense, straightforward policy that will help us bring down
4094 cost and reduce risk.
4095 So I encourage my colleagues on both sides of the aisle
4096 to cosponsor the bill and to support reinsurance.
4097 Thank you so much.

4098 And, Madam Chair, I yield back.

4099 *Ms. Eshoo. Thank you, Congresswoman Craig.

4100 And I think that all of the members of our subcommittee
4101 have a special appreciation for the new members that have
4102 come to our subcommittee, great, crisp new ideas, all the
4103 energy in the world. So they are on display. You have heard
4104 them, and we are all really collectively proud, and you have
4105 got an important bill there.

4106 Now, let's see. Who is next? We will go to the
4107 gentleman from Texas, Mr. Veasey, who is also waiving on.

4108 And you are always welcome at our subcommittee, and you
4109 are recognized for five minutes of questions.

4110 *Mr. Veasey. Madam Chair, thank you very much. I
4111 appreciate you letting me waive on.

4112 *Ms. Eshoo. Sure.

4113 *Mr. Veasey. I wanted to talk about this because this
4114 is hugely important.

4115 You know, Medicaid has done a lot, particularly after
4116 the ACA was passed, for so many different States, but there
4117 are still 12 States in the Union that have not expanded
4118 Medicaid.

4119 And my State of Texas, the Lone Star State, we are one
4120 of those 12, and it is really sad because even though over
4121 the last ten years we have had a tremendous amount of
4122 economic growth all around the State, including here in the

4123 Dallas-Fort Worth Metroplex, we still have over a million
4124 uninsured just here in the DFW area.
4125 The district I represent, about a third or more of the
4126 constituents I represent do not have healthcare insurance.
4127 It is really that bad.
4128 And so that is one of the reasons why I am proud of the
4129 legislation incentivizing Medicaid Expansion Act that I
4130 introduced as part of today's discussion, because the bill
4131 would establish incentives to expand Medicaid by providing
4132 the States with 100 percent matching fund rate for expansion
4133 during the first three years and gradually decline the rates
4134 to 93 percent by year six of expansion.
4135 And I think that this bill is really important now
4136 because of what we have seen as it relates to COVID-19 and
4137 how it has really hurt our State because of so much
4138 mismanagement.
4139 I wanted to ask specifically Cindy Mann.
4140 Cindy, you know, we have seven years of data, and we
4141 have been able to look at Medicaid expansion and the impact
4142 that has had on the country. Have researchers found any
4143 positive health effects of Medicaid expansion?
4144 Because I know that there has been a lot of talk about,
4145 you know, people being able to finally see physicians on a
4146 regular basis, and I was wondering if you all could tackle
4147 that.

4148 *Ms. Mann. Absolutely, and what an important question.
4149 And I am hopeful, Congressman, that Texas policy makers
4150 will see the new incentive as an opportunity to rethink their
4151 decisions about Medicaid expansion.
4152 So we have, with the anniversary of 11 years and
4153 coverage being in effect since 2014. There is lots of
4154 evidence and research, and it continues to mount showing the
4155 health impacts and value of coverage generally and of the
4156 Medicaid expansion in particular.
4157 We have seen cancer screening rates and cancer treatment
4158 rates increase among the expansion population. We certainly
4159 see people being able to access behavioral health services
4160 and services for substance use disorders that otherwise were
4161 not available to them.
4162 We have seen the ability for people with chronic
4163 illnesses to be able to get those illnesses managed, and we
4164 have seen reductions in low-birth-weight babies. We have
4165 seen reductions in maternal morbidity.
4166 There has really been a gamut of kinds of changes that
4167 you might expect when suddenly a population that historically
4168 has been marginalized and underserved begins to be able to
4169 access the care that they need.
4170 *Mr. Veasey. At this point when you take that data that
4171 you just spoke about and you look at all of the other
4172 benefits, is there any legitimate reason, if you were a Greg

