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PATIENT RELIEF FROM COLLAPSING HEALTH MARKETS

THURSDAY, FEBRUARY 2, 2016

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in Room 2123 Rayburn House Office Building, Hon. Michael Burgess [chairman of the subcommittee] presiding.

Present: Representatives Burgess, Guthrie, Shimkus, Murphy, Blackburn, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Mullin, Hudson, Collins, Carter, Barton, Upton, Walden (ex officio), Green, Engel, Schakowsky, Butterfield, Matsui, Castor, Sarbanes, Lujan, Schrader, Kennedy, Cardenas, Eshoo, DeGette, McNerney, Tonko, and Pallone (ex officio).

Staff present: Mike Bloomquist, Deputy Staff Director; Adam Buckalew, Professional Staff, Health; Karen Christian, General

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Counsel; Jordan Davis, Director of Policy and External Affairs; Paige Decker, Executive Assistant and Committee Clerk; Paul Edattel, Chief Counsel, Health; Blair Ellis, Digital Coordinator/Press Secretary; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff, Health; Jay Gulshen, Legislative Clerk, Health; Zach Hunter, Director of Communications; Peter Kielty, Deputy General Counsel; Katie McKeough, Press Assistant; Carly McWilliams, Professional Staff Member, Health; James Paluskiewicz, Professional Staff, Health; Kristin Shatynski, Professional Staff Member, Health; Jennifer Sherman, Press Secretary; Josh Trent, Deputy Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Luke Wallwork, Staff Assistant; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Jessica Martinez, Minority Outreach and Member Services Coordinator; Dan Miller, Minority Staff Assistant; Samantha Satchell, Minority Policy Analyst; Matt Schumacher, Minority Press Assistant; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Arielle Woronoff, Minority Health Counsel.

Mr. Burgess. I want to thank our guests for being with us this morning. I thank everyone for their indulgence. The Subcommittee on Health will now come to order. I will recognize

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51 myself for 5 minutes.

52 We are all here to help Americans, all Americans, insured,
53 uninsured and functionally uninsured. We want people to get
54 access to quality affordable health care. Our system is plagued
55 with problems that impose the highest burden on individuals and
56 consumers who have fewer choices, sometimes burdensome mandates,
57 costs that continue to spike and -- Americans who remain
58 uninsured.

59 Leading up to the 2016 elections, promises were made to
60 voters that the health care system would get back on track. We
61 laid out a step-by-step plan to prioritize access to quality
62 affordable health care not just insurance. The new
63 administration has taken steps to reduce the regulatory burden
64 and this hearing marks another step in that journey to stabilize
65 and rebuild our health care system.

66 I will be the first to admit we do not agree on everything,
67 but members of this subcommittee, both sides of the dais, have
68 a strong track record of advancing bipartisan legislation. I am
69 confident we can continue to advance bills through an open and
70 through an inclusive process to protect and empower patients.

71 In today's hearing we will consider policies that bolster
72 the health markets and reassure Americans that help is on the way.
73 To start, we all agree that individuals should have the comfort
74 of knowing that they will not be denied a health plan from an
75 insurer based upon their health status.

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Chairman Walden has offered a bill that will maintain safeguards for patients with preexisting conditions following the repeal of the Affordable Care Act. In addition, Representative Brooks is working on a bill that will go beyond protections for preexisting conditions by creating incentives for continuous coverage.

Currently, individuals moving from one job to another are protected from rate increases by existing law. Extending these protections to the individual market is a simple but important reform that will encourage Americans to enroll in coverage and to stay enrolled. Rather than forcing people to buy insurance that fails to meet their needs, this policy will reward people for making responsible decisions.

Young, healthy adults have faced the highest rate hikes in premiums to account for the higher costs of covering older, less healthy individuals. Today we will discuss legislation offered by Representative Bucshon to modify age rating restrictions and bring younger, healthier individuals into the insurance market.

Regulations have allowed individuals to keep coverage for a full 3 months without paying premiums. Dozens of statutory and regulatory instances allow individuals to enroll in a plan through a special enrollment period. To stabilize the market, Representative Flores and Representative Blackburn have offered legislation intended to end manipulation of health insurance rules.

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I look forward to hearing from our witnesses on the merits of setting the grace period to 30 days for nonpayment of premiums and requiring verification of eligibility for those special enrollment periods. I think it is important to note that all of these bills, all of these bills would allow states the flexibility to modify the requirements. After all, states understand what their residents need better than Washington.

Good policy that will stand the test of time requires hard work. It requires compromise. It requires the scrutiny of the American people. As we learned as with the Affordable Care Act, policy hastily built by folks behind closed doors results in devastating consequences. We are committed to large-scale reform. Real people are struggling as we speak and we are not waiting to take action.

These bills are an important example of the work we are doing right now, right now to advance member-driven solutions that will improve health care for Americans. I am hopeful, hopeful that we can work together to reform our health system for the benefit of the American people.

And I would now like to yield the remainder of my time to Dr. Larry Bucshon of Indiana.

[The statement of Mr. Burgess follows:]

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

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125 Mr. Bucshon. Thank you, Mr. Chairman. Currently the
126 Affordable Care Act requires that the most generous plan costs
127 no more than three times the least generous plan according to age.
128 As a consequence, younger healthier individuals have been priced
129 out of the health insurance market, destabilizing risk pools and
130 driving premiums higher for everyone.

131 H.R. 708, the State Age Rating Flexibility Act of 2017 would
132 set this ratio at 5:1 or also allow states to set their own age
133 rating based on their unique patient population. For example,
134 Indiana had no age rating prior to the ACA. This solution
135 encourages more actuarially sound plans to enter the marketplace,
136 providing more affordable options for younger, healthier
137 individuals and bringing them back into the insurance market to
138 more adequately balance the risk pools and drive down the premiums
139 for almost everyone. I yield back.

140 [The statement of Mr. Bucshon follows:]

141

142 *****COMMITTEE INSERT 2*****

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143 Mr. Burgess. The gentleman yields back. The chair thanks
144 the gentleman and the chair recognizes the gentleman from Texas,
145 Mr. Green, 5 minutes for the purpose of an opening statement,
146 please.

147 Mr. Green. Thank you, Mr. Chairman. Before I start, we
148 have a member of our Energy and Commerce Committee but not a member
149 of the subcommittee. I would like to ask to waive on Jerry
150 McNerney who will be here shortly and I just wanted to give notice
151 that --

152 Mr. Burgess. Is the gentleman making a unanimous consent
153 request?

154 Mr. Green. Yes.

155 Mr. Burgess. Without objection, so ordered.

156 Mr. Green. Okay, and Congressman Paul Tonko also, unanimous
157 consent.

158 Mr. Burgess. Again, without objection, so ordered.

159 Mr. Green. Thank you, Mr. Chairman. Thanks to the
160 Affordable Care Act, 20 million previously uninsured Americans
161 now have health coverage. For the first time ever, less than nine
162 percent of Americans are uninsured with the uninsured rate
163 currently at 8.6 percent. Since the enactment of the ACA, for
164 roughly 150,000 million Americans who have coverage through their
165 employer, premium growth remains much lower than in the past and
166 everyone benefits from consumer protections and provisions that
167 improve and expand coverage. Unfortunately, my colleagues want

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to undo the progress we have made. There should be no repeal of health care reform without an immediate adequate replacement that achieves the same historical gains in coverage, ensures people with preexisting conditions aren't blocked or priced out of the market, and that health plans cover a basic set of benefits and consumer protections.

Repealing the Affordable Care Act in whole or in part without an adequate replacement in place would cause chaos and is downright irresponsible. It has been 7 years and despite claims to have a better way, the bills we are considering today will only further sabotage the existing system and offer only unfinished, inadequate proposals that as written would leave Americans worse off and put insurance companies back in charge.

It is truly fitting that today is Groundhog Day, except unlike Bill Murray it is not a comedy. For 7 years we have asked Republicans to work with us to strengthen the ACA and make health care more affordable and accessible and for 7 years they told us they would not. This is real and not an abstract intellectual debate and the discussion draft my colleagues have put forward today is just indefensible. Thirty million people would stand to lose their health insurance if the ACA is repealed. The emergency room should not be the point of entry for our health care system. It is bad for patients, budgets and the health care system as a whole. Repeal and replace is a slogan not a meaningful policy and would likely put us on a path to catastrophe.

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193 The gravity of the situation is hard to overstate. There
194 are real people with real concerns who deserve more than a half
195 written bill and inadequate talking points. Proceeding with
196 repeal with half-baked ideas for replacement is offensive and
197 confusing and alarming. My colleagues across the aisle control
198 the Congress and the White House. Millions of people are relying
199 on them and looking to them for what they are going to do to protect
200 them. We are well past talking points and the American people
201 deserve answers. As always, I stand to work with my
202 colleagues, with anyone, to amend and improve the Affordable Care
203 Act. And thank you, Mr. Chairman. I yield the remaining balance
204 of time to Congresswoman Schakowsky.

205 Ms. Schakowsky. Thank you. It has been reported that some
206 of our Republican colleagues have recently voiced important and
207 specific concerns about repealing the ACA. And for example,
208 Congressman Tom McClintock of California, quote, said we better
209 be sure that we are prepared to live with the market we have created
210 that is going to be called Trumpcare. Republicans will own that
211 lock, stock and barrel. And then Congressman Tom McArthur of New
212 Jersey said, quote, we are telling those people that we are not
213 going -- oh, that we are not going to pull the rug out from under
214 them, and if we do this too fast we are in fact going to pull the
215 rug out from under them.

216 Mr. Cassidy pointed out that their plan to tax employer
217 sponsored insurance will increase taxes on the middle class and

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218 these serious concerns and unanswered questions show that
219 Republicans are finally starting to realize what Democrats have
220 known all along that their plan to sabotage the ACA will leave
221 millions of Americans without coverage, will reduce the quality
222 of insurance and will raise costs for everyone.

223 And regardless of the rhetoric that we may hear today, we
224 know that this half written, half-baked bill put forth by Chairman
225 Walden will allow insurance companies to charge people with
226 preexisting conditions whatever they want and charge them
227 whatever they want for their coverage. That is what the bill
228 actually does.

229 Now that Republicans have started to recognize the
230 consequences of their plan to take away coverage from 30 million
231 Americans, I hope that they will finally actually work with us
232 to make health care more affordable and more accessible. We are
233 ready to sit down. We have been ready for 7, 8 years to do exactly
234 that. Let's do it.

235 I do agree with the chairman of the subcommittee that we all
236 agree that we want to provide quality, affordable health care.
237 Those Republicans who have misgivings are right to have that. So
238 let's sit down and do it together instead of these continual
239 proposals that will hurt all of our constituents. And I yield
240 back to the gentleman from Texas.

241 [The statement of Ms. Schakowsky follows:]
242

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*****COMMITTEE INSERT 3*****

244 Mr. Burgess. The gentle chair thanks the gentlelady. The
245 gentlelady yields back. The chair would like to recount the
246 number of times it was rebuffed by the Obama administration on
247 those very points, but I will reserve that until later. The chair
248 now recognizes the chairman of the full committee, Mr. Walden,
249 5 minutes for questions, please, for opening statement, please.

250 The Chairman. Yes, thank you. Thank you, Mr. Chairman, I
251 appreciate it and I appreciate the concerns of my colleagues. I
252 would note from the record there have been multiple pieces of
253 legislation since Obamacare was enacted that have received
254 Democrat and Republican votes and actually signed by the President
255 to repeal problems in Obamacare. Those became law.

256 So to argue that nothing has ever been done to try and
257 straighten it out is false. I think Democrats combined cast 4,775
258 votes to repeal, to reform, to change Obamacare, so check the
259 facts. We are here today, we know on our side we are going to
260 repeal Obamacare. It is not working. It has left a lot of
261 wreckage around. We are here to clean it up. And in fact we are
262 wide open to hearing from our colleagues on policy. That is what
263 we are about.

264 We know Obamacare has, what it has done to the health care
265 system. It is why we are hard at work crafting reconciliation
266 language to repeal it, and today we begin the important work of
267 laying the foundation to rebuild America's health care markets
268 as we dismantle Obamacare. We have to save this individual health

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care insurance market. It is collapsing. And if you want to walk away and just let it collapse, a pox on your side. That is not what I am about. I have always been a problem solver.

You will hear us in a minute talk about bipartisan legislation, go after those who try and corner certain markets, drive up costs -- things like EpiPen. I am happy to work with you, but it has to be something that can move this forward and take care of people. There is no shortage of evidence that patients and families are hurting under the overwhelming weight of Obamacare. Patients in 21 states have seen average premium increases of 25 percent or more this year. People in seven states will experience premium increases of 50 percent or more. That is not sustainable. In 2016 there were 225 counties across America that had just one insurance choice in the market, just one on the exchange. This year that number has climbed to a 1,022, 1,022 counties with just one insurer. That is a third of the entire number of counties in the country, a third. Five entire states now, patients there have just one choice.

And if you focus on what those plans are saying, they are evaluating right now whether they can even stay in these markets in the outlying years because of what is coming in existing law passed in a partisan manner by Democrats. Over five of the original 23 insurance co-ops remain in business, five of 23. They tried it, it didn't work. Two of those failed co-ops are sadly in my own state of Oregon and we are pretty progressive about

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trying new things and a lot of it has worked. These did not.

We have the responsibility to prevent a real train wreck for millions of Americans. Not only can we solve this problem but we must solve this problem. It is time to end the partisan rhetoric and actually come to the table and solve these problems and I commend my colleagues on both sides of the aisle who are willing to do that.

The proposals before us today close enrollment gaps, protect taxpayers and give patients cost relief. The first three bills should come as no surprise. They were introduced last Congress and were the topic of two hearings in this subcommittee. The other proposal is equally important to all of us. We will ensure patients with preexisting conditions will always have access to coverage and care, period.

To take this a step further, we have included a placeholder as all of you have sort of referenced in your testimony, and I appreciate your testimony. Everybody has a different view of this. We want to get it right. That is why there is placeholder language. Our Better Way agenda envisions a new patient protection in the individual market for helping patients keep health coverage. HIPAA, Medicare Part B, Medicare Part D can serve as guidance for the Congress as we consider how best to achieve the goals of protecting America's sickest patients and maintaining market stability. We can do both without Obamacare's unpopular individual mandate where all these carve-outs have

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319 occurred. We have got the best minds focused on helping us
320 including our witnesses today. We are going to get this right.
321 We are going to take the time to get this right. That is why you
322 see a placeholder language in the draft. And my colleague Susan
323 Brooks is championing these efforts and I would actually like to
324 yield her a few minutes for remarks at this time, and then I will
325 conclude with one other announcement.

326 [The statement of Mr. Walden follows:]

327

328 *****COMMITTEE INSERT 4*****

Mrs. Brooks. Thank you, Mr. Chairman. Yes, I agree. We all agree we have to save the individual market, yet we all know current law requires individuals to buy government dictated insurance. Instead, we propose giving people freedom from this mandate, it is only fair. Continuous coverage isn't a new idea. It has been discussed by reputable public policy organizations like the economic and political freedom center at Hoover Institution, free enterprise-focused American Enterprise Institute and others.

We don't pretend that this is the only solution, but we are confident that continuous coverage provides promise. That is why it is part of our Better Way Plan, a fairness agenda for helping patients get relief. And today this placeholder provides the clearest signal yet that we are working with patients and health care groups to draft language that balances important health status protections with necessary risk mitigation tools.

I look forward to the panelists' expert feedback today on the value of how this idea might help patients get and keep health coverage and with that I yield back.

[The statement of Mrs. Brooks follows:]

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

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351 The Chairman. Mr. Chairman, if I could just conclude.
352 While I know our focus today is on insurance reforms, we are also
353 working in other areas of health care to bring relief to patients.
354 Next week we will take up legislation sponsored by Representatives
355 Bilirakis and Schrader, bipartisan bill that would incentivize
356 generic drug development and increased competition in the market.

357 And for those in the industry who think it is okay to corner
358 a market and drive up prices and rip off consumers, know that your
359 days are numbered. President Trump made it clear in the White
360 House meeting I attended with him and Vice President Pence, he
361 wants competition that will bring lower drug prices and that is
362 precisely what this measure will help accomplish.

363 Patients are tired of waiting for relief. We are going to
364 move forward in a bipartisan way to give them help. It is an
365 important first step. It needs to happen now. Specifically, the
366 bill would require FDA to prioritize and expedite the review of
367 generic applications for drug products that are currently in
368 shortage or where there are few manufacturers on the market.

369 We all remember recent situations where bad actors jacked
370 up the price of older, off-patent drugs because there was no
371 competition. We want to make sure that does not happen again.
372 This bill would also increase transparency around the current
373 generic backlog at FDA, and while progress has been made there
374 are still an unacceptably high number of generic drug applications
375 sitting at the Food and Drug Administration that if and when

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376 approved could bring additional lower cost alternatives to
377 patients.

378 Whether it is examples like Daraprim or EpiPen, patients need
379 solutions. I believe this bipartisan bill gives us a new tool
380 to fight back on their behalf. I thank you for the indulgence
381 of the committee and I yield back the balance of my time.

382 Mr. Burgess. The chair thanks the gentleman. The chair
383 recognizes the gentleman from New Jersey, Mr. Pallone, 5 minutes
384 for an opening statement, please.

385 Mr. Pallone. Thank you, Mr. Chairman. I am trying not to
386 blow up here today because I like Chairman Walden, he is a nice
387 guy. I like the gentlewoman from Indiana, she is a lovely woman.
388 But I just, the statements that are coming out from the two of
389 you about what you think you are doing versus what is really
390 happening here are very disturbing to me.

391 No one has a problem with making improvements to the ACA,
392 but you are not seeking to make improvements. You are seeking
393 to repeal it without saying how you are going to replace it. And,
394 you know, you can do a little, you know, if you really wanted to
395 make some changes and do some things without repealing it, you
396 know, we would be fine to work together, but there is no suggestion
397 of that. And the idea that this is collapsing of its own weight
398 is simply not true. The reason that the ACA is going to have
399 problems here is because you and the President are purposely, in
400 my opinion, making it collapse because of the policies that you

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are espousing. You know, the best example of that was when the White House last week announced that they weren't going to anymore promotion. They were going to pull the ads, so that people wouldn't even be able to sign up or wouldn't even know what they were signing up for.

So, you know, don't suggest to me that somehow this is going to collapse because of the bill, because of the ACA. It is going to collapse because of purposeful Republican policies. And, you know, the gentleman from Indiana mentioned the individual mandate. You know that without the individual mandate that the younger and healthier people are not going to sign up, and then the insurance pool becomes broken and then the insurance companies pull out and gradually the ACA collapses, again if you eliminate the individual mandate.

So I just have to say, you know, Republicans have been rooting for the demise of the Affordable Care Act for 7 years, actively trying to sabotage the law. They have done this under the guise of having a better way, but today it is clear that this was never the case. Now that the time has come for them to actually show the public this better way they are in complete disarray and today it is clear that Republicans have no plan to replace the ACA. Every day their timeline changes and all they have successfully done so far is create chaos and uncertainty among patients and insurance companies. Chaos here with the ACA, chaos with immigration, chaos with foreign policy, the list goes on from this

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426 badly motivated person, in my opinion, who is in the White House.

427 The bills we are discussing today are supposedly the first
428 pieces of the Republican's elusive plan, so essentially after a
429 7-year smear campaign on the ACA they intend to move forward three
430 bills from last Congress that help insurance companies instead
431 of people.

432 And another bill, the only so-called replacement, is
433 literally half written. You know, I had to laugh -- again I love
434 you, Dr. Burgess, but I had to laugh when you said that the ACA
435 was hastily built upon. I mean the chairman's bill literally runs
436 off the page. I mean I took it this morning and I started to read
437 it and then I got to Title II Continuous Coverage, it says
438 incentive placeholder. Talk about hastily built, what is this
439 half built? I mean I just, I don't even know where to begin.

440 I am going to stop because I have to give some time to
441 Congressman Kennedy and then if there is also time to
442 Representative Castor, so I will yield to the gentleman from
443 Massachusetts initially.

444 [The statement of Mr. Pallone follows:]

445

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

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447 Mr. Kennedy. Thank you, and I thank the ranking member. I
448 want to thank Chairman Burgess and Ranking Member Green for their
449 leadership as we confront one of the most contentious debates this
450 body will address in the coming year. All of us in the
451 subcommittee can agree that there is room for improvement in our
452 health care system from premium deductibles that should be lower,
453 insurance options in rural and underserved areas that must be
454 increased.

455 But there are also areas where the law is working well. In
456 Massachusetts we have a 2.8 percent unemployment rate and a 2.8
457 percent uninsured rate. On this side of the dais we are happy
458 to have the debate about fixing the Affordable Care Act, but
459 repealing the ACA without a replacement, and the four half
460 measures today before us are not a replacement, will only
461 exacerbate those problems. More than that it will erode the very
462 minor progress that we have made to reform our mental health care
463 system in this very room last year with 21st Century Cures.

464 For the roughly 43 million Americans suffering from mental
465 illness, parity laws that currently guarantee coverage will
466 crumble. For the 30 percent of patients with a mental health
467 issue that is covered by the Medicaid expansion treatment will
468 no longer be within reach. For constituents in all of our
469 districts, red or blue, rural and urban, preventive screenings
470 for behavioral health that can save lives will be unaffordable
471 and inaccessible. Simply put, no matter where you live if you

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472 have coverage or you are uninsured, you are on an uncertain path
473 that will lead to seismic, tragic shifts in our behavioral health
474 care system. Today is an opportunity for all of our colleagues
475 to commit to changing course. I yield back.

476 [The statement of Mr. Kennedy follows:]

477

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

479 Mr. Pallone. Mr. Chairman, Mr. Walden had like an extra
480 minute and a half and I would like Ms. Castor to have a minute
481 if possible. I would ask unanimous consent.

482 Mr. Burgess. Are you asking an unanimous consent request?
483 So ordered.

484 Ms. Castor. Well, thank you very much. Members, the fear
485 across America is widespread about the Republican plan to withdraw
486 this lifeline that is the Affordable Care Act. I wanted to tell
487 you about a woman who approached me recently back in Tampa. 60
488 year old Kathy Palmer is a single parent with a student in high
489 school, she is doing everything right. She is working part-time
490 at a small company. She is working towards her bachelor's degree
491 in accounting. She is paying her fair share in taxes.

492 She took personal responsibility because her company is so
493 small and doesn't provide health insurance, she took personal
494 responsibility and went shopping out on healthcare.gov, and in
495 our very robust market, far from collapsing in the Tampa Bay area
496 where we have 61 plans to choose from, she chose a plan and she
497 has been paying her premiums.

498 And thank goodness for that because in December she wound
499 up in the hospital with what she thought was a heart attack. When
500 she got out of the hospital that bill for all the care she received
501 was \$70,000. Without the Affordable Care Act she would be
502 bankrupt. Her future and probably her child's future would have
503 been very bleak.

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504 So I ask my Republican colleagues to listen to our
505 constituents all across this country. Before you go and do the
506 damage of repealing the Affordable Care Act understand what it
507 will mean for the families that we represent and their economic
508 futures. I yield back.

509 [The statement of Ms. Castor follows:]

510

511 *****COMMITTEE INSERT 8*****

512 Mr. Burgess. Does the gentleman from New Jersey yield back?

513 Mr. Pallone. Yes, Mr. Chairman.

514 Mr. Burgess. The chair thanks the gentleman. The
515 gentleman yields back. We now conclude with member opening
516 statements. The chair would remind members that pursuant to
517 committee rules, all members opening statements will be made part
518 of the record. We want to thank our witnesses for being here
519 today, for taking time to testify before the subcommittee. Each
520 witness will have the opportunity to give an opening statement
521 followed by questions from our members.

522 We are pleased today to welcome Dr. Doug Holtz-Eakin, no
523 stranger to this committee room, president of the American Action
524 Forum; Mr. J.P. Wieske, deputy commissioner for insurance for the
525 State of Wisconsin; and Dr. Leonard Lichtenfeld, deputy chief
526 medical officer for the American Cancer Society.

527 We appreciate each of you being here today. We will begin
528 our panel with Dr. Holtz-Eakin, and you are recognized 5 minutes
529 for the purpose of an opening statement.

530 Mr. Kennedy. Mr. Chairman, just before we begin the
531 statements I would like to raise a parliamentary inquiry.

532 Mr. Burgess. The gentleman from Massachusetts, what
533 purpose does the gentleman from Massachusetts seek recognition?

534 Mr. Kennedy. Mr. Chairman, I ask a parliamentary inquiry
535 to try to understand from you, sir, given some of the hearing --

536 Mr. Burgess. The gentleman will state his parliamentary

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537 inquiry.

538 Mr. Kennedy. I would like assurance, Mr. Chairman, given
539 what we have learned in the past several days about coordination
540 between various House staffers and the Administration and
541 transition team and the signing of nondisclosure agreements.

542 Mr. Burgess. The gentleman --

543 Mr. Kennedy. Would like to understand if such agreements
544 --

545 Mr. Burgess. The gentleman has actually not stated a
546 parliamentary inquiry, but I do want to accommodate your request.
547 We are here of course to take testimony on bills before the
548 committee. I think that can proceed, and I will defer to the
549 chairman of the full committee for a discussion with you on your
550 parliamentary inquiry.

551 The gentleman, Dr. Holtz-Eakin, is recognized for 5 minutes
552 for an opening statement, please.

553 Mr. Kennedy. So Mr. Chairman, when -- I appreciate your
554 deference to the full committee chairman as to what is going to
555 happen next. What, just so I understand given as you did indicate
556 the challenge of hastily built --

557 Mr. Burgess. The gentleman did not state a parliamentary
558 inquiry.

559 Mr. Kennedy. And so my question about --

560 Mr. Pallone. He didn't finish his sentence.

561 Mr. Kennedy. -- the existence of nondisclosure agreements

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562 is unanswered, so it is unanswered.

