Statement for the Record

Tax-Related Member Proposals to Improve Health Care

House Committee on Ways and Means
Subcommittee on Health

The Honorable Randy Hultgren (IL-14)
Member of Congress

May 17, 2016

Chairman Tiberi and Ranking Member McDermott, thank you for the opportunity to provide testimony before the Health Subcommittee. Since its passage six years ago, the Patient Protection and Affordable Care Act (ACA) has been a misnomer. For too many Americans, the ACA has failed to live up to its promise of more affordable, more accessible health care. For people in my home state of Illinois and its 14th Congressional District, the pendulum has swung in the opposite direction, carrying with it higher insurance premiums, unattainable deductibles, and fewer plan choices by way of a consolidated marketplace. This post-ACA reality is pricing families out of sufficient insurance – under the law, the underinsured population has doubled to 31 million, or fully one quarter of insured people.[1] The ACA is covering Americans in name only, and the federal government is not living up to the promises it made the American people.

Policymakers have long been after an alternative to the ACA, a comprehensive platform that creates more competition in insurance markets, allows insurers to compete across state lines, reforms caps and rollover rules on health savings accounts, and establishes a more modest premium tax credit system for low-income individuals. These are worthwhile proposals and objectives, but in the time it continues to take Congress to debate and legislate such ideas, states are suffering. American families are watching their premiums and their deductibles increase every year with no tangible hope for change because there is not yet a functional, achievable way out of the ACA. States are stuck.

Stories from My District

In the summer of 2015 I organized a Community Leadership Forum on Health Care in Illinois's 14th Congressional District. I solicited the ideas, concerns, and advice of insurers, employers, hospitals, providers, patients, and caregivers regarding the local impact of a sweeping overall of our nation's health care system called the ACA. Their message was clear – the centralization of national health care and insurance planning has precluded the market from improving access by relieving all players of rising costs. It became abundantly clear to me that the best ideas in health care come from its practitioners and its participants, that while we continue to pursue comprehensive reform in Washington we

[1] Sarah Ferris, "Study: 'Underinsured' population has doubled to 31 million," *The Hill*. May 20, 2015. http://thehill.com/policy/healthcare/242584-study-underinsured-population-has-doubled-to-31-million

should rely on our laboratories of democracy for some free-market test runs. Out of that effort was born a legislative solution to the ills of the ACA.

H.R. 3352, the State Health Care Options Act

The State Health Care Options Act (State Options) expands Americans' access to affordable health insurance options through state innovation. The bill offers states facing daunting rate, deductible, and out of pocket cost increases a parachute – a mechanism that would allow them the flexibility to immediately, inventively address rising health insurance costs and diminishing plan options. State Options gives states the opportunity to chart their own course away from centralized control and regulation of health care and coverage and toward a more free-market approach that better suits the insurance, care, provider, and patient needs characteristic of their unique populations.

The ACA already gives us a place to start. State Options revamps Section 1332 of the law to streamline and expand the process and parameters for the provision's state innovation waivers. The process that the U.S. Department of Health and Human Services (HHS) laid out and reaffirmed in its final rulemaking presents states with barriers to these waivers that are all but insurmountable. In March 2011, just two months after the inauguration of a new Congress, the Centers for Medicaid and Medicare Services (CMS) announced rules pursuant to Section 1332 – the quietly announced proposed regulations elicited only 27 public comments, and the final rules included a series of Herculean tasks including: state-passed legislation authorizing a waiver request; a 10-year, revenue-neutral budget plan; and an offering of exhaustive state resident data, including age, income, health expenses, and health insurance status of state residents.

While ACA supporters in Congress paid lip service to a waiver option and process in statute, CMS made it functionally impossible for states to access this important tool, for which there is a great deal of legal precedent. For example, after No Child Left Behind, states were left with federal standards to improve and assess their unique school systems. Forty-five states, including Illinois, said they could do it better, and the U.S. Department of Education let them try. The administration gave state educational agencies the flexibility to request waivers for 10 provisions of the law and implement plans to improve outcomes for their students and teachers.

The federal government overreached when it came to our children's education, and states were rightfully granted a way out. State Options replicates this effective model to include state ACA waivers in statute, allowing applicants to simply select a waiver, the approval of which is only contingent on waiver-specific information provided to HHS. This information includes:

- The years for which the waiver will be effective.
- The ACA provisions the state intends to waive.
- An assurance that the state will report annually to HHS on progress made with respect to affordability, access, and transparency.
- An assurance that the state will effectively take over for a state or federal exchange with respect to collecting health information and certifying health plans for the purpose of determining subsidy eligibility.

Additionally, whereas states could not be approved for a 1332 waiver until 2017 under the ACA, State Options allows state applicants to notify HHS of their intent to opt out of certain allowed provisions of the law immediately upon passage of the bill.