4173 Abbott and you were sitting in Austin, Texas right now, is
4174 there any legitimate reason to continue to deny people the
4175 right to be able to access Medicaid expansion?
4176 *Ms. Mann. Well, I am sure Governor Abbott has reasons,
4177 and it is far from me to say that his reasons are not
4178 legitimate, but as I see the evidence and the evidence,
4179 again, that is very strong and very mounting, it has been an
4180 undeniable success and the evidence all points to the value
4181 of going forward.
4182 And we have seen 36 States go forward. Two additional
4183 ones are coming forward in July. It is a very popular change
4184 in the States, and not one of those States, no matter what
4185 the political makeup is of the State policy makers, not one
4186 of those States has decided not really a good deal, not
4187 really helpful for my residents or my providers or for my
4188 State budget. They have all retained Medicaid expansion and
4189 continue.
4190 So that is voting with their feet.
4191 *Mr. Veasey. Yes, and thank you very much.
4192 And, Madam Chair, let me say this in closing, that
4193 oftentimes during this argument about Medicaid expansion and
4194 other services that are similar to that, the constituents
4195 like the ones that I represent, I represent a district that
4196 is heavily Hispanic and Black, and oftentimes their story is
4197 told of people who are working hard to support people like

4198 the ones who live in my district at their expense, and become
4199 the foil for this narrative that you hear over and over
4200 again.

4201 But this Medicaid expansion would not only help
4202 constituents like I represent, but many of the ones that
4203 consider themselves Republicans that live in their districts,
4204 too.

4205 And I want to be clear about that, 100 percent clear
4206 about that. This is something that has helped a lot of
4207 Americans, and we need to try and expand it, especially in
4208 States like mine that are growing so rapidly.

4209 Thank you.

4210 *Ms. Eshoo. Thank you, Mr. Veasey.

4211 Each member that waived on is value added to today's
4212 hearing.

4213 I do not see any other virtual hands raised. So to each
4214 one of our witnesses, thank you. We are very, very grateful
4215 to you.

4216 To Katie Keith; Dean Cameron, you are always welcome at
4217 our committee. You have testified before. We always welcome
4218 you.

4219 To Cindy Mann, we have called on you. I knew Chuck
4220 Manatt many, many years ago. So you know, his leadership is
4221 still around. He would be really proud of you, as we all
4222 are.

4223 To Marni Jameson Carey, thank you for your excellent
4224 testimony.
4225 To Laura LeBrun Hatcher, thank you. And give our best
4226 to Simon. Tell Simon that we are with him. We stand with
4227 him, and we thank him for everything he has done for telling
4228 his story. The Little Lobbyists are giants really.
4229 You know, I started out this morning in my opening
4230 statement talking about the letter that Senator Kennedy wrote
4231 before he died. The letter was to President Obama and that
4232 it was not to be opened until he went to heaven.
4233 And that letter I have read and reread many times. I
4234 think that the cause that Senator Kennedy spoke of in that
4235 letter of ensure that the state of a family's health will
4236 never again depend on the amount of the family's wealth was
4237 the great unfinished business of our society.
4238 I think that together this morning, even though we have
4239 differences of opinion on various parts of this, but we have
4240 really moved the needle. We are in the process of moving the
4241 needle again to make good on that cause of ensuring.
4242 So I want to thank all of the members of the time
4243 investment they made today, the excellent questions both
4244 sides of the aisle, our witnesses, and that together that we
4245 will reach that North Star of every American, every American
4246 having good health insurance, not only access to it, but that
4247 they can afford it.

4248 That certainly has been the North Star of my public
4249 service and I think it is for others as well.
4250 So from a very deep place in my congressional heart, I
4251 thank each one of you.
4252 Now, to my pal, the ranking member of the subcommittee,
4253 we have 21 documents that need to be entered into the record.
4254 So I would like to ask you for unanimous consent, unless you
4255 want --
4256 *Mr. Guthrie. My choice is to have you read all 21,
4257 right?
4258 *Ms. Eshoo. -- to read all 21 documents.
4259 *Mr. Guthrie. Yes, as much as I have enjoyed our time
4260 together and great testimony and questions, I will give
4261 unanimous consent to that we dispense of reading them all.
4262 *Ms. Eshoo. And I thank the gentleman.
4263 We will submit these for the record.
4264 [The information follows:]
4265
4266 **********COMMITTEE INSERT**********
4267

4268 *Ms. Eshoo. And pursuant to committee rules, members do
4269 have ten business days to submit additional questions for the
4270 record, and I know that the witnesses welcome those
4271 questions, and we ask that you respond as promptly as you can
4272 to the questions that any of the members submit to you.
4273 And with all of my thanks to everyone, at this time the
4274 subcommittee is adjourned. So I think I will use my coffee
4275 cup as the mug (sic).
4276 Our meeting is adjourned. Thank you, everyone. And
4277 happy anniversary, ACA.
4278 [Whereupon, at 2:48 p.m., the subcommittee was
4279 adjourned.]