563 Mr. Burgess. The gentleman, Mr. Holtz-Eakin, is recognized
564 5 minutes for the purpose of summarizing your opening statement.

565 Mr. Griffith. Mr. Chairman. Mr. Chairman, parliamentary
566 inquiry.

567 Mr. Burgess. For what purpose does the gentleman from
568 Virginia seek recognition?

569 Mr. Griffith. Mr. Chairman, I inquire that if a member asks
570 a question that is not a parliamentary inquiry is it not improper
571 for the chairman to answer?

572 Mr. Burgess. Yes.

573 Mr. Griffith. So then you would actually be out of order
574 if you attempted to answer Mr. Kennedy's question; am I not
575 correct?

576 Mr. Burgess. Yes.

577 Mr. Griffith. I yield.

578 Mr. Pallone. Mr. Chairman.

579 Mr. Burgess. For what purpose does the gentleman from New
580 Jersey seek --

581 Mr. Pallone. I just, I am not sure I understood what you
582 were saying. You are saying you are going to get back to us about
583 -- I understand you are saying it is not a parliamentary inquiry,
584 but did you say you are going to get back to Mr. Kennedy and respond
585 to his question or that Chairman Walden would; is that what you
586 said?

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587 Mr. Burgess. Well, the parliamentary inquiry was not about
588 the proceeding with today's hearing on taking testimony from
589 witnesses on the bill in front of us. I do respect the gentleman
590 from Massachusetts a great deal as he knows, and I do want to see
591 his question answered for him and I will seek the proper forum
592 with the chairman of the full committee for him to do so.

593 Mr. Pallone. So you will get back to us to respond to his
594 question.

595 Mr. Burgess. We will seek the appropriate forum.

596 The gentleman, Dr. Holtz-Eakin is recognized.

597 Mr. Butterfield. Mr. Chairman. Mr. Chairman.

598 Mr. Burgess. For what purpose does the gentleman from North
599 Carolina seek recognition?

600 Mr. Butterfield. I have a unanimous consent request.

601 Mr. Burgess. The gentleman will state his unanimous consent
602 request.

603 Mr. Butterfield. I would ask unanimous consent that the
604 gentleman from Massachusetts be allowed to restate his
605 parliamentary inquiry because I did not hear it. He was
606 interrupted in the middle of the sentence.

607 Mr. Griffith. I object.

608 Mr. Burgess. Objection is heard.

609 The chair yields 5 minutes to Dr. Holtz-Eakin for the purpose
610 of summarizing your opening statement.

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611 STATEMENTS OF DOUGLAS HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION
612 FORUM; J. P. WIESKE, DEPUTY COMMISSIONER, WISCONSIN OFFICE OF THE
613 COMMISSIONER OF INSURANCE; AND, J. LEONARD LICHTENFELD, M.D.,
614 DEPUTY CHIEF MEDICAL OFFICER, AMERICAN CANCER SOCIETY

615

616 STATEMENT OF DOUGLAS HOLTZ-EAKIN

617 Mr. Holtz-Eakin. Thank you, Mr. Chairman, Ranking Member
618 Green and members of the committee. I appreciate the chance to
619 be here today.

620 Mr. Burgess. Is your microphone on? I can't hear you.

621 Mr. Holtz-Eakin. Microphone is on.

622 Mr. Burgess. Okay.

623 Mr. Holtz-Eakin. Okay. Mr. Chairman, Ranking Member
624 Green, members of the committee, I appreciate the chance to be
625 here today to discuss these proposals to stabilize the ACA
626 individual market. I am going to make three simple points.
627 Point number one is that doing nothing is not an option. Under
628 current law the trend in the individual market is quite bad in
629 terms of premiums rising, insurers exiting and coverage
630 ultimately declining.

631 Second is that the proposals under consideration, reforms
632 to grace periods, special enrollment periods, the age rating bands
633 and continuous coverage provisions are all sensible policy that
634 I would hope would garner bipartisan support. And then third that
635 if indeed these measures were enacted there would still be much

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work left to do; that that would not be enough to stabilize them.
Let me elaborate on each and then I look forward to your questions.

Under current law the exchanges are headed in the wrong direction. In 2017, the benchmark Silver Plans rose at an average rate of 27 percent coming on the heels of ten percent rises in 2016, so the insurance is becoming increasingly expensive. As was noted by Mr. Walden, in five states and in one-third of U.S. counties there is only one insurer that is a choice for those participating in this market.

Seventeen of 23 co-ops have failed and the insurance that is out there is not really equivalent to affordable care. Eighty-four percent of participants require taxpayer assistance to purchase these policies and when they do they face family deductibles that are about average \$7,400 in the Silver Plans, average \$12,300 in the Bronze Plans, which means in many cases they are never getting to the point where the insurance is paying anything even after they have purchased it. My expectation is that if current law were unchanged and things were left on autopilot we would see exchange enrollments decline, decline substantially perhaps as low as eight million or so by 2020.

Clearly something needs to be done. In each case these measures would tend to improve the risk pools, lower the premiums and thus attract people in and stabilize the markets in that fashion. Grace periods in the Affordable Care Act are 90 days. In all but two states, grace periods off the exchanges would be

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661 30 or 31 days.

662 So the playing field is not level in the individual market
663 between off-exchange and on-exchange products. These long grace
664 periods raise the prospect of an individual paying for 9 months
665 and actually consuming a full year's worth of health care
666 coverage. That leads to obvious problems for insurers and the
667 costs have to be shifted.

668 In some cases they will be shifted to the taxpayer and in
669 some cases they will be shifted to other customers in the form
670 of higher premiums and thus exacerbating the upward pressure on
671 premiums. And in some cases insurers will be obligated to pay
672 only 1 month of those costs and 2 months will be shifted to
673 providers who will no longer want to participate in providing care
674 to the people who need it in these markets. Moving the grace
675 periods to match those off the exchange would be a very sensible
676 way to take those pressures off.

677 For the special enrollment periods the ACA has 30 conditions
678 in which individuals can enroll. By comparison, Medicare has
679 seven and HIPAA provides for three. These special enrollment
680 periods are a way for high cost patients, and all the evidence
681 which is in my testimony suggests they are higher cost than the
682 other enrollees, to enter into the market. Again insurers have
683 to jack up premiums in anticipation of this and the result is that
684 a large number, perhaps as many as a third of the participants
685 in the individual market, have entered using this mechanism.

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686 Tightening them up would be a sensible way to stabilize the market
687 and take pressure off premiums.

688 The age ratings are 3:1. This relatively raises the cost
689 of insurance for the young and healthy that is a group that has
690 under-enrolled in the ACA exchanges. Getting them in is a key
691 part of stabilizing it. Moving to 5:1 would match the data that
692 is the ratio in costs and be a sensible thing for the committee
693 to consider.

694 And then lastly is the proposal for continuous coverage.
695 Here I think it is simply the case that the individual mandate
696 is not working as envisioned. There are about six and half
697 million people in 2015 who simply paid the penalty. There are
698 another 12.7 who are simply exempt. The continuous coverage
699 provision would be a way to encourage the young to enter the market
700 at the age of 26, buy coverage, remain covered, and because they
701 remain covered they can never be medically underwritten and
702 charged a special premium because of a preexisting condition. It
703 is a way to stabilize the pools and to ensure that they do not
704 continue to deteriorate. So I thank the committee for the
705 chance to be hear today. I think these are sensible ideas which
706 would be good steps towards stabilizing the individual markets,
707 and I look forward to answering your questions.

708 [The statement of Douglas Holtz-Eakin follows:]

709

710 *****INSERT 9*****

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711 Mr. Burgess. The chair thanks the gentleman. Mr. Wieske,
712 you are recognized 5 minutes to summarize your opening statement,
713 please.

STATEMENT OF J. P. WIESKE

Mr. Wieske. Thank you, Chairman, and thank you, Ranking Member. I appreciate the time and the effort in discussing this important issue. As you know, as a regulator in the state of Wisconsin we have been on the front lines of having to deal with the issues surrounding the implementation of Obamacare. It has been frustrating to hear consistently that the folks don't seem to understand that states have an important role here and that states do have existing laws in place that have protected their consumers.

I would like to just kind of flash back before the ACA and talk a little bit about the Wisconsin insurance market before the ACA, what happened with the ACA, and what we hope to see in the future. In short, prior to the ACA Wisconsin had an excellent uninsured rating and we continue to do so in Wisconsin. We could rate consistently in the top six for the least number of uninsured. We still rank in the top six for the number of uninsured in the last report.

Wisconsin covered its folks who were vulnerable and were not eligible for the private market through a high risk pool. And I know there has been a lot of talk about high risk pools across the country. Wisconsin's high risk pool works, worked while it existed. In fact, I got a call 2 weeks ago from a legislator who had constituents asking him to reinstate the Wisconsin high risk

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739 pool because the coverage they had under Obamacare was inferior
740 to what they had under the high risk pool.

741 They had numerous plan options. The coverage was obviously
742 expensive. There is no question about that. Although if you see
743 the numbers in my testimony with the federal subsidy those rates
744 went down considerably. And I think one of the most important
745 features that Wisconsinites had in that high risk pool was they
746 could go to any doctor in the state. There is not a single plan
747 in our exchange where you can go to any doctor in the state and
748 get coverage without having really significant deductibles and
749 having out-of-network costs.

750 It was funded on assessments on the insurers as well as
751 mandatory discounts for the providers, and the coverage,
752 consumers had huge number of options inside that plan. And
753 typically, I think what is interesting about the high risk pools
754 is that they stayed on those high risk pools for about 3 to 4 years
755 and once they were there they moved into other group coverage
756 later, so it was a great gap coverage.

757 I will also note that we had relatively low premiums in
758 Wisconsin compared to, and you can see in my testimony that the
759 rates went up considerably. They went up much more on the young
760 folks than they went up on the older folks because of the age band
761 and that has caused an abandonment by and large of the market,
762 individual market, by a lot of the folks in the younger age bands
763 unless they have medical conditions. It has been very

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expensive for coverage. The fortunate thing in Wisconsin is we haven't seen the high increases. We had 16 percent increases this last year. We still have 15 insurers in the state doing business. We still have a co-op doing business and that is in part because we recognize that our job as a regulator is to minimize the consumer disruption. However, I think one of the big issues going forward is if we don't look at the transition coverage and if we don't make changes going forward we are expecting to see the small group market start to implode and that is going to put folks, more folks in the individual market which is unaffordable And that will impact taxes. That will impact everything across the board.

So we have serious concerns about not reforming the individual market impacting the small group market, not repealing Obamacare and ending up killing the small group market as well, which is on its way. About 80 percent of folks in the small group market are still in transition plans, so that is important to understand.

Going forward I think it is important to understand that states have a number of laws on the books. We have preexisting condition laws in Wisconsin. We have mental health parity laws. We had the coverage to age 27, in fact, not 26 in the state prior to Obamacare passing. We did a number of consumer protections and we take consumer protections seriously in the state and we do a lot of work and we deal with consumers directly, and we deal with insurers directly and we have discussions with insurers

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789 directly. We have done this for years. We have been regulating
790 the health insurance market since the 1940s.

791 And I will stop and indicate that we are ready to be here
792 and help and be part of the solution as state regulators and that
793 not all of these solutions need to be federally centric. Thank
794 you.

795 [The statement of J. P. Wieske follows:]

796

797 *****INSERT 10*****

798 Mr. Burgess. The gentleman yields back. The chair thanks
799 the gentleman. Dr. Lichtenfeld, you are recognized 5 minutes to
800 summarize your opening statement, please.

STATEMENT OF J. LEONARD LICHTENFELD, M.D.

Dr. Lichtenfeld. Thank you, Mr. Chairman and Ranking Member Green and members of the subcommittee. My name is Len Lichtenfeld. I am Deputy Chief Medical Officer for the American Cancer Society and I appreciate having the opportunity to be with you today.

I am also pleased to be here on behalf of the nearly two million patients and people who will be diagnosed with cancer this year and the over 15 million cancer survivors that are living today as a result of successful treatment. These Americans who are your constituents, for them access to comprehensive, affordable health insurance coverage truly is a matter of life and death.

Mr. Chairman, we appreciate your stated support for retaining two very important patient protections enacted as part of the ACA, the pre-ex provision that bans discrimination against people based on their health condition; and secondly, guaranteed issue of coverage. And we look forward to working with you on the language in the legislation to make sure these provisions work to do just that. Providing patient access to coverage is obviously meaningful, but only insofar as the coverage itself is affordable and provides enough benefits to be meaningful for someone with cancer. And that is certainly the lens through which we view these particular pieces of proposed legislation.

Prior to 2010 the insurance coverage was defined as just

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about anything marketed and sold by the industry and often contained exclusions, and hidden clauses resulted in denial of claims for all sorts of medically needed services. Current law requires that insurance provide major health coverage. When people buy insurance, especially when they are required to do so either by mandate or continuous coverage requirements, it is important to remember that insurance must cover a defined set of benefits to cover those individuals when they do become ill.

My written statement goes into greater detail, but in the limited time I have with you today I want to focus on why cancer patients need access to health insurance and how we can improve the system to address their needs. Research shows that individuals who lack health insurance coverage are less likely to get screened for cancer, more likely to have their cancer diagnosed at a later stage when the chance of survival diminishes and the treatments are certainly much more complicated. I know from my days as a practicing oncologist that it is very difficult to tell someone they have cancer; it is even more difficult to guide them through what is hopefully successful treatment. What is worse than that is being told by a patient they can't afford the treatment because they lack health insurance coverage or because their health insurance doesn't provide coverage for the oncology and cancer related services necessary for their journey.

Individuals with cancer including cancer survivors know how important it is to maintain health coverage. And unfortunately,

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851 before the patient protections provided under the ACA many were
852 unable to obtain health insurance coverage because of the cancer
853 diagnosis constituting a preexisting condition and others faced
854 lifetime or annual limits on their coverage while others were
855 still only able to purchase a health insurance coverage with
856 limited benefits that provide inadequate reimbursement when they
857 needed it most. Individuals with cancer want and need
858 continuous access to comprehensive health insurance coverage.
859 Unfortunately, the realities of life sometimes interfere with
860 this goal. We have made great strides in cancer treatments over
861 the years, but unfortunately many treatments still result in
862 unimaginable fatigue and other symptoms that can be very
863 debilitating such that the individual is unable to work.

864 Research suggests that between 40 and 65 percent of cancer
865 patients stop working while receiving cancer treatment with
866 absence from work that ranges from 45 days to 6 months depending
867 on the treatment, and sometimes these folks lose their jobs and
868 their affordable employer-sponsored coverage. Imagine a
869 diagnosis with cancer and undergoing treatments that make work
870 impossible, repeated absences result in a loss of your livelihood,
871 you have no income, yet you had a terrible disease and you need
872 to get coverage for that illness. Cancer treatments have left
873 you physically unable to even look for a new job. This is not
874 only a hypothetical it is very real, and everyone in this room
875 knows patients with cancer who have gone through such experience.

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876 So as you contemplate changes to the health care market, we
877 urge you to give great consideration to how the various policies
878 under consideration intersect and how an individual with cancer
879 would be impacted. We are not saying the current market is
880 perfect, more needs to be done to ensure affordability, but
881 affordability cannot be judged on premium alone. We need to also
882 consider out-of-pocket costs and the value of the benefits
883 provided. Catastrophic plans will have lower premiums, but few
884 cancer patients will be able to afford the deductibles, co-pays
885 and other out-of-pocket costs associated with oncology treatment.

886 In closing, I appreciate the opportunity to share our views
887 from the American Cancer Society on how the health care system
888 needs to ensure that individuals with cancer have access to the
889 products and services necessary for their treatment, and I am glad
890 to answer any questions from the committee. Thank you very much.

891 [The statement of Dr. Lichtenfeld follows:]

892
893 *****INSERT 11*****

894 Mr. Burgess. And the chair thanks the gentleman. The chair
895 thanks all of our witnesses for being here today and for your
896 testimony. We will move into the question portion of the hearing.
897 The chair does note that he was delayed in arriving at the hearing,
898 so in compensation for that I am going to defer my questions to
899 the end and recognize the gentleman from Texas, Mr. Barton, for
900 questions.

901 Mr. Barton. It is rare that I am speechless, Mr. Chairman,
902 but I am tempted to defer also because I had to go to a private
903 meeting and missed -- I was going to read my briefing book. I
904 guess I am -- but if you are recognizing me I am going to try to
905 go through it.

906 I am tempted, but since you are Diet Coke man and not a Diet
907 Dr. Pepper man I am a little skeptical.

908 I do want to, first of all, commend the chairman for holding
909 the hearing and commend our witnesses. I am going to ask a general
910 question about the overall effectiveness or necessity of
911 maintaining some sort of a health exchange option as we move away
912 from the Affordable Care Act. Could each of you gentlemen comment
913 on whether as we move to replace the Affordable Care Act we should
914 give states the option to have something similar to a health
915 exchange and also if we should have a national exchange in addition
916 to that.

917 Mr. Holtz-Eakin. I certainly think there is good reason to
918 give the states such an option. I have always thought that the

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919 most important thing would be to have healthy competition in the
920 individual market. Exchanges can provide the consumer
921 information necessary to make that competition work better, and
922 the place where I have reservations is only when the exchange
923 becomes a means for excessive regulation.

924 But the exchange, per se, is a marketplace where consumers
925 can get information and purchase policies that they like. It is
926 a very valuable concept.

927 Mr. Barton. Okay.

928 Mr. Wieske. I think the concept of the exchange, it is good
929 way to deliver subsidies but it is a three percent cost on top
930 of the insurance. That is roughly what they are charging back
931 the insurers for coverage to the exchange, and this is a website.
932 I am not so sure three percent is the, I mean that may reflect
933 the actual cost, so I think there is a value proposition there.
934 I think prior to the ACA there were a number of websites that
935 provided coverage as well.

936 And again, depending on what the purpose of the exchange is
937 I think he is right that it has become a means to add to the
938 regulatory burden on insurers and consumers, so I am not so sure
939 of the value in part because of the cost, but I don't think, you
940 know, I think there is, there may some reason for it.

941 Dr. Lichtenfeld. Mr. Barton, I appreciate your question.
942 But speaking on behalf of the American Cancer Society our major
943 concern is that consumers have the opportunity to get affordable

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944 coverage that is going to meet their needs at their time of need,
945 and the mechanism by which the committee decides going forward
946 to achieve that must provide the information that people need to
947 make the decision in a reasonable way.

948 There obviously are folks here who are involved in the
949 insurance community much more directly than I am or that we are,
950 but it is a matter of information, affordability and access and
951 that adequate coverages are available and that the consumer be
952 aware of those options as they go forward with their insurance.

953 Mr. Burgess. Mr., is it Wieske or Wieske?

954 Mr. Wieske. Wieske, yes, sir.

955 Mr. Burgess. Wieske, not wise guy, just Wieske. Your state
956 has a high risk pool, and another thing that we want to try to
957 do as we move away from the ACA is guarantee that people with
958 preexisting conditions get adequate access to insurance. Mr. --
959 the full committee chairman has put out kind of a placeholder bill
960 dealing with high risk pools. How would you envision based on
961 your state's experience that working absent all the bells and
962 whistles and mandates that we have currently under the ACA?

963 Mr. Wieske. So sure, you know, I think the first thing is,
964 is a high risk pool isn't necessarily the solution for every state.
965 I don't want to speak for other states. I will say that in the
966 state of Wisconsin while we had a high risk pool it was highly
967 effective. It is still politically popular amongst both
968 Republicans, Democrats and especially amongst some subscribers

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969 of the high risk pool. And they miss the coverage. It was a well
970 thought out coverage. It was a well thought out program.

971 So I think, you know, I think the key issue is always how
972 you deal with the funding. And that has been one of the bugaboos,
973 I think, in a number of states is when there is insufficient
974 funding for a high risk pool. You know, there was one state,
975 California had a waiting list for their high risk pool. Florida
976 closed their high risk pool in the early 1990s and it remained
977 closed for a number of years. Other states had relatively low
978 dollar caps.

979 So there are issues in design, so the important piece is
980 design. The other important piece is understanding how the
981 funding works and having a stable funding source. I think it has
982 been consistent that the insurance industry is required through
983 the individual small group and large group market to contribute
984 to the cost of the high risk pool to make sure that it is affordable
985 for consumers. I think as well having good medical discounts that
986 attach to it are also important, but funding is sort of the key
987 piece in making sure that it is maintained over time.

988 Mr. Barton. You think it can be workable.

989 Mr. Wieske. I think it worked incredibly well in Wisconsin
990 and it provided great coverage and a lot of options for consumers,
991 yes.

992 Mr. Barton. My time has expired. Thank you, Mr. Chairman,
993 for your --

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994 Mr. Burgess. The gentleman yields back. The chair thanks
995 the gentleman. The chair recognizes the gentleman from Texas,
996 Mr. Green, 5 minutes for questions, please.

997 Mr. Green. Thank you, Mr. Chairman. Last Congress our
998 committee passed several important pieces of legislation on
999 health care, a number of them fixing the SGR, extending FQHCs,
1000 and 21st Century Cures is probably the biggest one. Speaker Ryan
1001 once described the 21st Century Cures as the most important
1002 legislation to be passed in the 114th Congress.

1003 During the process of passing the Cures many members of our
1004 committee heard stories from patients and advocates across the
1005 country who were battling tough diseases and hoping for new
1006 treatments. Passing the Cures which contained new funding for
1007 research on diseases such as cancer we gave so many of them hope
1008 that one day they would get that treatment to be needed.
1009 Nationwide, the ACA is that delivery. It doesn't do us any good
1010 to invest in medical research if we don't have a physician or a
1011 facility -- and I am from the Houston area, we are fortunate to
1012 have MD Anderson. Although up until the Affordable Care Act,
1013 MD Anderson being a state institution did not take a significant
1014 number of indigent persons even though they were Texans, and, but
1015 now they have something even if it is Medicaid. And of course
1016 Texas didn't expand Medicaid expansion so we need to have this
1017 delivery system.

1018 And we can do things bipartisan, you know, I am hoping that

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1019 is what we can do to fix the ACA because there has never been a
1020 law passed by Congress that doesn't need to be looked at over a
1021 period of years. And by the way I served 20 years in the state
1022 legislature in Texas and we wrestled with our high risk pool. The
1023 problem is, is that we didn't fund it and if you only have high
1024 risk people they can't afford the insurance.

1025 How does Wisconsin, Mr. Wieske, fund your high risk pools?
1026 Is it premium? I thought I saw in your remarks it was premium
1027 taxes.

1028 Mr. Wieske. So there are number of funding mechanisms, so
1029 it was divided out equally. There was no actual state dollars
1030 that went into it. However, it was divided out between a 40/30/30
1031 share, so 40 percent was the cost for consumers, 30 percent was
1032 the cost for insurers, and 30 percent was the cost for the medical
1033 providers. They were required to have that level of contribution
1034 remain consistently over time which was true-upped every year in
1035 order to maintain the affordability. There was enough money
1036 there that it was private sourcing that actually provided the
1037 subsidy for folks under \$34,000 of family income, so there was
1038 subsidies for folks under \$34,000 of income as well.

1039 Mr. Green. Well, again and other states have tried that.
1040 I, like I said, worked as a state legislator doing work across
1041 state lines to see what we could do, but -- and I have a district
1042 in Houston. It is very urban. Up until the Affordable Care Act
1043 44 percent of my constituents who worked did not get insurance

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1044 through their employer.

1045 And so that is why the ACA is so important to an urban area
1046 and there are places all over the country. I would be interested
1047 sometime just to talk with you how Milwaukee, a very urban area,
1048 compares with most of the rest of Wisconsin, but, you know, that
1049 is my concern that not every state is like Wisconsin.

1050 Dr. Lichtenfeld, thank you for being here. This bill
1051 requires insurers to cover preexisting conditions like cancer,
1052 but the bill doesn't say that insurers can't charge more for that
1053 cancer patient. That is one of the major issues, you know, the
1054 requirement that people have insurance so the insurance companies
1055 can spread that risk. Insurance is about spreading the risk, and
1056 if you only have cancer patients in the insurance plan nobody will
1057 be able to afford it. So that is why -- and if they have to, you
1058 know, once you are diagnosed and you will have to spend it, tell
1059 me, is that one of the problems the American Cancer, your client
1060 has problems with?

1061 Dr. Lichtenfeld. I am part of the American Cancer Society
1062 and honored to be so. Of course it is a concern. You know, nobody
1063 goes out and says I want cancer or that I know I am going to get
1064 cancer, and that is what insurance is about, making sure that the
1065 benefits are adequate, that the cost is affordable and as I
1066 mentioned not only the premium cost but also the ancillary costs
1067 that inevitably come along. Making sure that patients and
1068 consumers have access to care is what this is all about.

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1069 We are not here to in a sense solve all the problems in our
1070 testimony today. We are here today on behalf of cancer patients
1071 throughout this nation and consumers to try to make sure that those
1072 principles are adhered to. That some of the fundamental
1073 protections in terms of affordability, limits on out-of-pocket
1074 expenses --

1075 Mr. Green. Before I run out of time, you don't see this
1076 proposed legislation is serving cancer patients?

1077 Dr. Lichtenfeld. What we believe is that this is a work in
1078 progress and we want to participate in that progress and help reach
1079 solutions in a manner that is acceptable for the people we serve.

1080 Mr. Green. Thank you. Thank you, Mr. Chairman.

1081 Mr. Burgess. The chair thanks the gentleman. The
1082 gentleman yields back. The chair now recognizes the gentleman
1083 from Kentucky, the vice chairman of the Health Subcommittee, 5
1084 minutes for questions, please.