Health Flex Waivers

Under State Options, states that apply for an innovation waiver would have two clear options for health care and insurance flexibility, and the authority of HHS to limit state ingenuity would be scaled back significantly.

The health flex waivers included in State Options are functionally the same opt-out mechanisms described in Section 1332 of the ACA, sans the prohibiting application and approval requirements. States that select the health flex waiver option are able to opt out of all provisions articulated in Sections 1301, 1302, and 1303 of the ACA – most prominently the benchmarks and services that currently comprise an essential health benefits package and certify that a coverage option is a qualified health plan. At its most basic level, the health flex waiver allows a health insurance market in a state to offer basic or catastrophic health plans made unlawful by the ACA.

The health flex waiver system also allows states to opt out of the ACA's plan rating mechanism, replacing a multi-layered system of tiers with one that more

simply identifies which plans include more benefits than average, which plans offer standard coverage, and which basic plans cover catastrophic medical events. States with health flex waivers are able to offer insurers the leeway to develop a larger buffet of coverage options and consumers the flexibility to purchase a plan without paying for benefits they do not need or want.

Exchange Waivers

Instead of or in addition to a health flex waiver, states are able to opt out of the ACA's exchange requirements. States with an exchange they established themselves could dismantle the existing marketplace and open up other purchasing channels for consumers. Residents of these waivers states would then be able to buy a health plan through an agent or broker, on a private exchange, or directly from an insurer.

Under State Options, exchange waiver states assume responsibility for certain exchange functions, including serving as the certifying entity for health plans. States are offered subsidy eligibility information from HHS and the Department of the Treasury for the purpose of calculating premium assistance credits and cost-sharing arrangements. On matters of health insurance cost assistance and product standards, the state takes the role of the federal government as the certification and regulatory hub in these presumably more diverse, decentralized insurance markets.

Additionally, State Options creates a new "no lock-out provision." Because these states will have shaken off the rigid framework and regulation that comes with reliance on an exchange, people who buy insurance in these exchange waiver states are able to fluidly move in and out of plans should they experience changes to their income, employment status, and/or health. Consumers should not be locked into a health plan with only one opportunity each year to make a change.

Health flex waivers and exchange waivers are neither mutually exclusive, nor are they a package deal – states interested in opting out of certain ACA provisions may freely choose one, the other, or both.

Health Insurance Subsidy Reform

The existing income threshold for federal health insurance subsidy eligibility under the ACA is 400 percent of the federal poverty level. Based on 2014 federal poverty guidelines, a family of four making $95,400 is eligible for a premium subsidy this year. Because the U.S. Census Bureau routinely updates this national benchmark based on the Consumer Price Index, the federal poverty level rises with inflation. With respect to insurance subsidies, this meant that the eligible income for a family of four increased by $1,600 between 2014 and 2015. If we allow this trend to continue, the ACA will be subsidizing coverage for two-parents families with two children with a combined six-figure income by 2018.

State Options reduces this threshold to 300 percent of the federal poverty level for individuals and families who obtain coverage through a plan issued in a waiver state. Subsidy eligibility is capped at $35,310 for individuals and $72,750 for a family of four to ensure that the availability of this important federal financial assistance is concentrated among the truly needy.

Affordability Standards

The ACA currently exempts from the individual mandate and its financial penalty anyone who is unable to find a ACA-compliant health insurance coverage in his/her home state that is less than eight percent of his/her household income for that taxable year, effectively creating a new benchmark for affordability. The problem with this measure is that health care costs are increasing considerably, and as this trend continues, more and more Americans will be spending more than eight percent of their annual income on insurance premiums and out-of-pocket costs. The ACA's only "solution" to this cost dilemma is to relieve these individuals of a penalty should they decide to forego insurance coverage altogether. This "fix" means more uninsured people, not more affordability.

Before the ACA passed, it was possible in each state to find and purchase a health plan at or below 6.5 percent of that state's median household income. To ensure that waiver states are outpacing the ACA with respect to affordability, they must guarantee the availability of at least one health plan that provides a basic level of coverage for which an enrollee's required contribution does not exceed 6.5 percent of the median household income of residents in that state for the most recent taxable year.

Transparency Standards

Because state and federal exchange applications often limit their questions to age, location, income, and gender, consumers who experience a dramatic premium, deductible, or out-of-pocket cost increase are left in the dark about the impetus for the price jump. State Options requires the issuer of health plans in waiver states to make available information about the demographics of the population enrolled in their plans, the utilization of health care services by these customers, and any other pertinent factors that may serve as a justification for premium levels – including any premium increases – under the plan.

Closing

While Congress continues its laborious work to repeal and replace the ACA with a system that is affordable, accessible, and sustainable, we can do something now to keep states from waiting on us.