1085 Mr. Guthrie. Thank you, Mr. Chairman. I have a chart. I
1086 would like to start by walking through a chart if we can have that
1087 posted.

1088 Now the chart we see here uses CBO data on where folks get
1089 their health insurance coverage in 2016. As you can see, roughly
1090 half of the country received coverage through their employer.
1091 That is 155 million people. Fifty seven million patients are
1092 enrolled in Medicare, another 57 million are Medicaid
1093 beneficiaries that were eligible before the Affordable Care Act.

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1094 When it comes to the Affordable Care Act there are 11 million
1095 recipients who were made Medicaid eligible by law, and a little
1096 under 11 million folks on exchange programs and roughly one
1097 million enrolled through basic health programs. What this chart
1098 illustrates is that we are talking about seven percent of the
1099 population all at the potential disruption of where 93 percent
1100 of people across the country receive their health coverage. Even
1101 more, the IRS said about eight million folks paid the mandate
1102 penalty and another 12 million claimed an exemption from the
1103 penalty.

1104 So of the 27 million uninsured Americans, 20 million chose
1105 to either to pay the individual mandate tax or claim an exemption.
1106 Look, we are going to hear a lot of numbers today and remember
1107 these. Seven percent of the country can be directly associate
1108 their coverage through the Affordable Care Act and all but seven
1109 million uninsured Americans paid the penalty or claimed an
1110 exemption.

1111 So instead about talking numbers let's talk about people
1112 behind the numbers. So Dr. Holtz-Eakin, can you tell me the
1113 national average of premium increases for on-exchange patients
1114 this year?

1115 Mr. Holtz-Eakin. For the benchmark Silver Plan it is 27
1116 percent.

1117 Mr. Guthrie. And Commissioner Wieske, what is the number
1118 for your home state of Wisconsin?

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1119 Mr. Wieske. It was roughly 16 percent.

1120 Mr. Guthrie. Let's talk about ways to drive these costs
1121 down. Dr. Holtz-Eakin, as you point out in these reforms noticed
1122 today, taken individually or separately are good policy and should
1123 receive bipartisan support. If our immediate task is to stop the
1124 leaks before replacing the pipes, is this a good place to start
1125 with the bills before us today?

1126 Mr. Holtz-Eakin. I believe so. Yes, these are sensible
1127 reforms that will get part of the way.

1128 Mr. Guthrie. Thank you, and I agree with your written
1129 conclusion this will not fix everything but these are necessary
1130 changes. One of those longer term changes we strongly considered
1131 is continuous coverage. Would you please briefly describe the
1132 value of this incentive model and how it is aimed at patients
1133 keeping health care instead of simply getting coverage?

1134 Mr. Holtz-Eakin. So the basic concept is to deal with
1135 preexisting conditions in two ways. The first is for existing
1136 folks you go to a high risk pool model like has been discussed.
1137 But for a young person, the minute they come off their parents'
1138 policy at age 26 they are young and cheap and if they buy a policy
1139 and keep coverage in any form throughout their life, regardless
1140 of whatever condition they develop, they cannot be medically
1141 underwritten and their premium cannot be raised based on their
1142 health condition.

1143 As a result, there is a huge incentive to get the young people

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1144 in the pool and have insurance, because they are keeping the
1145 insurance over a lifetime insurers have a very different view of
1146 them than now. Now they are a 1-year snapshot, they should do
1147 everything they can to avoid costs. If you are looking at them
1148 over a lifetime you want to do the prevention, you want to do the
1149 wellness, you want to take care of them in very different ways.
1150 So this continuous coverage solves the problem of preexisting
1151 conditions by getting them in the pool to begin with and provides
1152 a better foundation for a different kind of medical model.

1153 Mr. Guthrie. Okay, thank you. And Mr. Wieske, you answered
1154 some of these in your testimony but I will just give you a couple
1155 minutes, a minute and a half here to kind of drill down on some
1156 of the things that you said and just point it out again. Can you
1157 compare the market, what the market looked like in your state
1158 before and after the passage of the ACA?

1159 Mr. Wieske. Yes, I think roughly, I mean we actually did
1160 not see any gain in coverage if you look at the numbers, if you
1161 count our exchange folks, the current exchange folks, and then
1162 you look at the high risk pool and you look at the market before.
1163 And so roughly we saw no gain in coverage as a result of Obamacare,
1164 at least the numbers don't bear that out.

1165 And it is important to note that the methodology to calculate
1166 the uninsured changed in 2013 so it is an apple to oranges
1167 comparison to a certain degree. But our market was much more
1168 affordable pre-ACA, there was access to coverage.

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1169 Mr. Guthrie. What were the difference in options before and
1170 after?

1171 Mr. Wieske. Well, we had roughly 25 carriers operating in
1172 the individual market in Wisconsin and along with the high risk
1173 pool and now we have about 15 in the exchange, but if you look
1174 at any particular region we have roughly five at the most, closer
1175 to three. There is only one region where we have one, and I think
1176 three counties where we have two.

1177 So there are fewer choices in our individual market. It is
1178 more costly and the plans are obviously centered, they are sort
1179 of government designed plans rather than having a lot of different
1180 options for --

1181 Mr. Guthrie. But not an increase in coverage?

1182 Mr. Wieske. Pardon me?

1183 Mr. Guthrie. You have fewer options, more costly and not
1184 an increase in coverage?

1185 Mr. Wieske. Correct.

1186 Mr. Guthrie. Thank you. I am out of time. I yield back.

1187 Mr. Burgess. The gentleman yields back. The chair thanks
1188 the gentleman. The chair recognizes the gentleman from New
1189 Jersey, 5 minutes for questions, please.

1190 Mr. Pallone. Thank you, Mr. Chairman. The gentleman from
1191 Kentucky put up that chart and, you know, acting as if when you
1192 repeal the ACA the only thing you are impacting is people who
1193 bought individual policies on the marketplace. But the subject,

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1194 certainly the Walden bill, the chairman's bill today is talking
1195 about standards. He is talking about, you know, preexisting
1196 conditions. That affects over a hundred million people.

1197 There is no reference in this half-baked bill we would assume
1198 because it doesn't put it back in that the essential benefit
1199 package is impacted, which is going to be my question to Mr.
1200 Lichtenfeld. So, you know, I don't understand how you are putting
1201 up that chart and acting as if what we are talking about here today
1202 is just the people in the marketplace. This affects everyone.
1203 The ACA guaranteed an essential benefit package. You start
1204 cutting back on that and offering skeletal or catastrophic plans,
1205 that is going to affect everybody on that chart including those
1206 who have, the majority that have employer-sponsored plans and the
1207 same thing with preexisting conditions.

1208 So, you know, I want everyone to understand. When you start
1209 talking about standards and repealing this bill,
1210 anti-discriminatory practices, essential benefits, this isn't
1211 just the people in the marketplace.

1212 Now Mr. Lichtenfeld, my concern about the Walden draft is
1213 it would not limit in any way what insurers can charge for
1214 insurance. Before the ACA under HIPAA some people were
1215 guaranteed access to non-group policies for which they could not
1216 be turned down nor have preexisting conditions excluded, but there
1217 was no limit on what they could be charged. And left with this
1218 only remaining option for discriminating based on health status,

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1219 insurers charged very high rates for coverage effectively
1220 blocking access for a lot of cancer patients sometimes 2000
1221 percent of standard rates.

1222 So roughly what percent of cancer patients do you think could
1223 afford to pay such highly surcharged premiums, and in your
1224 experience what happens to people who are diagnosed with cancer
1225 who can't afford health insurance? How is their access to
1226 treatment affected?

1227 Dr. Lichtenfeld. What we know at the American Cancer
1228 Society is that we did a considerable amount of research in the
1229 early 2000s to help support our views, shall we say, on the
1230 necessity of insurance. And what we found from that research,
1231 which we can certainly provide to the committee, is that patients
1232 were diagnosed at a later stage and did poorly compared to those
1233 who had insurance.

1234 So we do think that the legislation, the current policy has
1235 enabled patients in order to get access to care. Certainly there
1236 are issues. We recognize that there are imperfections that have
1237 to be worked on. One of our concerns with regard to the essential
1238 health benefits is the reality that we need to make sure that
1239 whatever we do here, whatever the committee in its wisdom decides,
1240 that we have adequate coverage to make sure that patients who have
1241 cancer can get the care they need without the limitations that
1242 might otherwise occur. And clearly affordability is a major
1243 issue. Most patients, it is no secret the majority of patients

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1244 who would be impacted by this discussion today are people who are
1245 age 50 and older. And those folks would have, if they end up in
1246 a situation where there is a high premium and they couldn't afford
1247 it they would be put back in a situation where they would have
1248 difficulty getting the care they need for the illness that they
1249 have.

1250 So in response to your question, these are certainly concerns
1251 that we have and hopefully we will be able to work with the
1252 committee moving forward to address those issues.

1253 Mr. Pallone. Well, thank you, Doctor. You see, my concern
1254 is that when the GOP talk about replacement, what they really want
1255 is competition downward, skeletal, skimpy plans, you know, plans
1256 that -- you know, before the ACA you could buy a plan that didn't
1257 cover prescription drugs or even hospitalization. And, you know,
1258 now we have these essential benefits, but Mr. Walden's draft
1259 assumes to repeal the entire ACA including essential health
1260 benefits. Sixty two percent of plans before we put the ACA in
1261 place lacked maternity coverage, I mean there was all kinds of
1262 exclusions.

1263 And, you know, just give me -- I mean if the ACA benefit
1264 standards were to be repealed how would cancer patients be
1265 affected? I mean they might -- limited doctor visits, much higher
1266 deductibles. I have only got a few seconds, but if you will just
1267 comment. I know you kind of mentioned it.

1268 Dr. Lichtenfeld. Mr. Pallone, I have lived through that

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experience as a physician and I am aware of what happened in the past and we at the American Cancer Society would be very concerned if we went back to that. We hope that there are solutions within the committee that will avoid that and provide -- speaking with my colleague to my right, certainly some states have been excellent. Unfortunately others have not and we had huge problems in the past that we do not want to revisit. Cancer patients really need to know that they have insurance that works. Thank you.

Mr. Pallone. Thank you, sir.

Mr. Burgess. The gentleman yields back. The chair thanks the gentleman. The chair recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for your questions, please.

Mr. Murphy. Thank you, Mr. Chairman. Dr. Lichtenfeld, thanks for your statement on the importance of maintaining preexisting conditions. We all agree with that. Those protections are important and guaranteeing issue is part of Chairman Walden's bill too. We agree that these rating protections are important as well and really look forward to working with in your patient community and the broader chronic condition patient community.

Can you talk about how Medicare Part D could serve as a role model, as a model for how we do this, how we approach this?

Dr. Lichtenfeld. Well, as you are aware, Mr. Murphy, sometimes in some respects Medicare Part D works and in some places

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1294 there have been some difficulties with how it has been applied.
1295 I am not sure that that is necessarily the model. I am not sure
1296 that there is any single model. I think that this is obviously
1297 a work in progress to be discussed and we look forward to
1298 participating in those discussions.

1299 At the end of the day we need to make certain that cancer
1300 patients can afford with regard to Part D, can afford their
1301 medications whether given in the doctor's office, whether they
1302 are bought over the counter or at a pharmacy. Those are critical.
1303 And it is also important to make sure that that coverage is uniform
1304 across the country. That is what we think is --

1305 Mr. Murphy. Dr. Holtz-Eakin, can you comment quickly on
1306 that too, just in a few seconds comment quickly on that question
1307 too about how Part D can serve as a role model on that?

1308 Mr. Holtz-Eakin. I think the Part D program has been
1309 enormously successful because it is built on very strong
1310 competitive pressures and on the ability to have very flexible
1311 plan design. And so we have seen that in the prescription drug
1312 plans competing with one another and offering products that
1313 seniors very much approve of.

1314 Mr. Murphy. Thank you. Mr. Wieske, did Wisconsin -- let
1315 me talk about the high risk pool. So does Wisconsin collect data
1316 on patients who are in these high risk pools by medical condition,
1317 so cancer, certain chronic illnesses and infections, mental
1318 health?

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1319 Mr. Wieske. We did. I served on the board of the high risk
1320 pool. They had extensive information obviously on all the
1321 patients. It was -- and some of them were there for an extended
1322 period of time, others were not. They had an intensive care
1323 management. So it was a very high risk, number of high risk
1324 conditions.

1325 Mr. Murphy. I am wondering how deep you could dive into that
1326 data. So Kaiser tells us about in terms of the number of people
1327 who remain in the high risk pool about 45 percent are in their
1328 second year. Many have acute conditions and get better.

1329 And whether it is a chronic condition like cancer or, you
1330 know, the short term ones, maternity, and other complications like
1331 mental health, did you do a deeper dive when multiple illnesses
1332 occurred to see who were those people who were the big over
1333 utilizers by behaviors or high utilizers by medical conditions,
1334 so we can help analyze what are the differences there?

1335 Mr. Wieske. Yes. In short, yes. There weren't a lot of
1336 incentives. There were deductibles that attached. I think the
1337 lowest was \$1,000 deductible. So there were specific efforts
1338 made to deal with high utilizers that were utilizing
1339 inappropriately in contacts from the administrator. But
1340 most of the folks on the high risk pool were there about 3 to 4
1341 years. They had specific medical conditions. Presumably they
1342 were covered or had group coverage at the end of their --

1343 Mr. Murphy. So here is an issue in where I think both sides

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1344 of the aisle can agree that when you have a high deductible which
1345 is meant to discourage people from overutilizing the system that
1346 may work in some cases to keep people from running to the emergency
1347 room for every problem. On the other hand it hurts people from
1348 going to get medical care when they need it early on, which Dr.
1349 Lichtenfeld was describing the person for early stage cancer.

1350 I am particularly concerned here about such things as the
1351 mental health disorders. Generally a person with serious mental
1352 illness goes 60 to 80 weeks and adults longer between first
1353 symptoms and first treatment. And those complications were for
1354 example in Medicaid, five percent of Medicaid patients it is 55
1355 percent of Medicaid spending and virtually all of those have a
1356 concurrent mental health problem. Your state has gone above and
1357 beyond the numbers in terms of mental health parity.

1358 Mr. Wieske. Right.

1359 Mr. Murphy. Have you looked at that also as an issue in terms
1360 of having parity and making sure people are getting concurrent
1361 mental health services whether they start with a chronic illness
1362 or start with a mental illness that does something to help drive
1363 down costs?

1364 Mr. Wieske. Well, I think we have done a number of efforts
1365 I think both through the Medicaid program has done a fabulous job
1366 of working through that. I think we have new efforts related to
1367 the opioid issue which has gotten more attention and certainly
1368 in the opioid task force.

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1369 There are a number of issues that we get to, but I think you
1370 are exactly right that there is this management in reflection of
1371 that this is an illness like any other illness and you need to
1372 treat it as such is sort of ingrained in Wisconsin.

1373 We have had mandates that attached mental health for decades,
1374 so while we have some mental health parity that applies we also
1375 have requirements that go back into the 1980s. We have had mental
1376 health coverage since the 1980s.

1377 Mr. Murphy. Well, I might take issue with you when you say
1378 Medicaid has done a fabulous job on that because we have had a
1379 lot of problems this committee has discussed. But I mentioned
1380 Wisconsin's data because we have seen from private markets and
1381 others that when private companies insure and they make sure their
1382 employees are covered with mental health benefits and
1383 concurrently looking at the impact, the cross pollination here
1384 of chronic illness and mental illness, cancer is an example of
1385 that -- high rate of depression, anxiety, panic -- it drives people
1386 back to the emergency room versus if a doctor is working with them,
1387 so a lot of serious concerns there.

1388 If you are able to give us more data on that or if you and
1389 I could sit down and talk about that, the same with Dr. Holtz-Eakin
1390 and Dr. Lichtenfeld, I would love to talk to you. This is an area
1391 where I have got to believe both sides of this committee can agree
1392 we can work on more effective health care and driving down costs.

1393 I realize I am out of time, Mr. Chairman. Thank you for

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1394 indulging me.

1395 Mr. Burgess. The chair thanks the gentleman. The
1396 gentleman yields back. The chair recognizes the gentlelady from
1397 Illinois, Ms. Schakowsky, 5 minutes for questions, please.

1398 Ms. Schakowsky. Thank you, Mr. Chairman. My colleagues on
1399 the other side of the aisle claim to be concerned with, quote,
1400 protecting infant lives, unquote, which is what they called their
1401 panel last year that investigated Planned Parenthood and failed
1402 to prove any wrongdoing. But we know full well that that panel
1403 was created to attack women's health choices and not protect
1404 infant lives.

1405 But because it actually comes to protecting infant lives,
1406 when it actually comes to protecting infant lives Republicans are
1407 happy to put insurance companies back in charge, allow them to
1408 reinstate lifetime caps on coverage and medical underwriting.
1409 This would directly impact some of the most fragile and vulnerable
1410 patients in our country including premature infants, infants with
1411 congenital abnormalities and their families.

1412 So I would like to enter into the record an article featured
1413 on Slate called Our Insurance Paid \$2.5 Million to Keep Our Child
1414 Alive.

1415 Mr. Burgess. Would the gentlelady yield? Is that a
1416 unanimous consent request?

1417 Ms. Schakowsky. Yes.

1418 Mr. Burgess. Without objection, so ordered.

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1419 [The information follows:]

1420

1421 *****COMMITTEE INSERT 12*****

1422 Ms. Schakowsky. The author explained that her child was
1423 born with congenital defects and their family accrued \$2.5 million
1424 in medical bills by the time that child was 3 years old. This
1425 by the way to make our Ranking Member Pallone's point, they had
1426 employer-based coverage and the benefit package made sure that
1427 they were covered.

1428 And should Republicans have their way and reinstate lifetime
1429 caps on insurance coverage this child might already have reached
1430 her lifetime limit on coverage at the age of 3 and would be forced
1431 to pay all of her future care out-of-pocket if they could possibly
1432 afford it. Because of the ACA, more than 27 million children have
1433 benefitted from the ban on lifetime caps and overall more than
1434 105 million Americans have benefitted.

1435 Before the ACA, 89 percent of insurance plans included a
1436 lifetime limit on benefits. To add insult to injury, under
1437 Chairman Walden's bill this child may be subjected to an
1438 astronomical premium cost for the rest of her live based on her
1439 preexisting condition from birth.

1440 Let me ask you, Dr. Lichtenfeld, what does it mean for
1441 premature infants or children born with congenital abnormalities
1442 if these conditions are once again permitted to be medically
1443 underwritten?

1444 Dr. Lichtenfeld. Well, obviously when speaking about that
1445 specific issue those costs can rise rapidly and last for a
1446 lifetime, and we are concerned on behalf of cancer patients that

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1447 lifetime caps or annual caps or whatever caps might in fact limit
1448 the treatment they receive.

1449 When you deal particularly in the cancer world with young
1450 people with cancer whether they be children, whether they be young
1451 adults, there is a very real issue about the cost of their care
1452 over time. And if in fact they become rated within the insurance
1453 market going forward as they age that would become obviously a
1454 very serious burden.

1455 Ms. Schakowsky. Have you seen that in your practice of young
1456 people who actually either have or live in fear of these lifetime
1457 caps?

1458 Dr. Lichtenfeld. Before the ACA it was a real problem and
1459 people even within organizations that I am familiar with would
1460 run up against, you know, and group insurance, would run up against
1461 caps and that would be a serious issue particularly patients for
1462 example with bone marrow transplants.

1463 When you talk about young people it is definitely, I can speak
1464 on information from the bone marrow transplant community, the
1465 financial toxicity of that care and the inability to work going
1466 forward for many of these young folks is a very real issue. And
1467 we do believe that that is something that needs attention as this
1468 again as this process moves forward.

1469 Ms. Schakowsky. And so once the ACA passed did you see then
1470 an improvement in those situations?

1471 Dr. Lichtenfeld. We do believe there was an improvement.

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1472 It certainly removed the major concern that cancer patients have.
1473 We talk a lot these days about financial toxicity. We talk about
1474 the stress. We talk about mental health issues as was brought
1475 up --

1476 Ms. Schakowsky. What is your phrase, financial --

1477 Dr. Lichtenfeld. Financial toxicity.

1478 Ms. Schakowsky. That is what I thought.

1479 Dr. Lichtenfeld. It is a very real issue within the cancer
1480 community, the high cost of drugs, the high cost of care, the
1481 deductibles, the co-pays, whatever it may be, caps is clearly
1482 something that is part of that conversation.

1483 Ms. Schakowsky. Have you seen Chairman Walden's bill and
1484 how it would impact children or adults that have cancer?

1485 Dr. Lichtenfeld. Well, you know, to be honest with you again
1486 that is, there are things that are in the bill and things that
1487 are not in the bill so we still have a ways to go. So rather than
1488 supposing what is going to be offered, I would rather defer that
1489 until we have more information.

1490 Ms. Schakowsky. Okay, thank you. And I yield back.

1491 Mr. Burgess. The gentlelady yields back. The chair thanks
1492 the gentlelady. The chair recognizes the gentleman from New
1493 Jersey, Mr. Lance, 5 minutes for your questions, please.

1494 Mr. Lance. Thank you very much, and good morning to the
1495 panel and I apologize for not being here for all of your testimony.
1496 We are shuttling back and forth between two subcommittees.

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1497 To Mr. Holtz-Eakin, thank you for being here. In your
1498 testimony you mentioned that the individual mandate was an
1499 ineffective mechanism to encourage the enrollment of young people
1500 in the exchanges. In what ways is the continuous coverage concept
1501 a more effective tool to engage people to gain and maintain health
1502 insurance coverage?

1503 Mr. Holtz-Eakin. It is a natural and economic incentive and
1504 health incentive. You know, most of the replacement plans that
1505 have been offered that we have looked at would maintain the
1506 provision under current law where you can stay on your parents'
1507 policy until you are 26.

1508 At that point a young person who recognizes they are cheap
1509 to insure so it is easy for them to get insurance, they may develop,
1510 may not be medically underwritten so they aren't going to get their
1511 premiums jacked up because of their health, that is a real
1512 incentive to get in early. That broadens the risk pool and when
1513 people do develop conditions you have both the high risks and the
1514 low risks in the pool. That is always the goal in insurance.

1515 Mr. Lance. Would others on the panel like to comment on
1516 that?

1517 Dr. Lichtenfeld. I would, thank you.

1518 Mr. Lance. Certainly.

1519 Dr. Lichtenfeld. You know, the continuous coverage issue
1520 is one that is obviously again under discussion, but our concern
1521 at the American Cancer Society is and on behalf of our

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1522 constituents, of our patients, is the details of what happens
1523 because the risk is very real.

1524 I mean what -- you know, no one again expects to get cancer,
1525 and sometimes when it happens it happens very quickly and it
1526 absorbs people and they can lose their jobs and then they might
1527 lose their insurance and then they enter the market under the
1528 proposals and they may be rated at a premium they can't afford.

1529 So how the committee addresses this going forward again is
1530 a major concern of ours to get it right, to make sure that the
1531 rules are appropriate and that people who get a sudden illness
1532 may not be capable of dealing with a continuous coverage provision
1533 of 30 days, for example, are able to have some leeway and
1534 understanding that meets their needs at their particular time.

1535 Mr. Lance. I certainly agree that we want to get it right.
1536 It is just my concern that young people have not been involved
1537 to the extent we would like them to be involved. And we want to
1538 repair the ACA and I have never favored its repeal without a
1539 replacement. I think it needs to be repaired and we are trying
1540 to focus on repairing it and that is why we are conducting this
1541 hearing along with other hearings.

1542 To the commissioner, given your background as a state
1543 insurance commissioner, could you speak to some of the effects
1544 you have seen at the state level regarding the 3:1 age band,
1545 special enrollment periods and the 90-day grace period?

1546 Mr. Wieske. I think you can see in our testimony that the

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1547 impact of cost, the increases have been borne by the young which
1548 has made it unaffordable, just caused the risk pool to deteriorate
1549 which has caused, you know, sort of a death spiral.

1550 We have seen consistent changes from the insurers in the
1551 areas that they are covering. There is a lot of chaos. We had
1552 37,000 folks that lost coverage from their particular insurer in
1553 Wisconsin last year which pales in comparison to the 100,000 in
1554 Minnesota that lost their coverage last year. So there have been
1555 pronounced effects.

1556 You know, the problem with the SEP process is it is confusing
1557 for consumers, it doesn't make, you know, the current one it
1558 doesn't make any sense. It is harm to insurers. If you use magic
1559 words that go into the, with HHS you get your SEP. If you don't
1560 use the right magic words even if you deserve it you don't get
1561 an SEP. That has been a consistent problem when it is done at
1562 the federal level, so there has been problems. We would like to
1563 see it go back to the companies to administer.

1564 Mr. Lance. Dr. Holtz-Eakin, would you care to comment on
1565 that please?

1566 Mr. Holtz-Eakin. I think all the evidence that we have seen
1567 on it and summarized in my written testimony suggests that this
1568 is exactly right. It is not just a Wisconsin problem, this is
1569 a pervasive problem. It is worse in the risk pool and it has had
1570 the insurers unable to price things effectively.

1571 Mr. Lance. And I hope that the American people who are

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1572 undoubtedly listening to our deliberations recognize that there
1573 has been this type of terrible situation across the country not
1574 only in Wisconsin and Minnesota but in other states as well. And
1575 the goal of the ACA was a good goal and the question is how to
1576 achieve that goal in the most effective and efficient manner
1577 recognizing that we want no one to be discriminated against, for
1578 example, based upon a preexisting condition. I yield back 5
1579 seconds, Mr. Chairman.

1580 Mr. Burgess. The chair thanks the gentleman. Before we go
1581 to our next question, the chair would ask that members on both
1582 sides of the dais who are engaged in conversations be mindful of
1583 the fact that I think Mr. Griffith of Virginia is hard of hearing
1584 and he is having difficulty in keeping up with the important
1585 discussions going on. So the chair would ask that side
1586 conversations be taken off the dais or kept to a minimum.

1587 The chair now recognizes the gentleman from North Carolina,
1588 Mr. Butterfield, 5 minutes for questions.

1589 Mr. Butterfield. Thank you very much, Mr. Chairman, for
1590 yielding time. Let me begin, Mr. Chairman, by just echoing some
1591 of the sentiments that were expressed by Ranking Member Pallone
1592 at the outset of this hearing. I share those concerns. This
1593 topic is very perplexing and very difficult for us to grapple.

1594 We hear different terminology as we have this debate. I hear
1595 Mr. Lance talk about repairing the ACA and I hear others talk about
1596 repealing the ACA, and so I am still trying to grapple with what

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1597 we are talking about today. This appears to be another hearing
1598 to discuss Republican plans to change the health care system and
1599 reduce people's access to care and to make health care more
1600 expensive. That is the way it appears to me.

1601 You are trying to enact these changes that will actually make
1602 health care more expensive for low-income individuals and
1603 children and families and older Americans. After 7 years of
1604 complaining about the ACA and actively trying to disrupt by
1605 ripping it apart and causing it to fail, it is disheartening now
1606 to see a plan that is half written and incomplete. I expect more.
1607 I think the American people expect more.

1608 And I will say what my colleagues have said repeatedly, we
1609 are prepared and willing to work with you to improve the Affordable
1610 Care Act, make no mistake about it. This is the second day we
1611 have been in this room discussing ways to make it harder for people
1612 to access health care.

1613 I represent one of the poorest districts in the country in
1614 North Carolina where nearly one in four people live in poverty.
1615 Every day I hear from constituents about increasing access to
1616 health care, not decreasing it. Many of my constituents talk to
1617 me about expanding Medicaid and strengthening the ACA not making
1618 it harder to access health care.

1619 My constituents overwhelmingly, Mr. Chairman -- maybe I
1620 spent too many years in a courtroom, Mr. Chairman. If the
1621 committee will come to order.

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1622 Mr. Burgess. The gentleman from North Carolina is correct.

1623 Mr. Butterfield. Yes.

1624 Mr. Burgess. The committee does need to be respectful to
1625 the people who are speaking. Can I ask the committee to come to
1626 order?

1627 Mr. Butterfield. My constituents, Mr. Chairman --

1628 Mr. Burgess. The gentleman continues suspend.

1629 Mr. Butterfield. Thank you. I guess I was spoiled by being
1630 in the courtroom, Mr. Chairman.

1631 Mr. Burgess. The gentleman may proceed.

1632 Mr. Butterfield. My constituents, Mr. Chairman,
1633 overwhelmingly support our new governor in North Carolina who is
1634 doing all that he can to expand Medicaid. In my district the
1635 uninsured rate has been cut by one-quarter. More than 35,000
1636 people have insurance as a result of the ACA. Across the country
1637 20 million people have obtained health insurance since 2010. The
1638 uninsured rate in our country is at an all-time low. That is a
1639 fact.

1640 I could talk for hours about the statistics that show North
1641 Carolinians and Americans are better off because of the ACA. Our
1642 health care system is better off because of it. It could be in
1643 an even better situation if detractors had not consistently fought
1644 it at every turn.

1645 Now Republicans want to turn back the clock. They want to
1646 put insurance companies back in charge of health care, make it

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1647 more difficult to keep your health care plan and make it more
1648 expensive for many Americans to pay for health care.

1649 Chairman Burgess, I agree with your comments yesterday that
1650 seemed to indicate that this committee has gotten off on the wrong
1651 foot. I believe it has. Democrats will not stand idly by while
1652 we are forced to consider proposals that will restrict access to
1653 health care. Mr. Chairman, I have received a letter from AARP
1654 which supports the positions that I have just articulated. I
1655 would ask unanimous consent that it be included in the record.

1656 Mr. Burgess. Without objection, so ordered.

1657 [The information follows:]

1658

1659 *****COMMITTEE INSERT 13*****

1660 Mr. Butterfield. All right, I have 1 minute remaining. Dr.
1661 Lichtenfeld, thank you for your testimony in support of many of
1662 the improvements to our system made by the ACA. Many of my
1663 constituents in eastern North Carolina are from minority groups,
1664 racial minority groups.

1665 Can you discuss some of the cancer health disparities
1666 experienced by ethnic and African Americans and Hispanic
1667 Americans and would some of the potential changes to our health
1668 care system discussed today further exacerbate these disparities?

1669 Dr. Lichtenfeld. Well, Mr. Butterfield, thank you for your
1670 question. I mean there is no question that ethnicity plays a role
1671 in access to care and there is also no question that socioeconomic
1672 status plays a role in access to care. Making certain that all
1673 individuals have appropriate access to affordable care that meets
1674 their needs particularly for cancer patients is so important.

1675 I have lived in a rural area. I have experienced and seen
1676 the issue. I am in a state that did not expand Medicaid as have
1677 19 other states have not done so, and what the evidence is showing
1678 us is that access to care through insurance by whatever mechanism
1679 is important to reduce the burden of cancer.

1680 So we are aware of that. We are hopeful in the committee
1681 going forward will address that issue as well.

1682 Mr. Butterfield. Thank you, Doctor, and thank you, Mr.
1683 Chairman. I yield back.

1684 Mr. Burgess. The chair thanks the gentleman. The

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1685 gentleman yields back. The chair now recognizes the gentleman
1686 from Oregon, the chairman of the full committee, Mr. Walden, 5
1687 minutes for your questions, please.

1688 The Chairman. Well, I thank the chairman. And I have been
1689 listening to the various comments and the testimony and let me
1690 say again, this is a discussion draft. It is not a finalized bill.
1691 We are not coming here to cram something through that nobody has
1692 had a chance to have input on or read. I thought that is what
1693 you wanted. It is what I want. And so there are some
1694 opportunities to weigh in. That is what a -- this may be unusual
1695 for some, but that is kind of what a legislative process is
1696 supposed to look like. And I will tell you what. I read all your
1697 testimony and I appreciate it from a lot of levels. I have heard
1698 some of the things hurled my way. I don't want lifetime caps.
1699 I care pretty deeply about older people and younger people
1700 including infants, very personal place.

1701 And I have seen markets that work and markets that don't.
1702 I fought on insurance companies when they were denying care and
1703 shouldn't. I fought to create high risk pools when in my home
1704 state you didn't have the fix on a preexisting condition. I have
1705 seen cancer up close. My mother died of ovarian cancer, my
1706 sister-in-law, brain cancer. Like many of you, you or people in
1707 your families or in your communities deal with this. The notion
1708 that somehow because there is a break in the dais we don't care
1709 about getting this right is beyond the pale.

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1710 So I hope going forward we can have a really constructive
1711 discussion here about how to make this bill work, how to make sure
1712 regardless of what we or some other Congress does going forward
1713 that if you had a preexisting condition you will always have access
1714 to care and that there won't be some artificial cap that says
1715 through no fault of your own you have a disease that keeps coming
1716 at you, but sorry, you are on your own and you are destitute. That
1717 is not the choice here. The choice is how do we get it right.

1718 The notion that this individual market is in a wonderful
1719 place is a fiction. All you have to do is listen to the experts
1720 that are out there and they will tell you this can't survive the
1721 way it is today. If Hillary Clinton were in the White House and
1722 Democrats controlled everything, I tell you, you would be back
1723 because just like we had to deal with other problems over the
1724 years, just like the laws that have been passed and voted on by
1725 Republicans and Democrats to deal with problems in Obamacare, we
1726 are going to repeal this and we are going to come back with a plan
1727 that will work for everybody. Now I want to ask the
1728 gentleman from Wisconsin, reading your testimony it was pretty
1729 evident you had a market that was working, not perfect but working.
1730 Tell me what happened when the ACA came down on top of what your
1731 state was doing and tell me this too. Is it possible for us here
1732 to pass this piece of legislation as appropriately written that
1733 will guarantee people have access to care of their preexisting
1734 conditions and that there won't be caps on lifetime coverage and

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1735 could you still put together a market with those two conditions?

1736 Mr. Wieske. We can in Wisconsin. I feel confident that --
1737 I mean we still have 15 insurers in the marketplace, in the market
1738 and selling insurance through the exchange. We have another six
1739 or seven that are selling off-exchange. We think that those will
1740 step up more to the plate if the rules reflect the actual costs.

1741 We have had a number of significant market exits. We think
1742 we can get them to return if the market rules are more reasonable
1743 across the country. It is not our rules that are the problem it
1744 is the federal rules. They are losing money. We have seen
1745 significant, if you talk to our financial folks you have seen
1746 significant loss of capital inside the insurers that will never
1747 return under this environment and that is why they are leaving
1748 the individual market.

1749 The individual market is a residual market as was shown in
1750 the slides. It is roughly, you know, seven percent, five percent
1751 of any state's market. It is very small and it is leading the
1752 losses and that is why they are exiting the market. That is what
1753 is causing the issue.

1754 So I think a return to that if it returned to market
1755 principles with appropriate consumer protections that the market
1756 will return. It will take some time. Kentucky destroyed their
1757 market in the 1990s. It eventually came back. And so I think
1758 it will come back, yes.

1759 The Chairman. Mr. Holtz-Eakin, do you agree with that

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1760 concept?

1761 Mr. Holtz-Eakin. I do agree with that. I think there is
1762 a lot of evidence that you can put in place sensible market rules
1763 and have vibrant individual markets. We don't right now, but it
1764 can be done.

1765 The Chairman. I know I have used up my time, Mr. Chairman,
1766 unless the doctor wants to respond. I would be happy to get his
1767 additional comments as well.

1768 Dr. Lichtenfeld. Thank you. Thank you, Mr. Chairman, I
1769 appreciate that.

1770 Mr. Burgess. Proceed.

1771 Dr. Lichtenfeld. You know, we sit here and we talk in
1772 certain words such as market principles, and I understand that.
1773 I accept that and that is not the problem. But when market
1774 principles get in the way with people having affordable care
1775 particularly the older people, then we run into difficulty.

1776 The Chairman. Right.

1777 Dr. Lichtenfeld. So as you said and I said earlier in my
1778 testimony or in my comments, this is a work in progress,
1779 understood, here to help try to meet a resolution.

1780 The Chairman. We appreciate that.

1781 Dr. Lichtenfeld. That is what we are aiming for so that we
1782 don't run into the problem where a principle becomes a barrier
1783 that then prevents people from getting access to care.

1784 The Chairman. Right, thank you. Thank you for your

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1785 indulgence and your help.

1786 Mr. Burgess. The chair thanks the gentleman. The
1787 gentleman yields back. The chair now recognizes the gentlelady
1788 from California, Ms. Matsui, 5 minutes for your questions, please.

1789 Ms. Matsui. Thank you, Mr. Chairman. When we started
1790 writing the ACA over 7 years ago, I consulted with a full range
1791 of health care leaders in my community in Sacramento. We called
1792 together the hospitals, the health plans, the community health
1793 centers, the patients, and all those that contribute to our health
1794 care systems. Everything was fully constructed because we knew
1795 that each policy affected the next and the system as a whole.

1796 We all know that health care is complicated. You can't
1797 simply consider these changes in a vacuum. The Republicans have
1798 been saying for almost 7 years that they have a better way, but
1799 what we have seen today does not protect people. It really does
1800 take coverage away.

1801 One of the bills shortens grace periods to 30 days, which
1802 means that if someone misses just 1 month's premium payment they
1803 can be kicked off of their health plan. For many workers with
1804 fluctuating income they may need to forego a payment 1 month in
1805 order to put food on the table and then pay it back the next when
1806 they receive their paycheck. Now if getting kicked off your
1807 plan wasn't bad enough, the second policy kicks, which says, or
1808 we assume it will say that you must maintain continuous coverage
1809 or else insurance companies will charge whatever they want the

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1810 next time you sign up. If they know you are sick they could offer
1811 you a plan but only if you paid thousands of dollars a month and
1812 what good is that? So now if a person ever misses even a single
1813 payment they could be locked out of receiving health coverage for
1814 years or even for life.

1815 Now we talk here in statistics and charts and things like
1816 that and that is very important. But I think we have to all
1817 understand that health care is very personal, to all of us here
1818 it is personal. Chairman Walden mentioned how personal it is to
1819 him with his mother having ovarian cancer. My mother had ovarian
1820 cancer. Many people here have had individuals with lymphoma,
1821 blood cancer. It is very personal. And I think to a certain
1822 degree we have to understand that there is certain diseases like
1823 cancer that may hit you with such a shock at the very beginning
1824 and you have to figure out what you are going to be doing next.

1825 So this is really a journey for most people with cancer is
1826 that type of disease. So Dr. Lichtenfeld, in your experience,
1827 do cancer patients often spend a lot of time with their doctors
1828 and care teams to help get them well?

1829 Dr. Lichtenfeld. I am sorry. Can you rephrase the question
1830 again? I may have missed it.

1831 Ms. Matsui. Do your patients, cancer patients, often spend
1832 a lot of time with their doctors and their care teams to try to
1833 figure out what to do next, how to get them well?

1834 Dr. Lichtenfeld. Cancer is a complex disease and there is

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1835 no question that the most important objective is to get the patient
1836 well and that takes time, it takes effort and it takes teams.
1837 There are, as I mentioned earlier there is increased attention
1838 to mental health issues with respect to cancer, financial toxicity
1839 issues, which are above and beyond the care discussion, and there
1840 are now requirements being put into place that expect that type
1841 of discussion.

1842 So yes, I mean it is not a simple process. It is complex.
1843 It is much more complex as time goes on. The drugs are more
1844 complex, the treatment, trying to help people get to the
1845 treatment, all of these are issues that have to be addressed as
1846 part of the cancer journey.

1847 Ms. Matsui. So during this process do cancer treatments
1848 like chemotherapy have side effects that make it hard for patients
1849 to accomplish daily tasks?

1850 Dr. Lichtenfeld. There is no question that the treatment
1851 is toxic for many situations and the fact that many patients are
1852 so impacted. I mean the fatigue issues are well known, the
1853 ability to work, whether someone, as I mentioned earlier the
1854 substantial number of people are not able to work. Meeting
1855 payment requirement is important, but yet perhaps the 30 days is
1856 not the right number that we should be talking about.

1857 Ms. Matsui. So cancer patients don't get a pass at all on
1858 taking care of the finances.

1859 Dr. Lichtenfeld. No, they don't get a pass. So I think we

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1860 have to look through that cancer lens to understand the
1861 implications of what we do, and understanding it through that lens
1862 will give us guidance, we believe, in terms of how this should
1863 be constructed going forward.

1864 Ms. Matsui. So it is possible that a cancer patient has to
1865 deal with so much that even when a loved one is managing their
1866 affairs a month's payment can be overlooked?

1867 Dr. Lichtenfeld. It is incredibly complex. We have many
1868 life situations that are complex and cancer is certainly one of
1869 the most complex that we have to deal with.

1870 Ms. Matsui. So if that patient is kicked off their plan for
1871 missing one payment what happens to that patient?

1872 Dr. Lichtenfeld. Well, they end up, whether they could get
1873 the care the care would be interrupted, and then when they come
1874 back into the system so to speak their premiums under some
1875 discussions may be much higher than they would have been otherwise
1876 and that may last a lifetime.

1877 Ms. Matsui. Okay. I yield back.

1878 Mr. Burgess. The gentlelady yields back. The chair thanks
1879 the gentlelady. The chair recognizes the gentleman from
1880 Virginia, Mr. Griffith, 5 minutes for your questions, please.

1881 Mr. Griffith. Thank you very much, Mr. Chairman. I have
1882 heard a lot of folks talk about things and what their constituents
1883 are telling them. And while I have constituents who certainly
1884 have liked the ACA, a vast majority of my constituents have had

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1885 problems similar to Mark from Stuart, Virginia, who writes in part
1886 talking about the increased premiums that he has had to pay. He
1887 says it has cost my family around \$21,000 over the last 3 years.

1888 He goes on to say, I would like nothing more than to see this
1889 law repealed as fast as possible and relegated to the trash heap
1890 of history. He goes further, please be responsible in what it
1891 is replaced with and make sure it consists of common sense measures
1892 that will help, not hurt, middle class families.

1893 And I think that is why we are here. We are trying to figure
1894 out how we can do things that balance it out which is why, Mr.
1895 Wieske, I want to talk to you about the high risk pools that were
1896 successful in your state. How many people did you all cover?

1897 Mr. Wieske. Roughly 25,000.

1898 Mr. Griffith. Okay. And what rates were you able to offer
1899 these patients? I know you said they were affordable but just
1900 give me some idea of what they were.

1901 Mr. Wieske. They varied, so the deductibles varied from
1902 \$1,000 deductible all the way up to a \$7,500 deductible. I
1903 believe the rates for the typical, in my testimony I compared it
1904 to the rates that what a Silver Plan would be and it was a little
1905 bit lower than what the ACA plans are in Wisconsin currently.

1906 Mr. Griffith. Okay.

1907 Mr. Wieske. So roughly about depending on, it varied based
1908 on age so between 200 and \$500 roughly.

1909 Mr. Griffith. Okay. And I thought it was interesting you

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1910 said that 40 percent was paid by the insured, 30 percent by the
1911 insurers, 30 percent by the medical folks taking some discounts
1912 --

1913 Mr. Wieske. Correct.

1914 Mr. Griffith. -- but then at one point I thought I heard
1915 you say there was also some private money?

1916 Mr. Wieske. There were subsidies that were also included
1917 as part of those assessments. So consumers who had, or members
1918 who had incomes at or below \$34,000 received subsidies, at the
1919 lowest end was up to a 43 percent subsidy on the premiums.

1920 Mr. Griffith. And the subsidy came from?

1921 Mr. Wieske. It came from the high risk pool.

1922 Mr. Griffith. It came from the high risk pool.

1923 Mr. Wieske. The high risk pool funds, yes.

1924 Mr. Griffith. Okay, so that would have been some state
1925 money?

1926 Mr. Wieske. No state money. There was no state money at
1927 that time.

1928 Mr. Griffith. Explain that to me. It came from the high
1929 risk, was that the insurers?

1930 Mr. Wieske. It was the insurers and the providers, the
1931 discounts. So they were able to provide --

1932 Mr. Griffith. So that was part of the 40/30/30 that you were
1933 talking about?

1934 Mr. Wieske. Correct, right.

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1935 Mr. Griffith. All right. And I think you have already
1936 answered it was not a one size fits all? You could make some
1937 choices within the high risk pool itself?

1938 Mr. Wieske. Yes, yes.

1939 Mr. Griffith. All right, so we are trying to figure out how
1940 to craft which is why, you know, it is interesting. I have heard
1941 some criticism that Chairman Walden's bill has a placeholder in
1942 it, but we are trying to figure out exactly, you know, what we
1943 can do to make this and get all the ideas, Democrat and Republican.

1944 So what in your opinion, if we are going to set up a high
1945 risk pool what are the most important factors to consider when
1946 states design these high risk pools? When we say to the states
1947 if we decide that is where we want to go, what should the states
1948 be doing to make their high risk pools work as yours did?

1949 Mr. Wieske. Yes, I think affordability is the key. I think
1950 having a good partnership between the providers and the insurers
1951 and having a strong board that is interested in governing, a
1952 long-term board. It was outside of the -- it was a
1953 quasi-governmental entity that ran the high risk pool. I think
1954 that was effective. They hired outside experts.

1955 They had, instead of taking the claims in-house they hired
1956 an administrator. They had a great administrator who did great
1957 work. So I think having a strong structure in place is the most
1958 important piece and then having the funding mechanism that is
1959 stable.

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1960 Mr. Griffith. All right. And, you know, one of the things
1961 that I had thought we might have to do, but you all didn't have
1962 any state money, do you think we need to at least prime the pump
1963 so to speak and have some federal money to help the states get
1964 their high risk pools started, or do you think they can take your
1965 model and not have any federal money?

1966 Mr. Wieske. I think you see if you look at the federal, so
1967 early on the ACA did include funding for high risk pools, and I
1968 think if you look at the premiums for that they dropped
1969 considerably. There was about a 150-\$200 drop depending on the
1970 age in premiums. So I think federal funding could certainly help
1971 make that coverage much more affordable.

1972 And again I will say that high risk pools are not for every
1973 state so there may have to be other options like re-insurance
1974 schemes or, you know, maybe some states do want to do guaranteed
1975 issue, but we found high risk pools effective.

1976 Mr. Griffith. Okay, I really do appreciate that. You know,
1977 this is a tough nut to crack on all those bills that we are
1978 considering, not only the ones for today but other bills you see
1979 us considering. All three of the witnesses, if you would please
1980 let us know.

1981 I mean I am making suggestions to Chairman Walden's team to
1982 make some improvements on his bill that I think might need to be
1983 in there, but we encourage you to let us know what you see and
1984 what you think you can do because we are looking for constructive

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1985 criticism. We want to take the time to get this right for the
1986 American people, and so as Mark from Stuart said to make that we
1987 are helping folks and not hurting middle class families in
1988 America. But thank you so much for being here today. I yield
1989 back.

1990 Mr. Burgess. The chair thanks the gentleman. The
1991 gentleman yields back. The chair now recognizes the gentlelady
1992 from Florida, Ms. Castor, 5 minutes for your questions, please.

1993 Ms. Castor. Well, thank you, Mr. Chairman, and thank you
1994 to the witnesses for being here. I wanted to make sure that we
1995 go back again to the point because we have the chart that was up
1996 on the screen and the impression that may have been left that
1997 repealing the ACA applies just to the healthcare.gov marketplace.

1998 And I think folks really need to understand that when you
1999 repeal the ACA as my Republicans are on track to do that affects
2000 all Americans, everyone. Medicare, Medicaid, or the folks, the
2001 20 million Americans who did get coverage under healthcare.gov,
2002 the marketplace -- and in Florida that was 1.7 million, larger
2003 than the population of some states have enrolled in the
2004 marketplace in Florida -- but the employer based insurers where
2005 most of our neighbors get their insurance.

2006 There are vital consumer protections that have improved the
2007 lives of our neighbors and you simply can't gloss over that or
2008 ignore it and people need to really understand what they have
2009 gained, and Florida is a great place to look. In Florida we have

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2010 8.8 million that have their insurance through their job that means
2011 that all of those folks can no longer be discriminated against
2012 if they have a preexisting condition like cancer, diabetes,
2013 asthma, heart disease -- we estimate that that is about 7 million
2014 Floridians.

2015 Under the Affordable Care Act, under your private policy your
2016 kids can stay on your policy until they are 26 years old.
2017 Insurance companies cannot cancel your policy if you get sick and
2018 they can't impose lifetime limits or caps. All of that will be
2019 lost under the ACA Republican appeal plan. These consumer
2020 protections have been a godsend to our neighbors.

2021 And let's talk a little bit about cost because I am very,
2022 I am sensitive to the fact that the markets are different across
2023 the country, but you can't deny that before the ACA health care
2024 costs were out of control. And if you look just in my state, the
2025 ACA has generated significant savings for Florida families.

2026 And we have got to do more to control the cost. If we can
2027 really tackle pharmaceutical costs that would be a great help for
2028 families. I don't see any bills on the agenda today that do that
2029 but that would be very positive. Florida families with employer
2030 coverage saw their premiums grow only 1.3 percent from 2010 to
2031 2015 compared to 8.2 percent over the previous decade before the
2032 Affordable Care Act. That means if you look at it in real dollars
2033 a savings of about \$7,600 per family.

2034 The ACA also requires, and this doesn't get a lot of play

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but it is very important. The ACA also requires health insurance companies to spend at least 80 percent of their premium dollars on actual health care, not administrative costs or profits, and if the insurance companies go over that 80 percent they have to -- consumers get a refund. HHS reports that Floridians with employer coverage have received \$109 million in refunds since 2012. That really makes a difference for the working families I represent.

So one of the bills that is on the agenda for discussion today is age rating. Boy, have you really hit a nerve back in Florida to ask that our older neighbors, and we are talking about those that are under 65, are going to pay a whole lot more for their insurance coverage.

The thing about the Affordable Care Act, it is this very considered, thoughtful balance. Over time it is going to need rebalancing. Like I said, markets like mine are very competitive even in the individual market with 61 plans to choose from. Not all parts of the country are like that. But if you start tinkering here and asking my older neighbors to pay a whole lot more before they go into Medicare that is not smart. We want them to be as healthy as possible before they go into Medicare because we have our challenges there as well.

So watch out for this age rating, and I go back to the woman that I mentioned during my opening remarks who is 60 years old, working part-time in a small business, taking care of her

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2060 youngster in high school, going to school. You ask her to pay
2061 five times the going rate instead of what is in the ACA now you
2062 probably price her out of this.

2063 So let's be thoughtful in what we do. We have got to turn
2064 back this repeal effort though and make more considered and
2065 thoughtful policy here in Washington, D.C. I yield back my time.

2066 Mr. Burgess. The chair thanks the gentlelady, the
2067 gentlelady yields back, and recognizes the gentleman from
2068 Florida, Mr. Bilirakis, 5 minutes for questions, please.

2069 Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it
2070 very much and I thank the panel for their testimony as well.

2071 Mr. Holtz-Eakin, I understand you run your, CBO, and you
2072 currently run a think tank?

2073 Mr. Holtz-Eakin. That is correct, sir.

2074 Mr. Bilirakis. Your organization recently did a review on
2075 the various replacement plans that conservatives had introduced.
2076 There is the Better Way by House Republican Conference, the
2077 Patient CARE Act, the Improving Health and Health Care Act,
2078 Empowering Patients First Act, the American Health Care Reform
2079 Act, the 2017 project in the World's Greatest Health Care Plan.