The realistic, accessible ACA waivers offered by State Options and the new parameters for attaining them give states genuine flexibility to tackle their unique health care and insurance problems. State Options is a parachute that gives Americans a way out of an upward health care cost and coverage spiral, a solution to health insurance market monopolization, and a clear exit from the broken ACA system more broadly. States have independently produced and tested successful approaches to countless national problems – health care should be no different.

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May 17, 2016

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Dear Chairman Brady and Ranking Member Levin:

Re: Statement for the Record from May 17, 2016 Members Day on Health-Tax Bills

Thank you for taking the time to hold this Member Day on health-tax related legislation. I would like to take this time to speak on a topic that many of you are already familiar – the so-called Cadillac Tax.

As you know, part of the *Affordable Care Act* included a provision that was inserted by the Senate that levies a 40% tax on high-cost health insurance plans that cost over $10,200 for singles and $27,500 for families. One of the main goals of the *Affordable Care Act* was to make health insurance more affordable for everyone. The Cadillac Tax, unfortunately, does the exact opposite. Though I understand that the true intent of this provision was to tax true "Cadillac' plans, such as those on Wall Street and K Street, but instead this tax is going to hit teachers, police officers, government workers, cancer patients, and families. That is, those with Ford Focus plans.

This provision has been the source of concern and opposition since debate over the health reform bill. Notably, during the House-Senate negotiations over the final form of the bill in 2010, over 190 members joined me expressing our serious opposition to the tax. Our efforts resulted in a delay in the implementation of the tax to 2018.

Since then, a growing coalition of stakeholders from labor to business, health insurers to heath advocacy groups, have kept up the drumbeat against the tax. With their support, and the backing of a majority of congress in favor of repeal, implementation of the tax was again delayed, this time to 2020, through last year's *Bipartisan Budget Act of 2015,* otherwise known as the Omnibus.

While delay has eased the pressure to a degree, the fact remains that many employers, particularly those that face negotiations over long term contracts, remain highly concerned about the tax. Some, I am sure, believe that we have 'fixed' the problem by delaying implementation

and modifying the tax with Administration-proposed changes. The truth is that for those negotiating health benefit plans, 2020 is now -- and proposed changes are not enough.

A variety of studies and surveys on employer behavior have shown that employers are downgrading the value of health plans offered to workers in order to make sure that their total costs fall well below the thresholds as to not trigger the tax. This means increased cost-sharing requirements through higher deductibles, higher copays, and less services fully covered for families across the country. So, though we successfully delayed the tax by two years, and the Administration offered a few modifications to the tax in order to correct perceived issues, these actions fall woefully short of fixing the underlying problem.

An April 2016 report released by Milliman analyzed the extent to which Administration proposals to modify the tax will change the perceived outcome of tax implementation. The report found that the changes do little to change the disproportionate impact that the tax will have on those who live in higher-cost geographic areas, those who happen to be female, older workers, and those who work in more physically demanding occupations.

In addition, a *CancerCare* Patient Access and Engagement Report was released in May 2016 that examines a number of factors patients experience while living with cancer. Of particular relevance is part of the study that addresses the financial and insurance concerns of patients and families. This study confirms many of the startling realities that I have been referencing all along – one third of survey respondents reported that in order to afford treatment, they cut back on things like groceries, transportation, missed bills, and choose to become delinquent on rent and mortgage payments.

It is important to note that this trend is not just relevant to cancer patients. Workers across the country have already been affected by employers downgrading their health insurance plans to avoid the tax. These hard working citizens are being forced to choose between every day essentials, and going to see their primary care physicians for small health issues, that can easily turn into acute illnesses if not addressed in a timely manner. In addition, those with chronic conditions are also skipping doctor appointments, and not adhering to medically-prescribed treatment regimens because they find medical care and the necessary prescriptive drugs and devices too expensive.

For these reasons, I am here today to remind this Committee of my bipartisan legislation, HR 2050, the *Middle Class Tax Benefits Repeal Act of 2015*. The legislation has 186 bipartisan cosponsors here in the House, and Senate versions (S. 2045 and S. 2075) have 37 bipartisan cosponsors between them. In addition, the Senate voted 90-10 during December 2015 Omnibus deliberations to repeal the Cadillac Tax altogether.

With the broad support of legislators from both sides of the isle, and both sides of the Hill, in partnership with stakeholders from across the American spectrum -- including Fortune 500 companies, towns and municipalities, patient advocate groups, organized labor, economists, and everyone in between -- we can alleviate the burden of this tax. I urge my colleagues on the committee to work with me to complete the repeal of this unworkable provision.

Thank you for the opportunity today to speak to the Committee on behalf of workers across the country who should not be penalized for things that they cannot control -- like where they live, how old they are, if they are male or female, and if they choose one occupation over another. I hope that we can work together as Democrats and Republicans to alleviate this burdensome tax once and for all.

Sincerely,

Joe Courtney

JOE COURTNEY
Member of Congress