2080 When people say Republicans don't have a plan that is simply
2081 not true. There are many plans and competing ideas. However,
2082 it would be fair that there are certain common areas that are in
2083 most of these plans. Can you talk about the ACA provisions that
2084 in your expert opinion would most likely be kept? If you would

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2085 elaborate, please.

2086 Mr. Holtz-Eakin. Yes, I mean one of the reasons we wrote
2087 the paper is that there is an enormous amount of overlap and so
2088 it seems to me to be sensible to expect those to be present in
2089 any replacement plan.

2090 So all of them allow children to stay on the parents' policy
2091 until age 26 as in current law, all prevent discrimination against
2092 those with preexisting conditions and guarantee the issuance of
2093 an insurance policy, all of them ban caps on annual or lifetime
2094 out-of-pockets for individuals, and then they all have subsidies
2095 for individuals, typically age based so the elderly, the older
2096 and more likely to be expensive patients get some help.

2097 All of them have some sort of risk pool for those who can't
2098 be managed in the normal pool and all have some sort of approach
2099 to the continuous coverage idea where the differences quite
2100 frankly are in how do you handle the gaps. Handling the gaps,
2101 I want to echo what was said, is a really important issue. All
2102 of them have some provision to cap the most exposure that an
2103 individual would face if somehow they did develop a coverage gap
2104 for reasons outside of their control. So there is always common
2105 elements in these replace plans.

2106 Mr. Bilirakis. Very good, thank you.

2107 Mr. Wieske, when the ACA was passed there were several
2108 promises made about it. The American people were promised it
2109 would bend and cost curve through increased competition the health

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2110 insurance market. In Florida today 73 percent of the counties
2111 have only one health insurer and average premiums increased by
2112 19 percent last year. I fear that what it will look like 2018.

2113 You mentioned that in Wisconsin you have an active insurance
2114 market pre-ACA --

2115 Mr. Wieske. Yes.

2116 Mr. Bilirakis. -- and then how was the health market before
2117 ACA and now with the ACA? Can you discuss it?

2118 Mr. Wieske. Yes, I think we saw the highly competitive
2119 markets were fortunate. We still have a lot of choice in our
2120 market, but it is evaporating slowly but surely. And we see
2121 carriers consistently move their market around, move their
2122 coverage areas around, so there is a lot of instability. They
2123 have changed their networks. They have changed their networks
2124 around in order to deal with affordability and competition and
2125 issues, and the net result for a consumer is consumers don't have
2126 as many choices as they had before the ACA. They have fewer
2127 choices in coverage.

2128 Mr. Bilirakis. Thank you. Mr. Holtz-Eakin, again just in
2129 case members of the minority might not be familiar with our Better
2130 Way agenda, can you please detail that the Center for Health and
2131 Economy analysis finds the plan broadly what it accomplishes.
2132 Again, the impact on premiums would they increase or decrease?
2133 What about provider access? Would there be an impact on the
2134 federal budget? Can you go ahead and discuss that?

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2135 Mr. Holtz-Eakin. The Center for Health and Economy of which
2136 I am a board member did an analysis of the Better Way plan. I
2137 won't remember all the numbers right, but broadly speaking the
2138 insurance market deregulation lowers premiums something in the
2139 vicinity of 15 percent or so. Lower premiums improve private
2140 coverage in that plan and expand coverage. As a result of both
2141 the lower premiums and the subject structure there is less stress
2142 on taxpayers and there is budget savings in the Better Way Plan.

2143 And underneath the plans is important I identify what kind
2144 of networks and provider access are available, and access has
2145 improved. And there is an index of medical productivity,
2146 something to think about in terms an index for bending the cost
2147 curve, and there is improved medical productivity in the plan.

2148 Mr. Bilirakis. Thank you very much. I yield back, Mr.
2149 Chairman, appreciate it.

2150 Mr. Burgess. The gentleman yields back. The chair thanks
2151 the gentleman. The chair recognizes the gentleman from Oregon,
2152 Dr. Schrader, 5 minutes for your questions, please.

2153 Mr. Schrader. Thank you very much, Mr. Chairman. I
2154 appreciate the panel for being here. I just want to put some
2155 emphasis on the goal of what we are trying to do here and that
2156 is not to just beef up an insurance market, but to provide good
2157 health care for Americans. That is really our goal.

2158 The vehicle we currently have is dealing with the insurance
2159 market, I get that. But I think when we are talking about you

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2160 can't have the plans you want, et cetera, the goal here is to
2161 provide the essential benefits that basically provide health care
2162 for the scope of the people of this great country. And if everyone
2163 just pays in their little bit just like you do in any insurance
2164 program everyone benefits at the end of the day.

2165 I think we have to focus on the health care aspects here.
2166 I am a little concerned about the tenor of the hearing. I want
2167 to make sure we are talking apples to apples as we go forward.

2168 Mr. Holtz-Eakin, you talked about that some of these fixes
2169 could help stabilize the markets, so I assume you don't see these
2170 as replacement for the ACA but to stabilize the current market
2171 structure?

2172 Mr. Holtz-Eakin. Yes, the special enrollment periods,
2173 grace periods, those kinds, again these are what I think of as
2174 near term Band-Aids to make sure the current deterioration doesn't
2175 continue and it works --

2176 Mr. Schrader. I think that is fair. So they are not going
2177 to replace the ACA in and of themselves.

2178 Mr. Wieske, you talked a lot about the high risk pools and
2179 you have a robust market in Wisconsin. Knock on wood we still
2180 do in Oregon, but some states don't, some counties don't depending
2181 on the state they are in. I get that. You talked about the
2182 federal subsidy driving down the cost of the program if you will
2183 making it more affordable for Wisconsinites.

2184 You know, if we get rid of the ACA in its entirety which has

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2185 been proposed, and all the revenues, the 800 billion plus some
2186 of the other policy changes that make sure this is a deficit
2187 reduction, a piece of legislation, you know, what do you think?
2188 Don't we need some federal revenues to make whatever system we
2189 have going forward affordable for Wisconsinites?

2190 Mr. Wieske. I mean I think federal revenues obviously make
2191 it easier, but functionally, I mean I will say our market
2192 functioned pretty well. There was guaranteed issue available.
2193 Nobody could be turned down in most states, I think all states
2194 because of a health condition once they were insured, so that
2195 didn't exist and that didn't exist in Wisconsin. People were not
2196 dropped off their coverage due to --

2197 Mr. Schrader. So I have to interrupt, I apologize. I don't
2198 have a lot of time. Yes, and I think there is different opinions
2199 about, you know, who should get, you know, well, apparently some
2200 different opinions about who should get covered. I think
2201 everyone should have coverage and that means making it affordable
2202 and maybe even giving some people more of a break than some people
2203 think they deserve, because it all costs us at the end of the day
2204 if they don't have health insurance and that is just not
2205 productive.

2206 I want to make a statement and I would like everyone to think
2207 about this both Democrat and Republican and you certified smart
2208 people over there on the dais. I am very worried these young
2209 people we are trying to get onto the individual marketplace they

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2210 don't exist. I see no evidence that these people are out there
2211 no matter what we do -- age bands, difference in premiums.

2212 The reason I say that is, and I would love to be proven wrong
2213 but no one has been able to give me the information, insurers,
2214 you know, providers, whatever is that a lot of young people are
2215 on their parents' plan, age 26. A lot of people have jobs,
2216 especially right now. They are working. The people that are on
2217 the individual market are, in my state and I think most states,
2218 adversely selected. They are 50 to 65 years old. They have got
2219 a bunch of medical conditions.

2220 And last but not least, with the Medicaid expansion that has
2221 been successful across the country and is part of the ACA -- I
2222 think we have to understand that the Medicaid expansion is part
2223 of the ACA -- the biggest portion of that population that signed
2224 up, they are young. Well, younger than me, under 45 years of age,
2225 eh. So that is good.

2226 I am worried that we are chasing a unicorn here, folks. I
2227 am worried we are chasing a unicorn. I don't care what plan I
2228 have heard from my Republican colleagues or as Democrats. So I
2229 think we need to put that into the mix as we think about how do
2230 we make sure this individual market is stabilized. It has been
2231 a boon for a lot of folks. It has worked very well for a lot of
2232 folks. It has some problems and maybe some of these fixes would
2233 get to them.

2234 And I would hope that the majority party would look at working

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2235 with the minority party on some of these. The age bands don't
2236 have to be 5:1. The grace period doesn't have to be 3 months,
2237 you know, there is accommodations that we have talked about in
2238 previous hearings.

2239 And I think we keep in mind that this is to stabilize the
2240 current ACA marketplace while my colleagues, trying to chase maybe
2241 a unicorn, maybe we have been chasing it and now it is their turn,
2242 but I hope we look at this and the goal again is to provide
2243 excellent health care to every single American in the greatest
2244 nation on earth. And I yield back.

2245 Mr. Burgess. The gentleman yields back. The chair thanks
2246 the gentleman. The chair now recognizes the gentleman from
2247 Indiana, Dr. Bucshon, 5 minutes for your questions, please.

2248 Mr. Bucshon. Thank you, Mr. Chairman. Dr. Holtz-Eakin,
2249 your written testimony is packed with incredible statistics on
2250 age rating bands and I would like to read a few, just some facts.
2251 Average health care expenses for a 64 year old are 4.8 times
2252 greater than that of a 21 year old, and according to U.S. Census
2253 data, the insured rate for those age 19 to 34 is 4.6 percent higher
2254 than the uninsured rate for those age 35 to 64.

2255 I raise this because you note that the Administration
2256 predicted that the individual market would need about 40 percent
2257 in the enrollee population to be made up of young, healthy
2258 patients. Today that number is 28 percent. So the 3:1 age band
2259 in my view is just not an actuarially sound principle based on

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2260 that. Would you agree that modifying the age variation in
2261 premiums would help balance risk and help stabilize the
2262 marketplace?

2263 Mr. Holtz-Eakin. Yes, it would help. It would allow
2264 insurers to offer relatively cheaper policies to the young and
2265 relatively inexpensive. It is true that they would be relatively
2266 more expensive for the older and sicker. That is a financial
2267 reality. But getting those into the pool helps everyone over the
2268 long term.

2269 Mr. Bucshon. So at the end of the day do you think one of
2270 the biggest problems with what is happening in the exchange
2271 marketplace is mostly based on the fact that it is 28 percent
2272 young, healthy people versus 40 percent? Would you consider that
2273 the major factor or are there other reasons?

2274 Mr. Holtz-Eakin. There are probably some other reasons. I
2275 think this sort of grace period or the special enrollment periods
2276 or things like that have exacerbated the fundamental problem.
2277 But this is a core problem and because of the exits and the rising
2278 premiums it is getting worse not better.

2279 And we have discussed a little bit about the design of high
2280 risk pools today, my basic theory is we have a high risk pool and
2281 it is called the exchange market and it is just getting more and
2282 more like one every day.

2283 Mr. Bucshon. Okay. Mr. Wieske, do you have any comments
2284 on that?

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2285 Mr. Wieske. No, I think that is exactly right. And part
2286 of to understand is as you get more of the young folks in that
2287 drives the average rate down so that 5:1 may still be a 5:1, but
2288 it is not necessarily the same 5:1. It is a lower figure that
2289 you are starting with when you multiply it times 5.

2290 Mr. Bucshon. Correct. So the 1 will be a lower starting
2291 point.

2292 Mr. Wieske. Correct.

2293 Mr. Bucshon. And I think that is one of the concepts I think
2294 that people try to overlook. If you take changing the age rating
2295 band and the concept that the 1 will stay in the same place that
2296 it is today, you can make the argument yes, costs will be so high
2297 for the older, sicker patients that it might price them out of
2298 the marketplace.

2299 But my, you know, shifting the idea is to shift the whole
2300 marketplace back to a more actuarially sound position.
2301 So it is not just this, but there is some other actuarially unsound
2302 principles in the ACA that in my view have predictably resulted
2303 in where we are today.

2304 Do you have any other final comments, Dr. Holtz-Eakin, on
2305 that? Anything else that is what you consider non-actuarially
2306 sound other than the age bands that we might be addressing that
2307 we haven't addressed? Do you have any other thoughts?

2308 Mr. Holtz-Eakin. I think the more you delegate the sort of
2309 regulatory process and the review process to the state insurance

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2310 commissioners, the better you are going to get this because the
2311 pools are different state by state, dramatically different.

2312 Mr. Bucshon. Very important concept.

2313 Mr. Holtz-Eakin. And so I think you should recognize that
2314 in going forward.

2315 Mr. Bucshon. Okay. Mr. Wieske.

2316 Mr. Wieske. Obviously we agree. And I think, you know, I
2317 think the other piece here is that you can take a look at the
2318 testimony and you can see the disparate impact that the ACA had
2319 on rates when it was implemented. And in my testimony we have
2320 numbers that show that the increases were substantially higher
2321 on the younger folks than they were on the older folks, so it is
2322 a return back to where it was before.

2323 Mr. Bucshon. Dr. Lichtenfeld, I was a cardiac surgeon
2324 before I was in Congress, so I am going to ask and this is a serious
2325 question. Before the ACA, prior to the ACA, if you were referred
2326 a patient, you know, that has cancer for example, say, a GI doctor
2327 referred you someone that has a colon cancer and that person did
2328 not have medical coverage how did you handle that situation?

2329 Dr. Lichtenfeld. With difficulty, quite frankly.

2330 Mr. Bucshon. Yes. Did the patient get medical care?

2331 Dr. Lichtenfeld. Well, they may have gotten some medical
2332 care but they didn't get adequate medical care.

2333 Mr. Bucshon. So if they needed follow-up chemo from their
2334 colon cancer for example what, a 5FU or whatever you guys do these

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2335 days, did they get that or they didn't get it?

2336 Dr. Lichtenfeld. 5FU is one question, the newer treatments
2337 we have today are entirely different, okay.

2338 Mr. Bucshon. Okay, the newer treatments then, yes. Okay.

2339 Dr. Lichtenfeld. And certainly, sir --

2340 Mr. Bucshon. I haven't done GI or colon stuff in 25 years
2341 so I am behind.

2342 Mr. Bucshon. I respect the work that you have done. In
2343 fact, one time in my life I wanted to be a cardiac surgeon and
2344 didn't make it, so --

2345 Mr. Bucshon. You made the right decision.

2346 Dr. Lichtenfeld. But the reality is, you know, we as
2347 physicians always want to do what we can to stabilize somebody
2348 in their time of need. That is very important.

2349 Mr. Bucshon. Yes.

2350 Dr. Lichtenfeld. Unfortunately cancer is a complex,
2351 long-term disease.

2352 Mr. Bucshon. Understood.

2353 Dr. Lichtenfeld. And those folks will fall through the
2354 cracks. They did and they are doing less so today.

2355 Mr. Bucshon. Okay, thank you. I yield back.

2356 Mr. Burgess. The gentleman yields back. The chair thanks
2357 the gentleman. The chair recognizes the gentleman from
2358 Massachusetts, Mr. Kennedy, 5 minutes for your questions, please.

2359 Mr. Kennedy. Thank you, Mr. Chairman, and I want to thank

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2360 the witnesses for their testimony today, touch on a couple of
2361 issues.

2362 Mr. Wieske, you had testified and you spoke an awful lot today
2363 about the benefits of the Wisconsin's high risk pool, sir. I
2364 wanted to make sure we just fleshed that out a little bit. My
2365 understanding is that when you talk about the comprehensive
2366 coverage that was provided to consumers and that the cost coverage
2367 closely mirrored the cost of private coverage in the state, I
2368 believe though that the premiums for the Wisconsin high risk pool
2369 were set at twice the individual marketplace; isn't that right?

2370 Mr. Wieske. No, that is not correct. They were set based
2371 on an actuarial basis, so the --

2372 Mr. Kennedy. So that is information coming from Kaiser
2373 Foundation.

2374 Mr. Wieske. -- I am sorry.

2375 Mr. Kennedy. I am sorry. The information coming from the
2376 Kaiser Family Foundation indicated that those prices were twice
2377 the --

2378 Mr. Wieske. The numbers in my testimony were actually
2379 provided through the Legislative Audit Bureau which did an audit
2380 of the state high risk pool. I sat on the state high risk pool
2381 board. The rates were set based on the actual contribution to
2382 costs by each of those that split the 40/30/30 that I talked about.

2383 So that was where it was. It was not set in an artificial
2384 200 percent of the federal -- I don't know where they got that

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2385 number unless it came from the federal high risk pool piece which
2386 is a separate and they had their own separate rules of how they
2387 set their rates.

2388 Mr. Kennedy. So if it is not -- I understand that you are
2389 saying they weren't pegged that way. Were the premiums though
2390 twice as high as they were for the high risk pool as they were
2391 for the individual markets?

2392 Mr. Wieske. Yes. I don't think so, no.

2393 Mr. Kennedy. No, okay. Didn't Wisconsin's high risk pool
2394 exclude coverage for 6 months for a preexisting condition that
2395 made patients actually eligible for that pool in the first place?

2396 Mr. Wieske. It depended on how you came into the pool. So
2397 folks who had continuous coverage it mirrored the preexisting
2398 condition piece so that is something that could certainly be
2399 fixed. But folks that came from no coverage similar to folks who
2400 were facing a grace period who have not signed up for the ACA and
2401 can't sign until the open enrollment period and have to wait until
2402 then to sign up if they don't have coverage, if they came from
2403 no coverage they did have a 6-month waiting period.

2404 Again it would be like an open enrollment period except you
2405 get to sign up anytime, but only for coverage of that condition.
2406 Now folks who came from other coverage that lost their coverage
2407 involuntarily did get preexisting condition credit and did not
2408 have a preexisting --

2409 Mr. Kennedy. So if I were, just to make sure I understand

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2410 that if I did not have coverage before and came down with cancer
2411 I would have to wait 6 months for those cancer treatments to get
2412 covered?

2413 Mr. Wieske. Similar to if you did not have --

2414 Mr. Kennedy. Yes.

2415 Mr. Wieske. -- coverage right now you could not buy
2416 coverage in the individual market. You have to wait until open
2417 enrollment.

2418 Mr. Kennedy. Dr. Lichtenfeld, can you tell me what the
2419 impact of having a cancer patient wait 6 months for treatment might
2420 be?

2421 Dr. Lichtenfeld. We have actually been through that in the
2422 past where in fact some of the commercial plans in the group plans
2423 had exclusions of 9 months, so it is a pretty serious issue. And
2424 we have also had issues with regard to women who were screened
2425 for cancer, mammography for example, who did not get automatic
2426 coverage.

2427 So the question was, well, you have screening, you know you
2428 may have breast cancer but you can't get the care. So that has
2429 been addressed in some respect through the breast and cervical
2430 cancer early detection program. So it is a very real issue cancer
2431 doesn't wait, and there is acute conditions that really don't
2432 wait. So obviously the 6-month exclusionary period which has
2433 existed in the past in some places is something to be concerned
2434 about.

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2435 Mr. Kennedy. So let me shift topics a little bit here, but
2436 I would appreciate your medical opinion on this. We have, as I
2437 mentioned in my opening comments a while ago now, this committee
2438 has dived into a partial examination of the failures of our mental
2439 health system across our country and some of the systemic failures
2440 with that marketplace.

2441 As you might be aware, the largest provider of mental health,
2442 or payer for mental health service in the country is Medicaid.
2443 And so the combination of mental health parity and the Medicaid
2444 expansion and some of the clauses in the Affordable Care Act
2445 themselves were a sea change in terms of access to care,
2446 understanding we still have an awfully long way to go.

2447 I was hoping you might be able to comment on what the impacts
2448 of either doing away with that Medicaid expansion or issues around
2449 preexisting conditions what that would mean for folks suffering
2450 from mental illness.

2451 Dr. Lichtenfeld. Mental health issues are serious and as
2452 I mentioned earlier they certainly impact patients with cancer
2453 and families of patients with cancer. Access to those services
2454 is very important. And clearly within the community and now with
2455 the opioid addiction epidemic that we have and the stress that
2456 that is putting on mental health services, we have to make certain
2457 that everyone has adequate access to mental health services just
2458 as we have talked about with respect to services for patients
2459 diagnosed with cancer.

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2460 Mr. Kennedy. Thank you, sir. I yield back.

2461 Mr. Burgess. The gentleman yields back. The chair thanks
2462 the gentleman. The chair recognizes the gentlelady from Indiana,
2463 Mrs. Brooks, 5 minutes for your questions, please.

2464 Mrs. Brooks. Thank you, Mr. Chairman. I just want to
2465 clarify, Dr. Lichtenfeld, under current law, current law, if a
2466 patient is diagnosed with cancer they also have to wait, do they
2467 not, to get into a market?

2468 Dr. Lichtenfeld. I am going to share with you that I can't
2469 respond to that directly. To my, you know, depending on the
2470 circumstances -- I am trying as I think through this -- they really
2471 are individual. If I may, they are individually specific to that
2472 person as to what happens to them, have they been engaged or not,
2473 and that is a very real --

2474 Mrs. Brooks. If they had not been engaged.

2475 Dr. Lichtenfeld. If they have not been then that could be
2476 problematic.

2477 Mrs. Brooks. Okay, so that -- and Commissioner Wieske,
2478 would you -- and I am sorry. How do you say your last name?

2479 Mr. Wieske. Wieske.

2480 Mrs. Brooks. Wieske, I am sorry. Is that your
2481 understanding --

2482 Mr. Wieske. Yes.

2483 Mrs. Brooks. -- that under current law if an individual
2484 had paid the penalty or had, you know, and was not insured right

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2485 now, if they develop cancer they too have to wait for open
2486 enrollment?

2487 Mr. Wieske. Healthy or not they have to wait until open
2488 enrollment. They cannot enroll until January of the next year
2489 unless there is a special enrollment period.

2490 Mrs. Brooks. Okay, thank you. I would like to talk about
2491 what we are trying to explore which has to do with continuous
2492 coverage and the importance of continuous coverage as a potential
2493 tool in incentivizing individuals to stay covered. And so some
2494 folks would suggest that this could lead to higher premiums based
2495 off of health status or preexisting conditions, but I believe that
2496 to be false.

2497 And because we want to prohibit rating based off of health
2498 status, we want to prohibit rating based off of preexisting
2499 conditions, critically important, but in order to accomplish this
2500 fairness goal we have to stabilize the markets, as I understand
2501 actuarially sound market stabilizers.

2502 And so, Commissioner Wieske, as chair of the NAIC Health Care
2503 Reform how do both the state of Wisconsin and the association view
2504 the concept of continuous coverage?

2505 Mr. Wieske. Well, I think it is important. I mean I think
2506 a lot of the issues that surround the individual health insurance
2507 market are driven by the fact that again it is a residual market
2508 and the fact that folks jump in and out from carrier to carrier
2509 which has been exacerbated by the ACA.

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2510 So I think insurers --

2511 Mrs. Brooks. Can you expand on that please?

2512 Mr. Wieske. Sure. That in the ACA that you have seen people
2513 typically jump from one carrier to another obviously based on
2514 price, based on their interest.

2515 Mrs. Brooks. And when you say they jump from one carrier
2516 to another what is the time period in which they have been doing
2517 that?

2518 Mr. Wieske. Every year they look to switch as to what their
2519 best options are. That is appropriate shopping. But I think if
2520 you can design a system that where their coverage is more
2521 continuous, I think that the interest of the insurers change in
2522 driving more long-term health and I think that is really where
2523 the issue is, is that if you have only got somebody for a year
2524 or 2 your investment in their long-term health never pays off.
2525 It pays off for the next insurer.

2526 So if you can have a long-term coverage with a single insurer
2527 you end up having a system where those further investments pay
2528 off for the insurer.

2529 Mrs. Brooks. And do we have some circumstances where people
2530 might be insured for 9 months and then drop out?

2531 Mr. Wieske. Yes, definitely we have heard that the -- yes,
2532 consistently.

2533 Mrs. Brooks. Dr. Holtz-Eakin, I understand -- what are your
2534 thoughts with respect to continuous coverage with respect to a

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2535 mechanism for stabilizing the health care markets?

2536 Mr. Holtz-Eakin. As I said before, I think it is a very
2537 important concept. Obviously there are details that need to be
2538 worked out, but the incentives to get the young into the pool are
2539 very powerful. The issue of having a balanced pool gets taken
2540 care of organically because the young are always jumping in. Some
2541 will become more expensive as they get older; they are all in the
2542 pool.

2543 But the fundamental issue has always been how do you get
2544 quality care at lower costs, and this gives insurers the correct
2545 incentives to look over a lifetime, work with the providers not
2546 just for short-term purposes but for the long term and that would
2547 be beneficial. We don't have those incentives in the system right
2548 now. The closest place for that quite frankly is employers.
2549 Self-insured employers often have employees for an average of 7
2550 years. That is a time period over which you can make a big
2551 difference.

2552 And I consider it no surprise that that is the place where
2553 we have seen the slowest cost growth in the U.S. health system.

2554 Mrs. Brooks. Can you share any actuarial cautions we should
2555 consider as we are shaping this process and what are some of the
2556 incentives that you believe could be really helpful?

2557 Mr. Holtz-Eakin. I think the most important thing is to
2558 separate what the system looks like from how we get there, and
2559 today's discussion is largely that sort of stabilizing it so that

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2560 you can get something in place. The high risk pools will be at
2561 a minimum a very important part of the transition mechanism.
2562 Figuring out who goes in and who comes out and gets back into the
2563 regular pool, I think, is going to be a really important part of
2564 this.

2565 Mrs. Brooks. Thank you. I yield back.

2566 Mr. Burgess. The gentlelady yields back. The chair thanks
2567 the gentlelady. The chair recognizes the gentlelady from
2568 California, Ms. Eshoo, 5 minutes for questions, please.

2569 Ms. Eshoo. Thank you, Mr. Chairman, and thank you to the
2570 witnesses for being here today. I guess it is an advantage to
2571 come early and hear what everyone has had to say and the questions
2572 that are asked and the answers that you have proposed.

2573 I want to start out by commenting on Chairman Walden's
2574 remarks. He is a good man and I take him at his word in terms
2575 of what he believes in. But for each one of us we are legislators.
2576 We are legislators. So while we can all talk about what we believe
2577 in what is actually written down in legislation which you are here
2578 to give testimony on, we came to a hearing where Title II
2579 Continuous Coverage Incentive is blank, blank. It is blank. So
2580 I can't help but comment on that first.

2581 There are so many things that have been said that I find
2582 either curious or really menacing. First of all, the Affordable
2583 Care Act in its promise which has been kept so far is that no one
2584 can take it away from you. That is not what the American people

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2585 experienced before that legislation became law. Now today the
2586 only ones that can take it away from you are the Republicans. And
2587 that is what repeal is. Repeal is a heavy, heavy word. It is
2588 a wrecking ball.

2589 We are sitting in a hearing room that was recently remodeled.
2590 The entirety of the Rayburn Building was not taken down. It
2591 wasn't destroyed and then rebuilt simply because these daises
2592 needed to be adjusted or the room repainted. So when the word
2593 repeal is used it is chilling and, you know what, it is chilling
2594 to markets. It is chilling to markets. And I don't think that
2595 has been taken into consideration by our witnesses today.

2596 Now this whole issue of insurance across state lines and what
2597 it is going to do, I can buy an insurance policy across state lines
2598 today. Maybe I pick Idaho, I don't know, Arizona, wherever.
2599 Terrific. Maybe it is lower cost than what I have now. The only
2600 problem is when I get sick I have to travel to that state in order
2601 to take advantage of it. And within our 50 states there are many
2602 different standards. Some states are low-ball states. They
2603 have practically no protections for consumers, so if that is what
2604 is opened up that is a disaster in my view.

2605 Now what I want to ask each one of you is do you support
2606 national insurance for people in our country, each one of you,
2607 yes or no? Quickly, because my time is running out.

2608 Mr. Holtz-Eakin. I don't know what national health
2609 insurance is.

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2610 Ms. Eshoo. That everyone in this country is able to get
2611 health insurance.

2612 Mr. Holtz-Eakin. Everyone has an opportunity to buy a
2613 policy, sure.

2614 Mr. Wieske. Everybody should have access to affordable
2615 health insurance.

2616 Ms. Eshoo. Just access or be able to get it? I can go to
2617 Nieman's. I can have access at Nieman's.

2618 Mr. Wieske. I think access means that they can get it. If
2619 it is affordable, access means they can get it.

2620 Ms. Eshoo. Dr. Lichtenfeld.

2621 Dr. Lichtenfeld. Ms. Eshoo, and my personal thoughts are
2622 not relevant to my presentation today, I am here on behalf of --

2623 Ms. Eshoo. Well, you are here on behalf of -- say yes or
2624 no.

2625 Dr. Lichtenfeld. I am here on behalf of the American Cancer
2626 Society and we are just like everything else we will certainly
2627 consider proposals if they are made. Our concern today is to make
2628 sure that --

2629 Ms. Eshoo. That is it. I am losing my time.

2630 Dr. Lichtenfeld. -- going forward that we --

2631 Ms. Eshoo. Do you support, you all say that you support the
2632 very good things that are in the ACA. No discrimination,
2633 preexisting conditions, women, up to 26 on their parents' policy,
2634 so you would support a mandate in whatever replaces the ACA to

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2635 include those because it is a mandate.

2636 Mr. Holtz-Eakin. I didn't say that. I said every
2637 replacement we have studied continued those --

2638 Ms. Eshoo. No, I am asking you do you support that? You
2639 accept that it is a mandate or is it voluntary? How are these
2640 things going to come about if they are not baked in as a mandate
2641 for an insurance policy?

2642 Mr. Holtz-Eakin. People are permitted to have their
2643 children on their policies up to age 26. They are not mandated
2644 to have them until 26.

2645 Ms. Eshoo. But there is a mandate to the insurance industry
2646 that those reforms which cover everyone --

2647 Mr. Holtz-Eakin. Yes, it is the current law.

2648 Ms. Eshoo. -- so you accept that?

2649 Mr. Holtz-Eakin. Yes.

2650 Mr. Wieske. We had these reforms in place --

2651 Ms. Eshoo. Do you, Mr. Wieske?

2652 Mr. Wieske. We had these, we performed --

2653 Ms. Eshoo. No, I don't want to hear about that. I just want
2654 to know if you --

2655 Mr. Wieske. But Wisconsin believes that it has a good market
2656 and it doesn't need a federal mandate to tell us what to do.

2657 Ms. Eshoo. But do you support those being mandated relative
2658 to the insurance industry in our country, those reforms?

2659 Mr. Wieske. We would look at it in state law, yes.

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2660 Ms. Eshoo. Do you think that beyond your state it should
2661 be?

2662 Mr. Wieske. I can't speak for other states.

2663 Ms. Eshoo. Do you want it for your state?

2664 Mr. Wieske. We will work with our legislature and the
2665 legislature will figure out what is --

2666 Ms. Eshoo. Well, you know what, this is like nailing Jell-O
2667 to a wall because I don't think there is a commitment. I think
2668 you talk about these things and that they are good things, but
2669 unless these reforms are held onto that were made and have made
2670 an enormous difference in people's lives including all the cancer
2671 patients in our country then there isn't a commitment to them.
2672 And I think that this is part of the basics of what the integrity
2673 of what insurance plans need to have in the country. This has
2674 revolutionized people's lives.

2675 Mr. Burgess. The chair thanks the gentlelady. The
2676 gentlelady's time has expired. The chair recognizes the
2677 gentleman from Oklahoma, 5 minutes for questions, please.

2678 Mr. Mullin. I feel sorry for the panel. It is funny,
2679 because it seems like when I go after a panel like that they always
2680 get upset because I am badgering the witness or something. I
2681 understand everybody's opinions runs high on this, I get that.
2682 But I will be real frank with everybody. The federal government
2683 should get out of the people's way and we shouldn't be mandating
2684 anybody to do anything. That is not the role of the federal

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2685 government. The federal government is to provide opportunities
2686 and resources for them to have access and affordable access and
2687 that is what we are trying to do here, affordable access.

2688 Oklahoma, which I represent, is one of the states that only
2689 has one insurer carrier in there. We are one of the one of five.
2690 We saw premiums raise by 76 percent last year. It is not because
2691 the Blue Cross Blue Shield is trying to be greedy, it is because
2692 they are trying to stay in business. I understand that. The
2693 regulatory environment is such that they have to continue to
2694 change so they can afford to provide the health care.

2695 But because of the regulatory environment underneath,
2696 ironically, Affordable Health Care which is anything but
2697 affordable, it is causing premiums to skyrocket and then it causes
2698 less affordability means less access to our constituents. And
2699 all this committee is trying to do is find a way to bring those
2700 premiums down and allow access to be created.

2701 So Mr. Wieske -- and I hope I pronounced that right.

2702 Mr. Wieske. You did.

2703 Mr. Mullin. Okay. My first questions to you, could you
2704 help explain why the regulatory environment that we are finding
2705 ourselves in right now is causing the premiums to literally
2706 skyrocket?

2707 Mr. Wieske. Sure. I think it starts with the risk pool.
2708 You know, you may have a large risk pool but when you have loaded
2709 dice it is very difficult to get a representative, you know, 1

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2710 through 6, a representative sample when the dice are loaded. In
2711 other words --

2712 Mr. Mullin. What do you mean by loaded dice?

2713 Mr. Wieske. What I mean is, is that the risk pool, the people
2714 who are purchasing coverage tend to need it and they tend to --
2715 that the folks who don't need coverage who are young and healthy
2716 are outside of the market. And so when you are looking at the
2717 people that are buying coverage through the ACA that they are
2718 tending to be sicker.

2719 And I think as Doug had indicated that it looks a lot like
2720 our high risk pool looked from a risk perspective. It is a little
2721 bit better, but it looks a lot like that from that perspective.
2722 That is the concern. I think you need to lower the premiums for
2723 younger folks to get them into the marketplace.

2724 I think a lot of the burdens, you know, the SEP issue I think
2725 is one. There is a number of others where the Obama
2726 administration has set such stringent rules that make no sense.
2727 Their three Rs program has been a disaster as far as hearing out
2728 how you pay for the re-insurance and adequately price for the risk.
2729 The timelines are ridiculous. You are pricing a policy in March
2730 for something that starts in January. You know, it used to be
2731 a month, month in a half before, insurers don't have the data.
2732 There is a whole host of -- I could go on probably for hours and
2733 bore everybody here.

2734 Mr. Mullin. Well, so if I am hearing you correctly, if we

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2735 keep things the way they are right now are we going to create an
2736 environment for more access or is it going to drive more insurers
2737 out of the market?

2738 Mr. Wieske. I think there will be a few states like
2739 Wisconsin that will hang on by our nails for a while, but I think
2740 you can see in a number of states where the Tennessee commissioner
2741 who testified yesterday in front of Senate Health indicated that
2742 her market was near collapse, I think that is what you are going
2743 to be looking at over time in a number of states in the current
2744 environment.

2745 Mr. Mullin. Well, you know, what we have been hearing is
2746 that both people, my side of the aisle and the other side of the
2747 aisle, we are passionate about our constituents. What strikes
2748 me is that here we are actually holding hearings on trying to fix
2749 a problem. I just wonder how much input you guys got to have when
2750 this thing was jammed down you all's throat. At least now we are
2751 trying to open it up and allow you guys to comment on it. If it
2752 is really about our constituents, then why would the other side
2753 be so upset that we are actually having public hearings on trying
2754 to fix it and get it better? I don't understand that.

2755 So I appreciate, I appreciate that you guys are coming here,
2756 giving your perspective, the states' perspective and we are
2757 getting input. And I appreciate the chairman who has taken the
2758 time to listen and actually put up with some of the shenanigans
2759 that is going on on the other side, your patience, as you can tell

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2760 I wouldn't put up with. I appreciate you doing that Chairman.

2761 But at the end of the day this is about getting it right and
2762 fixing it for our constituents. So thank you for your time, thank
2763 you for coming in here and giving your expert opinion and we look
2764 forward to working with you to bring down the premiums so it can
2765 be affordable and it can create access for our constituents to
2766 have health care coverage if they so choose to, not mandate to
2767 do. Thank you.

2768 Mr. Burgess. The gentleman yields back. The chair thanks
2769 the gentleman. The chair would advise the subcommittee and the
2770 witnesses that a series of votes have been called on the floor.
2771 We are going to hear questions from Ms. DeGette for 5 minutes and
2772 then I am sure the panel would appreciate a break. We will have
2773 one and then we will reconvene back here immediately after the
2774 vote series is over. So Ms. DeGette, you are recognized 5 minutes
2775 for questions, please.

2776 Ms. DeGette. Thank you, Mr. Chairman. I will just say
2777 before I start asking questions, my colleague from Oklahoma says,
2778 well, at least we are having hearings on legislation. But I would
2779 point out that we just learned today that we are going to have
2780 a markup of these bills that we are allegedly having the hearings
2781 today on, next Tuesday. And as my colleague from California said,
2782 Title II of the bill isn't even a title. It is Continuous Coverage
2783 Incentive, placeholder, and we are going to mark this up next
2784 Tuesday.

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2785 Mr. Mullin. At least we are having an opportunity to read
2786 it.

2787 Ms. DeGette. I think we should work together on this. Now
2788 I want to welcome the panel here. I especially want to welcome
2789 you, Dr. Holtz-Eakin. I know when you were director of CBO you
2790 appeared in front of this committee many times and I am glad to
2791 welcome you back. I want to ask -- I want to focus most of my
2792 questions on you. First of all, you state in your testimony that
2793 the ACA is in a downward spiral, correct?

2794 Mr. Holtz-Eakin. Correct.

2795 Ms. DeGette. And a downward spiral -- well, you state in
2796 a downward spiral prices rise and insurers will continue to leave
2797 the market, correct?

2798 Mr. Holtz-Eakin. Yes.

2799 Ms. DeGette. And the result of that is because people are
2800 leaving plans and therefore the programs will not be sustainable;
2801 isn't that correct?

2802 Mr. Holtz-Eakin. And there will be less competition and it
2803 will affect prices.

2804 Ms. DeGette. Right. So declining enrollment would be one
2805 characteristic of a death spiral would it not?

2806 Mr. Holtz-Eakin. Yes.

2807 Ms. DeGette. Yes, it would. So I want to -- my assistant
2808 is going to hand you actually a chart from the Congressional Budget
2809 Office and it shows that Obamacare enrollment will hold steady

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2810 from 2017 to 2027 and there won't be decreasing enrollment. Do
2811 you see that chart?

2812 Mr. Holtz-Eakin. I do.

2813 Ms. DeGette. Thank you very much. Now also, Dr.
2814 Holtz-Eakin.

2815 Mr. Burgess. Will the gentlelady yield?

2816 Ms. DeGette. No, I will not. Also Dr. Holtz-Eakin, the
2817 Congressional Budget Office, your former employer, issued a
2818 report in January 2017 called How Repealing Portions of the
2819 Affordable Care Act Would Affect Health Insurance Coverage and
2820 Premiums. Are you familiar with that report?

2821 Mr. Holtz-Eakin. I am not an expert on it but I have read
2822 it.

2823 Ms. DeGette. Okay. So what the report basically looked at
2824 was the plan President Obama vetoed before, but what that plan
2825 did was it eliminated in two steps the laws mandate penalties and
2826 subsidies, but it left the ACA's insurance market reforms in place
2827 like the preexisting condition and age 26 and all of that so it
2828 is pretty much like what we are talking about here today.

2829 And here is what the Congressional Budget Office found. It
2830 found that under a schematic like that, quote, the number of people
2831 who are uninsured would increase by 18 million in the first year
2832 following enactment of the plan. Later, after elimination of the
2833 ACA's expansion of Medicaid eligibility and the subsidies for
2834 insurance purchased through the marketplaces that number would

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2835 increase to 27 million and then to 30 million in 2026. Are you
2836 aware of that finding?

2837 Mr. Holtz-Eakin. Yes, and I think it is wrong.

2838 Ms. DeGette. Okay. Okay, I appreciate that but that was
2839 their finding.

2840 Mr. Holtz-Eakin. It is also out of date.

2841 Ms. DeGette. Now let me --

2842 Mr. Holtz-Eakin. You should, no, you should know before you
2843 --

2844 Ms. DeGette. No, no. Excuse me, sir. I am asking the
2845 questions.

2846 Mr. Holtz-Eakin. I am giving you some question advice.

2847 Ms. DeGette. The next finding that they made, the next
2848 finding what they made on page 1 of their findings -- and I do
2849 apologize. I only have 5 minutes. If you would like to
2850 supplement your testimony I would welcome that okay.

2851 The next finding was premiums in the non-group market for
2852 the individual policies purchased through the marketplaces or
2853 direct from insurers would increase by 20 percent to 25 percent.
2854 Are you familiar with that finding, sir?

2855 Mr. Holtz-Eakin. I don't remember that one.

2856 Ms. DeGette. You are not. Okay, well, Mr. Chairman, I am
2857 going to ask unanimous consent to put both this chart from the
2858 CBO and also the report from January 2017 in the record.

2859 Mr. Burgess. Without objection, so ordered.

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2860 [The information follows:]

2861

2862 *****COMMITTEE INSERT 14*****

2863 Ms. DeGette. Thank you. Now were you -- so if you want to
2864 talk about a death spiral, it seems to me that a death spiral would
2865 be caused if you left all of the things, the requirements for the
2866 insurance companies in place but then you eliminated the Medicaid
2867 expansion, you eliminated the exchanges and the subsidies and
2868 people left the markets in droves.

2869 One more thing I just want to talk about and that is premiums
2870 because there has been a lot of allegations thrown around today
2871 that premiums have been skyrocketing. Are you aware of the CMS
2872 data that showed from 2000 to 2005 premiums were growing at eight
2873 percent, from 2005 to 2010, 5.5 percent, and then under the ACA
2874 average premiums were growing at only 3.6 percent, Mr.
2875 Holtz-Eakin?

2876 Mr. Holtz-Eakin. What premiums?

2877 Ms. DeGette. Private insurance premiums.

2878 Mr. Holtz-Eakin. Employer?

2879 Ms. DeGette. Yes.

2880 Mr. Holtz-Eakin. The ACA didn't touch employers.

2881 Ms. DeGette. Yes, it did.

2882 Mr. Holtz-Eakin. That is why it continued to perform well.

2883 Ms. DeGette. Yes, it did. Thank you very much, Mr.

2884 Chairman.

2885 Mr. Burgess. The gentlelady yields back. The chair thanks
2886 the gentlelady. I do note the series of --

2887 Ms. DeGette. Mr. Chairman, may I just put this chart, ask

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2888 unanimous consent to put this chart in the record, because it also
2889 talks about Medicare and Medicaid going down.

2890 Mr. Burgess. If the gentlelady is willing to share that with
2891 the committee, unanimous consent request is made and without
2892 objection, so ordered.

2893 [The information follows:]

2894

2895 *****COMMITTEE INSERT 15*****

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2896 Mr. Burgess. We have 6 minutes left in our vote on the floor.
2897 The chair advises that the committee will stand in recess until
2898 immediately after votes.

2899 [Whereupon, at 1:15 p.m., the subcommittee recessed, to
2900 reconvene at 1:46 p.m., the same day.]

2901 Mr. Burgess. Call the subcommittee back to order, and to
2902 start I want to yield to Mr. Green for a point of personal
2903 privilege.

2904 Mr. Green. Thank you, Mr. Chairman, for the time and if I
2905 could have everybody's attention. I want to -- there is a decorum
2906 requirement we do in this committee, and it was after we went to
2907 vote but our witnesses are here as guests and if you get up and
2908 insult whether it is Republican or Democrat that is not part of
2909 the decorum no matter what. And I am just going to admonish that
2910 that is not acceptable.

2911 And so that is enough, Mr. Chairman. I just want to make
2912 sure that witnesses know where they are here to answer questions
2913 and not to engage in arguments. Thank you.

2914 Mr. Burgess. The chair thanks the gentleman, and certainly
2915 once again thanks the witnesses for being here. And I know it
2916 has been a long day for all of us.

2917 At this time the chair would recognize the gentleman from
2918 New York, Mr. Collins, 5 minutes for questions, please.

2919 Mr. Collins. Thank you, Mr. Chairman. I am going to pretty
2920 much direct this to Dr. Holtz-Eakin. And I know we touched on

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2921 the SEPs, the special enrollment periods. Representative
2922 Blackburn who was chairing the telecom, she is a sponsor of H.R.
2923 706, I am a co-sponsor. It goes back to the last Congress, and
2924 to the two of us and I think to many, there is a lot of common
2925 sense in working on our special enrollment periods.

2926 And what we have noticed is during the Obama administration
2927 the enforcement seemed to be quite lax when it came to the SEPs
2928 and in effect giving individuals what I would call presumptive
2929 eligibility instead of verified eligibility and in doing so there
2930 is always some costs that would come around.

2931 So Dr. Holtz-Eakin, the last time that you testified before
2932 this subcommittee you used the term, talking about the
2933 verification process, as being extremely generous. I think there
2934 was a little bit of tongue in cheek on that. Would you agree that
2935 that is still the case today, maybe if you want to expand on that
2936 at all?

2937 Mr. Holtz-Eakin. I think this is an important issue simply
2938 as a matter of the arithmetic as the risk pool. As many as up
2939 to a third of people in the pool entered through an SEP and there
2940 are a lot of SEPs compared to other programs, like Medicare has
2941 seven.

2942 So, you know, that is a big part of it and in the data these
2943 are more expensive participants than other members of the pool.
2944 So in a system where the fundamental problem has been the cost
2945 and the inability of insurers to appropriately plan for costs and

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2946 bake into their premiums those costs, this seems to me like a
2947 candidate for reform and a place that you should look right away.

2948 Mr. Collins. So in studying this how would you say it
2949 impacts the market?

2950 Mr. Holtz-Eakin. It does two things. It brings costs into
2951 the pool and those costs were unanticipated and that leads
2952 directly to insurer losses. The second thing it does is it makes
2953 insurers quite nervous about next year's unknowables and puts
2954 upward pressure on premiums just as a matter of caution to try
2955 to anticipate some of these people entering.

2956 Mr. Collins. So Commissioner, in your past life -- and I
2957 know you are familiar with the SEPs as well. I think in your
2958 written testimony you actually say what we found up in Wisconsin
2959 was extremely problematic. Even more problematic, it was clear
2960 many consumers were using the process to receive costly medical
2961 care and then immediately dropping coverage.

2962 Mr. Wieske. That is correct. We actually did this on a
2963 national basis, looked at this on a national basis as well. We
2964 chair the Health Care Reform Alternatives Working Group at the
2965 NAIC and one of the plans indicated loss ratios on that business
2966 in excess of 180 percent, so significant losses and because of
2967 the dropping of coverage and they did not maintain it throughout
2968 the year.

2969 Mr. Collins. So I will ask somewhat of a rhetorical
2970 question, but when that happens who is stuck paying for that?

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2971 Mr. Wieske. The whole pool is stuck paying, so the folks
2972 who are in the individual market because it is a single risk pool
2973 are paying higher premiums as a result.

2974 Mr. Collins. And I think it is also safe to say when -- I
2975 will just call this out for what it is, cheating, and when someone
2976 is cheating the system they are also cheating the sick and the
2977 vulnerable patients and potentially driving up their costs.
2978 There is always a cost to someone and, you know, that is just kind
2979 of a point taken.

2980 So Mr. Chairman, I will yield back. I know there is some
2981 airplanes to catch and thank you all for your testimony.

2982 Mr. Burgess. The gentleman yields back. The chair thanks
2983 the gentleman and the chair recognizes the gentleman from New
2984 York, Mr. Engel, 5 minutes for your questions, please.

2985 Mr. Engel. Thank you very much, Mr. Chairman. We all know
2986 the phrase be careful what you wish for. It is a saying that I
2987 think my friends on the other side of the aisle are finding
2988 particularly poignant lately. I think our colleagues are on the
2989 other side of the aisle are finally realizing that it is easy to
2990 make promises, it is a lot harder to deliver progress as the
2991 Affordable Care Act has. You know, there is no such thing as a
2992 free lunch. If all the good things about the Affordable Care Act
2993 are going to be kept costs are going to go up and a lot of people
2994 will not be insured.

2995 And so I think it is leading us down a primrose path. We

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2996 should have been working together all these years not to try to
2997 eliminate the Affordable Care Act 62 or 63 times, but to try to
2998 improve it.

2999 All major acts, all major bills, all major programs have to
3000 be implemented and then you see how it goes, what works, what
3001 doesn't and you tweak, you change it, you try to improve it. But
3002 all we have had here for the past several years is just
3003 ill-conceived votes to eliminate it entirely, and now that they
3004 apparently are they are going to be careful what they wish for.

3005 Mr. Green said this hearing is taking place on Groundhog Day.
3006 It is fitting because today Republicans are holding another
3007 hearing not on new ideas but the same ill-advised bills we have
3008 debated before in this committee. There is one exception, a half
3009 written draft that they claim would protect Americans living with
3010 preexisting conditions, but when you look closely we punish them
3011 instead.

3012 So I want to underscore how indefensible the situation is.
3013 My constituents are frightened. They are worried that their
3014 preventive services that the ACA guaranteed them free of charge
3015 are going to disappear. They are worried that insurance
3016 companies will again impose caps on their coverage. They are
3017 worried that without the ACA's protections they will be charged
3018 more for insurance. And my colleagues on the other side of the
3019 aisle are really doing nothing to allay their fears.

3020 Dr. Lichtenfeld, I would like to give you an opportunity to

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3021 speak one more time on a matter you were asked about earlier.
3022 Speaking for the American Cancer Society, can you tell me whether
3023 you support every American having high quality health insurance?

3024 Dr. Lichtenfeld. Thank you, Mr. Engel, and let me clarify
3025 the answer to that particular question which I may have misheard
3026 previously was that yes, I personally am the American Cancer
3027 Society. I do support universal access to adequate and
3028 affordable health care coverage.

3029 Mr. Engel. Thank you. This draft would require insurance
3030 companies cover people with preexisting health conditions,
3031 however there is nothing in this text that prevents insurance
3032 companies from charging you more if you have a preexisting
3033 condition like asthma or diabetes.

3034 So is it fair to say, Dr. Lichtenfeld, that under legislation
3035 without a ban on medical underwriting Americans with preexisting
3036 conditions like cancer could be priced out of the care they need?

3037 Dr. Lichtenfeld. Once again thank you for the question.
3038 And it is our read and our concern that in fact that could happen.

3039 Mr. Engel. Before the Affordable Care Act I think you did
3040 say in your testimony that cancer patients who could get coverage
3041 which didn't always happen were still vulnerable to enormous
3042 costs; isn't that right?

3043 Dr. Lichtenfeld. Yes, sir.

3044 Mr. Engel. And that would happen again without the ACA. So
3045 I want to talk about that last point for a moment because lately

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3046 we often hear Republicans use the phrase universal access as in
3047 they want everyone to have universal access to health care.

3048 They are careful to say universal access not coverage because
3049 this is what universal access is, a scheme in which insurers must
3050 cover you but can charge you whatever they want making it all but
3051 impossible for you to actually afford coverage. This is why they
3052 chose their words so carefully because the access they are
3053 promising isn't truly access at all.

3054 Democrats aren't making pie in the sky promises, they are
3055 showing progress. Thanks to the ACA 129 million Americans with
3056 preexisting conditions cannot be turned away or charged more
3057 because of their health status. Health care costs have been
3058 growing at the slowest rate in more than 50 years, and I could
3059 continue. Let me just say this.

3060 For 7 years Republicans have claimed to have a better way
3061 to reform America's health care system. If that were true then
3062 I believe that this hearing would have been the perfect
3063 opportunity to lay out that path forward. But instead after 7
3064 years we have the same old bills, tired bills and half of a draft.
3065 Our constituents have serious concerns. It is going to take a
3066 lot more than this to put those concerns to rest.

3067 So I just want to say that because I think there is nothing
3068 more important than people's health care, and I truly believe that
3069 if they destroy the ACA there is going to be a lot of people in
3070 this country that are going to be angry and scared. Thank you,

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3071 I yield back.

3072 Mr. Burgess. The gentleman yields back. The chair thanks
3073 the gentleman. The chair now recognizes the gentleman from
3074 Georgia, Mr. Carter, 5 minutes for your questions, please.

3075 Mr. Carter. Thank you very much, Mr. Chairman, and thank
3076 all of you for enduring this. We appreciate you being here and
3077 for seeing through this and for participating.

3078 I want to start with you, Mr. Holtz-Eakin. You pointed out
3079 throughout the hearing today that premiums are rising and that
3080 insurers are dropping out of certain markets and we know the horror
3081 stories of some states don't have but one insurance company that
3082 is participating now. And in full disclosure, before I became
3083 a member of Congress I was a pharmacist and I owned three
3084 independent retail pharmacies at that time and I am a firsthand
3085 witness to what has happened to the free market in health care
3086 since the Affordable Care Act has taken, and I think that is the
3087 worst thing that has happened is that it has taken the free market
3088 out of health care.

3089 How do we get it back? How do we get back to where we are
3090 competing? I often tell the story that right now Adam Smith is
3091 rolling over in his grave to see what we have done to the free
3092 market in health care. And how do we get the competition back?
3093 That is what is going to drive prices down, competition.

3094 Mr. Holtz-Eakin. It is a hard question. I think in the
3095 hallmark of a good competitive system is some flexibility in the

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3096 rules that surround competition. And I think the mistake of
3097 having something that is the same across all states where, you
3098 know, the market structures are very, very different is piece
3099 number one.

3100 And piece number two is you compete on whatever you pay for,
3101 and so if you pay for procedures people will compete by producing
3102 procedures that we want to pay for good outcomes. And that would
3103 be --

3104 Mr. Collins. You know, there are really three things that
3105 we want to do. We want to make health care accessible, we want
3106 to make it affordable and we want to cut out the red tape. We
3107 want to get the federal government out of the way of physicians
3108 and patients. And right now there are so many, there is so much
3109 bureaucracy between the patients and the health care
3110 professionals, and that is what we are trying to do is to cut it
3111 out.

3112 Mr. Wieske, I want to ask you because you have obviously
3113 experience in this. One of the things that I am concerned about
3114 is the anti-trust laws as they pertain to the insurance companies,
3115 and I really feel like this is hindering the competition in a
3116 number of different ways.

3117 I am really big on trying to find exactly what is going on
3118 with prescription drug prices and particularly the role that PBMs
3119 play in that because I don't feel like they bring any value
3120 whatsoever to the health care system. They only raise prices and

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3121 cause them to rise. And when you look at the PBMs, you have three
3122 PBMs that have 80 percent of the market. That is not competition
3123 yet they are protected by the anti-trust laws. I mean did you
3124 address that in Wisconsin at all?

3125 Mr. Wieske. So, you know, I think what is interesting about
3126 the ACA market from an anti-trust standpoint is actually that the
3127 insurers are competing not to get business, and I think that is
3128 where the problem is coming in. In fact, in one state they
3129 specifically wanted to get out of the cities and one company only
3130 wanted to do the rural areas so they would have less enrollment.

3131 And so, you know, I think that is what is interesting is they
3132 are actually not competing to get this business, they are
3133 competing to survive and just hope to live another day.

3134 Mr. Collins. Okay. Let me ask you this, because you said
3135 something earlier that really tweaked my interest. And you said
3136 that in your high risk pool that you had in the state of Wisconsin
3137 that all providers participated.

3138 Mr. Wieske. They did.

3139 Mr. Collins. Did you require them to?

3140 Mr. Wieske. It was required.

3141 Mr. Collins. How do you require them to?

3142 Mr. Wieske. So it was when they --

3143 Mr. Collins. Do you tie it in with licensing or something?

3144 Mr. Wieske. It was a requirement that they had to accept
3145 the high risk pool patients and the rate that the high risk pool

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3146 set. They were part of the boards. They got the opportunity to
3147 work on setting those rates, but they were expected to contribute
3148 30 percent to the surplus of the cost, 30 percent of the cost --

3149 Mr. Collins. Okay, you explained that. But what was the
3150 penalty if they didn't participate?

3151 Mr. Wieske. We never ran into that so we didn't have a
3152 penalty because they all participated. The patients went to the
3153 doctor, the doctor billed the high risk pool for the services.
3154 I mean ultimately if they didn't participate they just wouldn't
3155 get paid in the same rate I guess, but, you know, functionally
3156 --

3157 Mr. Collins. You know, I find that hard to believe
3158 especially if you have a favored nations clause in there and they
3159 are forced to accept that rate payment and then they are forced
3160 to give it to another insurance company as well.

3161 Mr. Wieske. We had a -- I mean before and after, I mean we
3162 do have an extremely competitive market. We don't have a dominant
3163 insurer that can get the most favored nation. The market share
3164 in Wisconsin, you know, the top about 18 comprise 80 percent, so,
3165 and the top 10 only comprise roughly about 45 percent or less of
3166 the market. So it is a different market.

3167 Mr. Collins. Well, again I just want to stress, and again
3168 thank all of you for being here. I want to stress again what we
3169 are trying to do here is to make health care accessible, to make
3170 it affordable and to cut out the red tape and to bring the free

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3171 market back. Let competition drive prices down. That is what
3172 is going to do it. That is what we are trying to do. Thank you
3173 again, all of you, for being here. And I yield back, Mr. Chairman.

3174 Mr. Burgess. The chair thanks the gentleman. The
3175 gentleman yields back. The chair recognizes the gentleman from
3176 New Mexico, Mr. Lujan, 5 minutes for your questions, please.

3177 Mr. Lujan. Mr. Chairman, thank you very much. Before I
3178 begin, there was a line of questioning from Mr. Kennedy to Mr.
3179 Wieske pertaining to a Kaiser report titled High-Risk Pools for
3180 Uninsurable Individuals-Appendix Tables-8903, the Henry J.
3181 Kaiser Family Foundation, which referenced the premium increases
3182 in the state of Wisconsin amongst other states. I would ask
3183 unanimous consent that that be submitted to the record.

3184 Mr. Burgess. If the gentleman is willing to share it with
3185 the chair, without objection, so ordered.

3186 [The information follows:]

3187

3188 *****COMMITTEE INSERT 16*****

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3189 Mr. Lujan. Just to note so that there is no question about
3190 this, what this report says is that the premiums were double in
3191 Wisconsin, so I know that we will get the chance to maybe go over
3192 that a little bit later.

3193 Mr. Chairman, if I could ask the staff to pull up the first
3194 slide upon our new smart screen, one thing that I wanted to go
3195 over was the question associated with where we are today with the
3196 bills that have been presented to this committee.

3197 President Trump recently said that he insists that everyone
3198 will have health insurance, insurance for everybody, he said.
3199 President Trump also said that there will be lower numbers, much
3200 lower deductibles. He went as far as to say that he is ready to
3201 reveal it alongside Senate Majority Leader Mitch McConnell and
3202 Speaker Paul Ryan. That was January 16th, 2017. And here is the
3203 important quote. It is a very much formulated down to the final
3204 strokes.

3205 So if we could go to the next slide, this is what we have
3206 today, down to the final strokes. So as we talk about these
3207 details I think it is just important that we keep an eye on what
3208 those final strokes really look like because that bracket sure
3209 is empty.

3210 If we could go to the next slide I wanted to answer a question
3211 that was brought up by one of my colleagues about this being shoved
3212 down people's throats. This is just a list of some of the hearings
3213 in the House and in the Senate that took place associated with

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3214 the markup of the Affordable Care Act. I brought my copy in if
3215 anyone wants to take a look at it, which is coffee stained and
3216 marked up, highlighted up for everyone to see that we used not
3217 only to study this bill but to go and explain it to our constituents
3218 and answer questions from our constituents.

3219 And if we could just go to the next slide, the next slide
3220 shows what this committee alone did with different amendments that
3221 came up before this committee. So Mr. Lichtenfeld, I understand
3222 that you are -- or Lichtenfeld, I understand that you are a
3223 physician. Have you read Chairman Walden's discussion draft?

3224 Dr. Lichtenfeld. I have read the paper that you have shown
3225 here to the committee.

3226 Mr. Lujan. Do you remember it saying anything about
3227 protecting young people and making sure they can stay on their
3228 parents' plans until they are 26?

3229 Dr. Lichtenfeld. My understanding is, Congressman, and so
3230 as I said before a work in progress and that there is obviously
3231 language that is still to be discussed and debated.

3232 Mr. Lujan. I will ask the question differently. Was it in
3233 the text that you read?

3234 Dr. Lichtenfeld. I am sorry, sir?

3235 Mr. Lujan. Was it in the text that you read?

3236 Dr. Lichtenfeld. No, sir.

3237 Mr. Lujan. Do you remember the text reading anything about
3238 establishing minimum standards of care to ensure Americans aren't

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3239 sold a lemon health insurance plan?

3240 Dr. Lichtenfeld. I do not recall that, sir.

3241 Mr. Lujan. Do you remember it saying anything about making
3242 sure behavioral and mental health services are covered?

3243 Dr. Lichtenfeld. Again I don't recall seeing that.

3244 Mr. Lujan. Mr. Lichtenfeld, you are an oncologist, correct,
3245 sir?

3246 Dr. Lichtenfeld. Yes, sir.

3247 Mr. Lujan. I thank you for your work. My father sadly
3248 passed from a fight with stage 4 lung cancer a little more than
3249 4 years ago. We appreciate the experts that provided our loved
3250 one's care. Do you remember in Chairman Walden's bill saying
3251 anything about making sure individuals are not penalized by
3252 lifetime caps on their insurance coverage?

3253 Dr. Lichtenfeld. I do not recall seeing that, sir.

3254 Mr. Lujan. So the discussion that we are hearing today is
3255 that there be an environment set up so that individuals rather
3256 than having a 90-day grace period with their coverage would be
3257 shortened to a 30-day grace period if they had a preexisting
3258 condition. And if they missed a payment, and the text doesn't
3259 protect anyone that may be late with a payment, then they lose
3260 coverage. What I have heard today is the notion that people with
3261 preexisting conditions that would lose coverage would still be
3262 able to get coverage from somewhere else, right. But there is
3263 nothing saying that they will not pay a higher premium fee.

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3264 And under the notion of, again if you could please bring up
3265 the first slide. Under the notion that our colleagues are saying
3266 that premiums will be lowered, deductibles will be lowered, care
3267 will be better, no one is going to be cut off, I just don't see
3268 it in anything that has been read to us.

3269 And then the last thing, after 7 years, if they bring the
3270 first slide up, please, the one with Fox News, we have not seen
3271 the Republican consensus plan before us. There was a lot of talk
3272 by one of our witnesses about a plan that was before us. There
3273 is no consensus plan before us. This is not a secret. For 7
3274 years, over 60 times my Republican colleagues have voted to repeal
3275 the Affordable Care Act. For 7 years we have not seen this text.

3276 I think it is important that when we are having these hearings
3277 about how to improve the Affordable Care Act it shouldn't be about
3278 repealing the Affordable Care Act. And I will just point that
3279 the text in Chairman Walden's discussion draft, in its title it
3280 says upon repeal of the Affordable Care Act. So people can spin
3281 this all that they want, please look at the text and what is
3282 happening right now. And there is a willingness for us to work
3283 together to make things better to improve things, but not under
3284 the guise of repealing this. Let's find a way to really come
3285 together and do the right thing for the American people and not
3286 just the political thing.

3287 Mr. Burgess. The gentleman's time is expired. The chair
3288 is advised that one of the witnesses needs to catch an airplane.

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3289 Is this accurate? The chair would ask unanimous consent that we
3290 allow the witness to make their -- no, we don't allow the witness.
3291 Okay, the chair would advise that the witness who identified
3292 himself as having travel plans will actually be leaving at 2:15.

3293 And I do ask all members to try to adhere to the 5-minute
3294 timeline. I have been lenient today because this is such an
3295 important topic.

3296 Mr. Green. Mr. Chairman, I ask unanimous consent to place
3297 into the record -- if you want me to start the list -- a statement
3298 from the Asian Pacific Islander American health care --

3299 Mr. Burgess. Without objection, so ordered. All of your
3300 --

3301 Mr. Green. All of it.

3302 Mr. Burgess. -- yes, consent requests will be honored.
3303 The chair recognizes Mr. Sarbanes 5 minutes for questions.

3304 Mr. Sarbanes. Thank you, Mr. Chairman. I just got in here
3305 under the wire, so I want to thank the panel. I wanted to ask
3306 Dr. Holtz-Eakin, what are some of the pieces of the Affordable
3307 Care Act that you think we ought to keep in place?

3308 Mr. Holtz-Eakin. Well, I think that, you know, the ban on,
3309 caps on benefits for annual and lifetime, 26 staying on your
3310 parents' policy. I certainly think that you should have some sort
3311 of provisions for preexisting conditions and access to insurance.

3312 Mr. Sarbanes. What about the efforts to close the exposure
3313 in the so-called donut hole in terms of the prescription drug costs

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3314 that our seniors had been facing, is that a piece we want to keep
3315 in place?

3316 Mr. Holtz-Eakin. I think there is, I would be happier if
3317 there was a more comprehensive approach to Medicare reform that
3318 sort of put together a more sensible insurance policy A, B and
3319 D, provided a broader coverage there.

3320 Mr. Sarbanes. But generally speaking this idea of trying
3321 to reduce the exposure that our seniors have to the prescription
3322 drug costs which the ACA addressed through this effort to close
3323 the donut hole, is that something you think we ought to hold onto?

3324 Mr. Holtz-Eakin. I guess the reason I am hesitating, my
3325 understanding is part of this is the private industry's agreement
3326 to cover 50 percent of costs in the donut hole. I honestly don't
3327 know how that works whether that has the force of law or if that
3328 is a voluntary action by them.

3329 Mr. Sarbanes. I think the industry's agreement to
3330 voluntarily address 50 percent of their costs in the donut hole
3331 was something that they were going to do transitionally as the
3332 donut hole was being closed through actually providing additional
3333 benefits under Part D.

3334 What about, you probably know that many seniors now as a
3335 result of the Affordable Care Act can have certain kinds of
3336 preventive screenings, annual wellness exams, other things where
3337 they used to have to come out of pocket for those expenses, those
3338 are now covered by the Affordable Care Act which is obviously a

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3339 huge benefit for our seniors. Is that a piece of the Affordable
3340 Care Act that you think ought to stay in place?

3341 Mr. Holtz-Eakin. Truthfully I don't know. The question
3342 there is what has been the effectiveness versus the cost, and I
3343 would be happy to get back to you on that.

3344 Mr. Sarbanes. Well, I think the effectiveness has been
3345 significant in terms of enhancing care and there is actually
3346 savings as well, because if you catch some things earlier that
3347 then don't lead to acute care on the back end which have high costs
3348 associated with it, because you do the screenings and the
3349 preventive care service because you actually are reducing costs
3350 as well.

3351 So I guess I am asking the questions just to make the point,
3352 Mr. Chairman, that once you break -- there is this kind of slogan
3353 of repeal the Affordable Care Act, you know, it hasn't delivered,
3354 et cetera. When you actually break it down into its component
3355 parts and look at the benefits that it is bringing, frankly, the
3356 public has a very positive view of a lot of these components to
3357 the plan.

3358 And as you just indicated in your answers, I think there is
3359 a recognition by the experts that there is many, many pieces of
3360 the Affordable Care Act that it would be regrettable to leave
3361 behind. So I think we need to start in an honest place of
3362 conversation when we are talking about this landmark health care
3363 reform and the benefits that it has brought to so many Americans

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3364 and move forward from that point. With that I yield back.

3365 Mr. Burgess. The gentleman yields back. The chair thanks
3366 the gentleman. The gentleman recognizes the gentleman from New
3367 Jersey, Mr. Long, 5 minutes for questions, please.

3368 Mr. Long. Thank you, Mr. Chairman. Mr. Wieske, you
3369 mentioned in your testimony that a number of your insurers have
3370 lost significant capital because of Obamacare. How has that
3371 affected coverage options as well as provider network access for
3372 individuals?

3373 Mr. Wieske. So as I said just a few minutes ago, I think
3374 there are actually --

3375 Mr. Long. My apologies if you --

3376 Mr. Wieske. No, no, no. My apologies. My apologies.

3377 Mr. Long. I sat here all morning long for my turn to ask
3378 and we went to votes, so --

3379 Mr. Wieske. No, no, no. And they are competing not to get
3380 the business in a lot of cases and, you know, they want a limited
3381 number of coverage and they are losing money on that coverage and
3382 so they have dialed back their presence across the state. They
3383 have limited their networks. Most plans have gone to narrower
3384 and narrower networks. They have changed their networks. They
3385 have partnered with providers, provider groups to do it
3386 differently. They have done it under different insurance
3387 licenses. So they have taken a number of steps to sort of minimize
3388 their exposure to the market.

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3389 Mr. Long. If nothing changes between now and next November,
3390 what would you see at that point?

3391 Mr. Wieske. I think we will see a number of carriers that
3392 -- I think we will see every year where we are sort of -- my fear
3393 because we deal directly with the filings and I deal directly with
3394 the filings, my fear is that I am a little bit panicked that we
3395 are going to have counties that are uncovered.

3396 We have one county that has one right now. We have three
3397 counties that only had one for a number of years. I am deathly
3398 afraid that four or more of our counties will be left uncovered
3399 with no insurer offering coverage.

3400 Mr. Long. Okay. And coming from an adverse state in terms
3401 of regions, have some areas of your state been hit harder by these
3402 changes?

3403 Mr. Wieske. Yes, there were big differences. I mean, you
3404 know, one of the issues is it almost feels like, and this is not
3405 insurance across state lines, but it narrowed the market
3406 considerably. So some of our plans that offered coverage that
3407 were near the border left those areas because of the rules and
3408 the way things work, and so that left those areas more exposed.

3409 So the areas near the borders have more problems than some
3410 of the other areas. Absolutely there has been winners and losers
3411 in the ACA.

3412 Mr. Long. And what has that meant for consumers? We call
3413 them consumers, I call them constituents, but what has that meant

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3414 for consumers and our constituents in those areas?

3415 Mr. Wieske. We have seen, you know, rising costs over time,
3416 you know, more than doubling of the average premiums that most
3417 consumers pay over the course of, you know, from what they were
3418 paying pre-ACA, so there are significant increases. The
3419 deductibles have increased over time. They are higher than they
3420 were pre-ACA on average.

3421 And the networks are narrower. They are finding, you know,
3422 less choice in the type of providers they want to see because there
3423 are fewer, you know, they just want to offer narrower and narrower
3424 networks.

3425 Mr. Long. When you say they are higher, I remember back at
3426 Christmastime went to a Christmas party the Saturday, I think,
3427 before Christmas, and a local business owner came up talking about
3428 just his family's premium had gone up 360 percent since the advent
3429 of the Affordable Care Act. I would hate to think what it was
3430 like if it wasn't affordable, but these are the type of stories
3431 that we get from our constituents that everybody acts like
3432 everything is a panacea and everything is great out there.

3433 But these numbers, I mean health care, health insurance
3434 always was going up, and the other side will argue, I have
3435 constituents that like it and they say oh, you know, health care
3436 goes up anyway. But 360 percent in that short of time is a pretty
3437 healthy increase, isn't it?

3438 Mr. Wieske. It is. And I think what I am afraid of is states

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3439 like Wisconsin that took advantage of the transition options,
3440 so-called grandmother plans, those plans will go the way at the
3441 end of '17 in the small group market. Roughly about 180-190,000
3442 of our 225-230,000 small group individuals are on those transition
3443 plans. They are going to get a significant increase when we roll
3444 from 2017 at the end of this year into '18.

3445 Mr. Long. That is kind of what I was --

3446 Mr. Wieske. On pre-ACA plans, yes.

3447 Mr. Long. That was kind of what I was getting to earlier
3448 when I asked you about November, what you foresaw for next
3449 November. And what are your projections and concerns of what the
3450 market is going to look like after that period in a few years if
3451 the current trajectory continues in your state?

3452 Mr. Wieske. We are expecting fewer carriers, probably
3453 regional. They happen to be regional in a lot of cases and
3454 probably only carriers, insurers that have a relationship, a
3455 contractual relationship with a health system. So you will have
3456 one health system and one insurer teamed up in a particular area
3457 and that will be the only coverage option. That is what we are
3458 afraid of in the future, no choice.

3459 Mr. Long. Do you view plan solvency in the market as a basic
3460 consumer protection?

3461 Mr. Wieske. Yes, we do. We do extensive work on solvency.
3462 Yes, sir.

3463 Mr. Long. What does that mean for consumers when their

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3464 insurers exit the market like they have in droves in a lot of
3465 places?

3466 Mr. Wieske. It means that they obviously lose the coverage.
3467 They end up in what I would call ghost plans or phantom plans that
3468 don't exist anymore but they still have coverage, and then you
3469 have to deal with the issue of the guarantee funds and making sure
3470 the consumers are covered. And it ends up, it is for a consumer
3471 it is confusing and it is problematic and it is a little bit of
3472 a nightmare if their insurer -- now we have been lucky. We haven't
3473 had any go insolvent in the state of Wisconsin. We have had
3474 carriers leave the market but we have not an insolvency in health
3475 that has had those problems so we have been lucky.

3476 Mr. Long. I have two daughters. One of them has a year and
3477 a half left in her residency program in pediatrics, so the future
3478 of health care is very concerning to her. And her younger sister
3479 just got a report out about 4 months ago from Hodgkin's lymphoma
3480 and she has been off chemo for 15 months, I guess.

3481 And so I know how important it is that people have coverage
3482 and stay covered because we had a little incident mid-chemo
3483 treatment when the Affordable Care Act told us she wasn't covered
3484 one day when we got over there for treatment. That was kind of
3485 hair raising. So there is no easy answers to any of this that
3486 we are doing today.

3487 And like I said, I was late because I was doing, to the first
3488 part of it because I had to do a telecom deal on rural broadband

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3489 so I wasn't here for the gavel and then I was here by the time
3490 we voted.

3491 Mr. Burgess. The chair accepts the gentleman's apology.
3492 The gentleman's time has expired. I do need to note it is past
3493 2:15. We have a witness that needs to leave. We will continue
3494 our -- and will be excused. We will continue our hearing with
3495 the remaining witnesses. Of course written questions may be
3496 submitted for Dr. Holtz-Eakin.

3497 And Dr. Holtz-Eakin, we appreciate you being here. You have
3498 always been a friend to this committee and we appreciate your
3499 participation today. So you are excused.

3500 Mr. Holtz-Eakin. Thank you, Mr. Chairman.

3501 Mr. Burgess. And the chair recognizes the gentleman from
3502 California, Mr. Cardenas, 5 minutes for your questions, please.

3503 Mr. Cardenas. Thank you, Mr. Chairman. I am glad we are
3504 discussing this incredibly critical and important issue that is
3505 critical to every American. I would like to read the following
3506 true story from a constituent from my city of Los Angeles,
3507 California.

3508 In 2012, and this is before the Affordable Care Act was made
3509 available to her and her family. In 2012 I was in between jobs
3510 and discovered that I was pregnant. My husband and I were
3511 thrilled to be expecting our baby. When I tried to sign up for
3512 insurance I was informed that my pregnancy was considered a
3513 pre-condition, preexisting condition, and no insurance company

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3514 would cover me.

3515 My husband was working as a contract employee and was
3516 uninsured. I considered Medi-Cal and Medicaid program in
3517 California, but I was told that it could take months until I could
3518 actually visit a clinic. Fortunately I was hired about a month
3519 later and I got back on a company's insurance. However, if I had
3520 not been hired I don't know what I would have done. It was that
3521 we almost missed seeing a doctor until the second trimester.

3522 And as I experienced extreme daily stress worrying about
3523 whether I would be insured before I gave birth or be charged tens
3524 of thousands of dollars, such stress is never good for a baby.
3525 The fact that becoming pregnant prevented me from buying insurance
3526 was truly outrageous. I was so horrified that our system could
3527 do something like this.

3528 True story, it happened, and unfortunately before the
3529 Affordable Care Act there were way too many stories like that.
3530 What I hope that we can prevent as members of Congress, as
3531 legislators, as responsible elected officials that we not go back
3532 to those days. This is America and this true story goes to the
3533 heart of what we are all here to talk about.

3534 Why are we spending time analyzing a half finished bill that
3535 doesn't take care of all the issues that were promised both by
3536 presidential candidates and people all over this United States
3537 Congress? Things like to ensure that a woman and a man pay the
3538 same price for their plans. This bill here that I have in my hand

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3539 which was introduced and what we are discussing today does not
3540 guarantee coverage for a preexisting condition. A lot of
3541 Americans don't realize that if your 8 year old daughter has asthma
3542 that is considered a preexisting condition.

3543 Also to ensure coverage that we actually have access, this
3544 bill that I have before me talks about access but it doesn't talk
3545 about ensuring coverage. The Affordable Care Act has stronger
3546 language such as ensuring coverage. This document speaks to
3547 access but it doesn't spell out what we really should be talking
3548 about. Are people going to be denied coverage for a preexisting
3549 condition? Are women going to be allowed just like before to pay
3550 more for their health care than it is for a man at the same age,
3551 conceivably right next door?

3552 We have had nearly 8 years of talk about replace, but we have
3553 come up with nothing better in that time. Why aren't we talking
3554 about enhancing the Affordable Care Act instead of these ideas
3555 of just repealing it?

3556 I have a question for Dr. Lichtenfeld. I want to first thank
3557 you for coming today and for sharing your expertise with us and
3558 also for making sure that we can get some more information before
3559 the public. Under the half written plan could individuals with
3560 preexisting conditions like cancer, asthma or diabetes be priced
3561 out of the care they desperately need?

3562 Dr. Lichtenfeld. Thank you, Mr. Cardenas. And our concern
3563 is that that could in fact happen unless it is absolutely laid

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3564 out clearly what the plan is that there could be problems down
3565 the line.

3566 Mr. Cardenas. And the bill as written today doesn't have
3567 any language guaranteeing that that would not happen, correct?

3568 Dr. Lichtenfeld. As I mentioned previously that is correct.
3569 Yes, sir.

3570 Mr. Cardenas. Okay. My next question is were the health
3571 insurance premiums across America in general going up year over
3572 year before the Affordable Care Act or were they on their way down
3573 year over year before the Affordable Care Act?

3574 Dr. Lichtenfeld. Premiums were going up.

3575 Mr. Cardenas. Okay. Now on those premiums going up people
3576 were still denied coverage because of a preexisting condition,
3577 correct?

3578 Dr. Lichtenfeld. Yes, sir.

3579 Mr. Cardenas. But under the Affordable Care Act that is not
3580 allowed in America today, correct?

3581 Dr. Lichtenfeld. That is correct.

3582 Mr. Cardenas. Okay. So I just wanted to point out a few
3583 things in the short time that I get to speak on this committee
3584 and just wanted to make sure that everybody out there understands
3585 we are talking about you. We are talking about your health, your
3586 grandparents to your grandbabies and everybody in between. We
3587 need to get this right. And right now the bill that we have isn't
3588 even close. I yield back.

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3589 Mr. Burgess. The chair thanks the gentleman. The chair
3590 would remind the gentleman he receives the same amount of time
3591 as every other member on the subcommittee and some who have waived
3592 on the subcommittee, and the chairman has been most generous with
3593 not hitting the gavel.

3594 The chair would like to recognize the gentlelady from
3595 Tennessee, Mrs. Blackburn, 5 minutes for your questions, please.

3596 Mrs. Blackburn. Thank you, Mr. Chairman, and thank you all
3597 for being here. I want to go to the bill that we are looking at
3598 on the special enrollment plans, the special enrollment periods.
3599 This is legislation that I have drafted and the reason I did it
3600 was because of what we saw happening with lack of verification
3601 in the special enrollment periods.

3602 And I saw us going down a road that we traveled in Tennessee
3603 with TennCare which was back in the mid-90s. No verification,
3604 all of a sudden your plan is, your enrollees are being crowded
3605 out if you will, people that really need services. You begin to
3606 see networks narrow, reimbursements drop, the length of time you
3607 wait for reimbursements goes from 30 days to 60 days to 90 days
3608 to 120, 180 days. And you all know the path. And my bill is just
3609 very straightforward and you need to prove why you need that
3610 special enrollment period, you need to prove that you are who you
3611 are and that you qualify. I think that is an important thing for
3612 us to be able to do.

3613 So the question, I have a couple of questions and I would

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3614 like to hear you all weigh in on the need for verification for
3615 special enrollment periods. I think it is important for the
3616 integrity of any program and I think it is fair for the taxpayers
3617 who foot the bill.

3618 But shouldn't we simply be able to confirm if someone
3619 qualifies for special treatment that they self-attest that they
3620 are eligible that indeed they are, and especially if taxpayer
3621 subsidies are involved? Shouldn't we require that? And would
3622 a very small, but modest improvement to the plan be to move this
3623 verification from post-enrollment, which experience has told us
3624 very seldom gets done, to pre-enrollment? And I would like to
3625 hear what you all have to say on that.

3626 Mr. Wieske. Your bill is exactly right. I mean this is not
3627 actually that hard to get verification in my experience. This
3628 is something, special enrollment periods did not start with the
3629 ACA. Special enrollment periods existed with HIPAA and existed
3630 prior to that in the Newborn and Mothers Act and other pieces.
3631 Insurance companies were doing these verifications for years
3632 prior to the ACA.

3633 The problem that we have run into is when the federal
3634 bureaucracy takes it over that that creates other problems and
3635 they don't have the time or the resources to verify. We had one
3636 person in our office who had spent months trying to solve the issue
3637 because he was not using the magic words that the customer service
3638 wanted them to use. So I think it shouldn't be that hard to get

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3639 to a verification.

3640 Dr. Lichtenfeld. Well, Mrs. Blackburn, thank you for the
3641 question. And we are aware of some of the issues that have come
3642 up with regard to special enrollment. However, when we look at
3643 it through that cancer lens we also need to understand that there
3644 are some other issues that have to be looked at.

3645 So it may be someone who is working and loses their job and
3646 has to go get insurance and within the cancer focus how quickly
3647 that is going to be done, what is going to be required and will
3648 it be done expeditiously. Should it be done pre- with the
3649 presumption of correctness and then later, or should it be done
3650 later when there may be a gap in care? Those gaps in care can
3651 be significant.

3652 Also aware that how the one that administers it, whether it
3653 be federal or whether be insurance, insurance company, what the
3654 guidelines are that set around those requirements in terms of
3655 timeliness, all those are things that have to be considered.

3656 Mrs. Blackburn. I think you might have missed the point that
3657 I am trying to drive forward. I think that -- I am not saying
3658 you don't need special enrollment periods.

3659 Dr. Lichtenfeld. No, I understand.

3660 Mrs. Blackburn. Just what you are inferring. I am saying
3661 that if we have a special enrollment period and one is necessary
3662 that it is out of fairness to the taxpayer and to the integrity
3663 of a program that an individual before they are admitted to a

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3664 program that they prove that they need it and that they prove that
3665 they are who they attest to be. That those attestations that they
3666 have made to get that coverage that those are vetted before they
3667 are allowed into that program.

3668 Dr. Lichtenfeld. Mrs. Blackburn, I apologize if I wasn't
3669 clear on my statement. I didn't say we don't need special -- I
3670 mean it wasn't my intent to say we don't need special enrollment.

3671 Mrs. Blackburn. Okay, right.

3672 Dr. Lichtenfeld. I said it is the construct of how it is
3673 done that is important where we may have discussions about that
3674 issue.

3675 Mrs. Blackburn. Okay, thank you. Yield back.

3676 Mr. Burgess. The gentlelady yields back. The chair thanks
3677 the gentlelady. The chair recognizes the gentleman from North
3678 Carolina, Mr. Hudson.

3679 Mr. Hudson. Thank you, Mr. Chairman, and I thank the panel
3680 for your time today. But since I arrived here directly from a
3681 dental procedure I will probably yield the balance of time,
3682 without objection from you, Mr. Chairman, to Mr. Griffith from
3683 Virginia.

3684 Mr. Burgess. The gentleman is recognized.

3685 Mr. Griffith. Thank you very much. I thank my colleague
3686 from North Carolina, so I think I ought to ask my North Carolina
3687 question first. My district shares a border with North Carolina.
3688 Mr. Wieske, you indicated earlier in answering one of the

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3689 questions that there were some issues around the borders. Could
3690 you tell me what was going on there and how that affected you all?

3691 Mr. Wieske. Sure. I mean I think when you are dealing with
3692 the exchange and the subsidy market it sort of shut down the sort
3693 of, you know, moving between the borders that happen, that those
3694 borders became a little bit harder than they were before. And
3695 so because you are one exchange versus another exchange it wasn't
3696 just buying health insurance it was that became an issue.

3697 Mr. Griffith. And let me ask you if you ran into any of the
3698 problems in your state that I ran into with constituents when it
3699 first rolled out. I had folks who were going to medical
3700 facilities -- because my district is the corner of Virginia so
3701 I border North Carolina, Tennessee, Kentucky and West Virginia.
3702 And so one of the things that popped up almost immediately was,
3703 and it was particularly a North Carolina situation, I had a
3704 constituent who was receiving cancer treatment in Winston-Salem.
3705 It might have been Duke, but I am pretty sure it was Bowman-Gray.

3706 And all of a sudden found out when she, she had to go on the
3707 exchange. She went on the exchange and found out that she could
3708 not leave the Commonwealth of Virginia more than one county.
3709 Well, that created all kinds of problems because she couldn't keep
3710 with her cancer team. Did you have some of those issues as well?

3711 Mr. Wieske. A few of those, but more insurers withdrew from
3712 the neighboring counties. So Pierce, Polk and St. Croix County
3713 typically use, which is on the western part of our state, typically

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3714 use providers in Minnesota, have Minnesota systems. All the
3715 Wisconsin systems essentially withdrew from that area and at least
3716 exchange wise, and so it was primarily a Minnesota company that
3717 provided coverage that was licensed in Wisconsin. So they just
3718 had fewer choices. They had to go, they had to go, across the
3719 border.

3720 Mr. Griffith. Right. And so it is kind of interesting
3721 because earlier one of the folks was making a statement on the
3722 other side of the aisle and seemed to indicate that whatever plans
3723 we were coming up with they wouldn't work because you couldn't
3724 go, you would have to go back to the other state, I believe she
3725 said, to see the doctors, and yet my experience in my district
3726 was that that problem exists with Obamacare.

3727 And it may be one of the things we need to take a look at
3728 it fixing, because that one county rule -- and I described my
3729 district to you and I only had problems in North Carolina. But
3730 one of the hospitals in the area that specializes in children's
3731 care in Tennessee serves a big chunk of southwest Virginia but
3732 because independent cities, Bristol, Virginia is an independent
3733 city, Bristol, Tennessee, and the county surrounding it is the
3734 one county you could go to and the hospital is just over the line
3735 in the next county.

3736 So it was not just the problem in North Carolina with cancer
3737 treatment, it was also problems with people being able to go see
3738 the specialists in North Carolina, because I had Bristol, Virginia

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3739 and Tennessee, where as you know from the GEICO commercial the
3740 line runs right down the middle of the main commercial street
3741 there. And then I also have Bluefield, Virginia, which also has
3742 Bluefield, West Virginia, and you have to figure out which side
3743 of the line you are on there. It is not quite as clear cut as
3744 Bristol, Virginia and Tennessee.

3745 So a lot of my constituents were impacted by that. And I
3746 know that it is -- I assume that it is not a good idea to change,
3747 Dr. Lichtenfeld, it is not a good idea to change your doctors
3748 midstream particularly when you are satisfied with the cancer
3749 treatment you have been getting. And so it is not a good idea
3750 to switch even though Virginia has some very good medical schools
3751 as well; would that be correct?

3752 Dr. Lichtenfeld. Well, actually my son was just interviewed
3753 at University of Virginia so we respect the medical schools for
3754 sure.

3755 Mr. Griffith. Yes.

3756 Dr. Lichtenfeld. You know, yes, that is correct. I mean
3757 continuity of care is important, how it is constructed, what the
3758 rules are, whether, what hospitals are allowed in the network,
3759 the location of the network, all that is important.

3760 Mr. Griffith. Right, and closeness matters too. And in
3761 fact, big parts of my district they are a lot closer to other
3762 states' hospitals then they are to the University of Virginia
3763 which would be closest to my district. Not to negate MCV, also

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3764 another fine institution and others.

3765 Let me switch gears, and I apologize, Mr. Wieske, you may
3766 not know the answer to this because it was a question for Dr.
3767 Holtz-Eakin about continuous coverage requirements. And he had
3768 said that that pushes providers and plans to invest in preventive
3769 and wellness programs to keep patients healthy, and the question
3770 would have been how does this impact the overall market, the
3771 overall risk pool? Are you in a position to answer that question?
3772 My team says you are but I don't know.

3773 Mr. Wieske. I think in general, I mean I think if you are
3774 able to keep people in the market and they stay in it and they
3775 stay with their insurer it provides better health, better health
3776 outcomes, and potentially over time it should lower, make the risk
3777 pool more representative and overall lower costs.

3778 Mr. Griffith. So similar to what I was talking about before.
3779 I see that Mr. Hudson's time is up and I yield back.

3780 Mr. Burgess. The chair thanks the gentleman and now
3781 recognizes the gentleman from New York, Mr. Tonko, 5 minutes for
3782 questions, please.

3783 Mr. Tonko. Thank you, Mr. Chair. And Mr. Wieske, first let
3784 me thank you for your service to the people of Wisconsin and for
3785 your testimony today. In your written statement you refer
3786 numerous times to Wisconsin's well-functioning health insurance
3787 market pre-ACA and expressed a desire to see the ACA repealed and
3788 returned to a pre-ACA marketplace.

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3789 So I would like to learn a little more about what Wisconsin's
3790 health insurance market looked like prior to the Affordable Care
3791 Act. I took and downloaded a publication from your office's
3792 website entitled Fact Sheet on Mandated Benefits in Health
3793 Insurance Policies, and with the permission of the chair I would
3794 like to ask unanimous consent that this document be entered into
3795 the record.

3796 Mr. Burgess. Without objection, so ordered.

3797 [The information follows:]

3798

3799 *****COMMITTEE INSERT 17*****

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3800 Mr. Tonko. Thank you. Now Mr. Wieske, prior to the
3801 Affordable Care Act did Wisconsin mandate that all health
3802 insurance plans serving the individual market cover hospital
3803 services or prescription drug coverage? Yes or no on that by the
3804 way.

3805 Mr. Wieske. I don't believe --

3806 Mr. Tonko. Yes or no.

3807 Mr. Wieske. I don't believe it was mandated, but --

3808 Mr. Tonko. The answer is no. Pre-ACA did Wisconsin mandate
3809 that all insurance plans serving the individual market cover
3810 mental health or substance use care, yes or no?

3811 Mr. Wieske. No.

3812 Mr. Tonko. The answer is no. Pre-ACA did Wisconsin mandate
3813 that all insurance plans serving the individual market cover
3814 maternity care, yes or no?

3815 Mr. Wieske. No.

3816 Mr. Tonko. Would it be fair to assume that plans in
3817 Wisconsin that offered these fundamental health care services in
3818 the individual market pre-ACA would be more expensive than plans
3819 that didn't offer these services, yes or no?

3820 Sir, can we move --

3821 Mr. Wieske. Well, the problem is --

3822 Mr. Tonko. Yes or no, because I have got to move on with
3823 my time here.

3824 Mr. Wieske. I am sorry I can't answer the question because

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3825 you have three there.

3826 Mr. Tonko. Well, fundamental health care services in the
3827 individual market pre-ACA, would it be more expensive than plans
3828 that didn't offer those services?

3829 Mr. Wieske. For maternity and for the mental health the
3830 answer is yes.

3831 Mr. Tonko. So given your expressed support for the pre-ACA
3832 marketplace where plans that covered even the most basic health
3833 care services were astronomically expensive in the individual
3834 market pricing out anyone who might actually need care, you
3835 clearly support returning to a system where women and all people
3836 with preexisting conditions are charged higher prices for the care
3837 they need?

3838 Mr. Wieske. No. My assumption is that the states would be
3839 able to --

3840 Mr. Tonko. Yes or -- so you are a no on that?

3841 Mr. Wieske. Yes, because the states will reform their laws
3842 and better reflect the market.

3843 Mr. Tonko. Well, we are looking at a federal plan that would
3844 cover all states, so thank you, Mr. Wieske. To summarize what
3845 we just learned for all the folks watching on TV, health insurance
3846 in Wisconsin was less expensive before the Affordable Care Act
3847 unless you actually wanted to go to the hospital, fill a
3848 prescription, be covered for mental health services or see a
3849 doctor. Women in Wisconsin were hit particularly hard, paying

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3850 up to 42 percent more for their health insurance than men before
3851 the Affordable Care Act.

3852 So when my Republican colleagues talk about their supposed
3853 desire to protect people with preexisting conditions, it is
3854 important to remember that you can't address this problem with
3855 a half-baked bill that doesn't actually require insurance plans
3856 to offer benefits to those who are sick. Otherwise, insurance
3857 companies will deny care to those with preexisting conditions with
3858 restrictive benefit designs that fail to cover basic services like
3859 hospitalizations, prescription drugs or mental health care.

3860 I appreciate this hearing today because I think it is really
3861 critical to clarify the stakes of this health care debate for the
3862 American people. What Mr. Wieske and my Republican colleagues
3863 want to do is to rip health care away from millions and take us
3864 back to a health care system controlled by the big insurance
3865 companies, the system where your health insurance is worth less
3866 than the paper it is printed on, a system where you get charged
3867 through the nose if you need mental health care or are a woman,
3868 or God forbid, man or woman, if you get sick and have to go to
3869 the hospital. I don't want to go back. The American people
3870 don't deserve to go back. We should instead be moving forward
3871 and building on the promise of high quality, affordable health
3872 care for all. And with that Mr. Chair --

3873 Ms. DeGette. Will the gentleman yield?

3874 Mr. Tonko. -- I yield back the balance of my time.

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3875 Ms. DeGette. Will the gentleman yield? Will the gentleman
3876 yield me his 39 seconds remaining?

3877 Mr. Tonko. Yes, I will. I will yield.

3878 Ms. DeGette. Mr. Wieske, I thought that what Mr. Tonko was
3879 asking you was really important, which is with this bill that we
3880 are looking at today there is no requirement that the states not
3881 charge people with preexisting conditions. That is just your
3882 hope that states wouldn't do that, right?

3883 Mr. Wieske. We had limits in place --

3884 Ms. DeGette. Yes, Wisconsin did, but maybe --

3885 Mr. Wieske. Correct.

3886 Ms. DeGette. -- Utah or Colorado or Idaho didn't, right?

3887 Mr. Wieske. Right.

3888 Ms. DeGette. That is just your hope?

3889 Mr. Wieske. Correct.

3890 Ms. DeGette. Thank you.

3891 Mr. Burgess. The chair thanks the gentleman. The
3892 gentleman yields back. The chair once again observes that I have
3893 delayed my time for questions until the end because I was delayed
3894 arriving this morning, so I recognize myself for the balance of
3895 the time.

3896 No, and I do appreciate our witnesses being here. I am sorry
3897 Dr. Holtz-Eakin had to leave because he always brings a lot to
3898 the discussion. Mr. Wieske, let me just ask you, and again I asked
3899 you while we were kind of in between on the votes, you have not

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3900 testified before our committee before, have you?

3901 Mr. Wieske. I have not.

3902 Mr. Burgess. And so that graphic that one of our members
3903 put up of all the hearings that were held prior to the Affordable
3904 Care Act you never participated in any of those hearings, did you?

3905 Mr. Wieske. Correct.

3906 Mr. Burgess. And I think that is a shame because I think
3907 you would have added to the discussion and you would have added
3908 to the debate and maybe some of the problems that we are now
3909 encountering and trying to fix could have been avoided had we
3910 listened to sane, rational voices like yours. I will also
3911 point out our two members from Indiana have had to leave, but we
3912 didn't hear from Governor Mitch Daniels, and Mitch Daniels was
3913 reported in the Wall Street Journal, while all the discussion of
3914 the Affordable Care Act was going on during the 2008 election cycle
3915 and we were having hearings here in this very room, Mitch Daniels
3916 with his Healthy Indiana Plan had actually reduced costs by 11
3917 percent over 2 years' time when every other HMO, PPO, Medicare,
3918 Medicaid was going up by seven or eight percent across the country.

3919 Why would not we have asked people who were experts and who
3920 were performing well, why would not have asked their opinions
3921 before writing this big law that changed health care from soup
3922 to nuts in this country? And I, it is obviously a rhetorical
3923 question. I think we should have.

3924 Much was made at the beginning of this session about the fact

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that Republicans wouldn't help, and I have to tell you that is not true. I contacted the transition team in 2008 and I said, look, I didn't give up a 25-year medical career to come sit on the sidelines while you guys do this. Talk to me. I am willing to talk to you.

Dr. Lichtenfeld, they could have put me in a tight spot, you know, because what if I had been offered to choose between -- you talked about toxic financial situations, what about our medical liability in a lot of states? That is a toxic situation. What if they had said to me, Dr. Burgess, we know you care a lot about medical liability. We would like to help you, but we have got to have your help on the public option. I don't know what I would have done. That would have been a pretty tough spot to put me in.

I don't know, maybe somebody who is familiar with making a deal might have, that might have occurred to them, but I was frozen out. I was frozen out by the then chairman of this committee, Henry Waxman. I went to see him personally and said I didn't give up a career in health care to come sit on the sidelines. So the notion that we have simply dug our heels in and refused to help, it is offensive to me when I hear that espoused on the panel.

Now let me just ask in particular with these bills that we have that we are considering, just on the issue of narrow networks now. Dr. Lichtenfeld, I mean you encountered narrow networks probably before the ACA was passed and after it was passed. Do

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3950 you have a feeling? Is it better or worse? Are narrow networks
3951 less restrictive now than they were before?

3952 Dr. Lichtenfeld. Speaking personally they are certainly
3953 are more restrictive and the testimony to that effect was made
3954 earlier. So the answer to that question is yes, they are more
3955 narrow.

3956 Mr. Burgess. You know, we all give our own experiences.
3957 There was a -- and I will confess that there was a special deal
3958 set up for members of Congress, the Grassley Amendment required
3959 us all to buy insurance under the Affordable Care Act and there
3960 was a special deal worked up between President Obama and
3961 then-Majority Leader Reid in the Senate that allowed us to receive
3962 a subsidy and walk it into the exchange. I didn't do that because
3963 my constituents back home would never understand that kind of a
3964 special deal.

3965 So I understand the difficulties that people felt in the
3966 individual market. My insurance was canceled at the end of 2013.
3967 I was one of the 5.7 million people who lost their insurance. I
3968 liked my coverage. I liked my doctor. But I couldn't keep it
3969 because I was told I had junk insurance and I had to get rid of
3970 it. I had to do something else. I had to buy all of these other
3971 things. It was not something that I asked for.

3972 And when my constituents come to my town halls and say why
3973 did I have to do this, why did I have to make these changes, I
3974 wasn't asking for that -- well, I felt their pain. And so I didn't

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3975 have an answer for them but I could look them in the eyes and say,
3976 yes, I agree with you. I think it was bad policy. I hope we get
3977 a chance to rectify things someday.

3978 So when people ask me did you lose your doctor or did you
3979 go on a narrow network, to tell you the truth I don't even know,
3980 because unlike every other American I bought on price, show me
3981 the cheapest Bronze Plan out there and that is what I bought and
3982 I really have no earthly idea who the people are that I had
3983 available to me.

3984 On the issue of this 30 days, 90 days, I worried about that
3985 when the law was in the enactment phase in 2014 because, Dr.
3986 Lichtenfeld, now correct me if I am wrong here, but you have a
3987 90-day grace period. You know, the insurance companies actually
3988 were talking a lot to the Democrats in those days, they weren't
3989 talking to Republicans. But 30 days, the insurance company is
3990 on the hook for that coverage. What happens to the rest of those
3991 60 days, Dr. Lichtenfeld? Who covers that bill if the patient
3992 doesn't pay their premium?

3993 Dr. Lichtenfeld. The answer to your question is that the
3994 person who provides the service ends up not getting paid under
3995 the current situation, if in fact the patient or the family doesn't
3996 pay that bill by 90 days.

3997 Mr. Burgess. And I do need to point out this is only for
3998 someone receiving a subsidy in healthcare.gov exchange, because
3999 I actually thought I had a 90-day grace period on my premium. It

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4000 turns out, no, you only get 30 days because you are not receiving
4001 a subsidy, so that 90-day period does not cover you.

4002 But I did worry about that because I worried that former
4003 colleagues who practiced medicine would in fact be on the hook
4004 for those bills and it hasn't turned out to be the problem I thought
4005 it was going to be, but I think it is a problem that should be
4006 corrected. We shouldn't allow for the system to be manipulated
4007 where physicians and hospitals actually don't receive the
4008 compensation for the care that they provide.

4009 There are a lot of things that we could still talk about.
4010 I have some questions that I will submit for the record. We have
4011 been here a long time. I do appreciate both of you being here.
4012 This is not easy. This is complex. I don't know. I don't know
4013 at the end of the day where this all shakes up but I do know this.
4014 If it was working perfectly, if it was working perfectly we
4015 wouldn't be here today. It is not working perfectly. There are
4016 serious problems. There are serious fractures and we have been
4017 charged with fixing them.

4018 So that is what this subcommittee does. You have got some
4019 of the smartest members of Congress on this subcommittee and I
4020 appreciate each and every one of them, those that are here and
4021 those that have had to leave. This is a good subcommittee, a great
4022 subcommittee. We are up to the task and we will deliver.

4023 So with that I will yield back the balance of my time and
4024 then -- oh my gosh, what have I got to do, all of these unanimous

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4025 consent requests. Seeing there are no further members wishing
4026 to ask questions I would like thank all of our witnesses again
4027 for being here today.

4028 Before we conclude the hearing I would like to submit the
4029 following items for the record, a statement from Representative
4030 Bill Flores, a statement from Blue Cross Blue Shield, a statement
4031 from the American College of Obstetricians and Gynecologists, a
4032 letter from the Alliance for Retired Americans, a letter from the
4033 Healthcare Leadership Council, and a statement from America's
4034 Health Insurance Plans.

4035 [The information follows:]

4036

4037 *****COMMITTEE INSERT 18*****

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4038 Mr. Burgess. Pursuant to committee rules I remind members
4039 they have 10 business days to submit additional questions for the
4040 record. I ask the witnesses to submit their response within 10
4041 business days upon receipt of the questions. Without objection,
4042 the Subcommittee is adjourned.

4043 [Whereupon, at 2:50 p.m., the Subcommittee was adjourned.]

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