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Good afternoon, Chair DeSaulnier, Ranking Member Allen, and members of the Subcommittee, and thank you for the opportunity to testify today. I am Katie Keith, a Visiting Professor and Director of the Health Policy and the Law Initiative at the nonpartisan O'Neill Institute for National & Global Health Law at Georgetown University, where I study and teach courses on private health insurance and the Affordable Care Act (ACA). I am also the author of the "Following the ACA" blog series for *Health Affairs*, the leading journal of health policy thought and research, where I serve as a contributing editor and am responsible for chronicling implementation of the ACA and new developments in health reform.

My testimony focuses on progress made under the ACA, the law's role in the pandemic response, the importance of the American Rescue Plan Act's enhancements to the ACA, the threat that non-comprehensive products pose to people with preexisting conditions, and the need for additional policies to improve access to affordable, high-quality coverage. The views I express today are my own and do not reflect those of Georgetown University or *Health Affairs*.

Significant Progress Under the Affordable Care Act

The ACA has resulted in historic coverage gains: the uninsured rate among the non-elderly population reached a record low in 2016,[1] and a record 31 million Americans had coverage through expanded Medicaid as of late 2020 and the marketplaces as of early 2021.[2] Millions more—including those with job-based coverage—have benefited from the law's consumer protections. These protections include the coverage of preventive services without cost-sharing, a cap on annual out-of-pocket expenses for care, and a ban on lifetime and annual dollar caps on care. The ACA's coverage expansions have helped improve families' financial stability and is linked to increased food security[3] and reduced out-of-pocket costs,[4] unpaid bills,[5] and evictions.[6]

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Trends in the U.S. Uninsured Population, 2010-2020, HP-2021-02 (Feb. 2021).

[2] The ACA's total effect on coverage is likely higher since the estimate of 31 million people does not include other coverage expansions such as an additional 1 million people enrolled in coverage through the ACA's Basic Health Program or the more than 2 million young adults who could remain on their parents' plan until age 26. *See* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates, HP-2021-13 (Jun. 2021).

[3] Gracie Himmelstein, "Effect of the Affordable Care Act's Medicaid Expansions on Food Security, 2010–2016," *Am J Public Health* (2019) 109(9):1243–8.

The ACA served as a critical part of the safety net throughout the pandemic. Prior recessions led to coverage losses as economic upheaval caused employees and their families to lose coverage.[7] Despite predictions of severe coverage losses as a result of the COVID-19 pandemic,[8] the uninsured rate remained stable in 2020.[9] Coverage losses were staved off in part because those who lost job-based coverage could enroll in individual market coverage or Medicaid.[10] Congress also leveraged existing ACA standards—such as the requirement to cover evidence-based preventive services without cost sharing—to quickly mandate the coverage of COVID-19 testing and vaccines for those with comprehensive coverage. Thanks to the ACA, millions of would-be uninsured people have instead been able to enroll in marketplace or Medicaid coverage that covers COVID-19 testing, vaccines, and treatment.

The ACA also narrowed racial and ethnic disparities in insurance coverage and access to care.[11] The uninsured rate for Black adults dropped from 24.4% in 2013 to 14.2% in 2019 while the rate for Hispanic adults fell even more significantly—from 40.2% to 25.7%—over the same period.[12] Improved access to coverage has led to improved access to health care. Black and Hispanic adults reported fewer cost-related access problems and were more likely to have a usual source of care (such as a primary care physician) in 2019 compared to 2013.[13] Coverage gains have also been observed for other historically underserved communities, such as Asian Americans and Pacific

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[4] Hiroshi Gotanda et al., "Out-of-Pocket Spending and Financial Burden Among Low Income Adults After Medicaid Expansions in the United States: Quasi-Experimental Difference-in-Difference Study," *British Med. J* (2020) 368:m40.

[5] Luojia Hu et al., "The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing," *J Public Econ* (2018) 163:99–112.

[6] Naomi Zewde et al., "The Effects of the ACA Medicaid Expansion on Nationwide Home Evictions and Eviction-Court Initiations: United States, 2000–2016" *Am J Public Health* (2019) 109(10):1379–83.

[7] *See, e.g.* John Holahan & Vicki Chen, Changes in Health Insurance Coverage in the Great Recession, 2007-2010, Kaiser Family Foundation (Dec. 2011).

[8] *See, e.g.*, Jessica Banthin & John Holahan, Making Sense of Competing Estimates: The COVID-19 Recession's Effects on Health Insurance Coverage, Urban Institute (Aug. 2020).

[9] *See* Katherine Keisler-Starkey & Lisa N. Bunch, Health Insurance Coverage in the United States: 2020, U.S. Census Bureau, Report No. P60-274 (Sep. 2021); *see also* Katie Keith, Uninsured Rate Steady But High; More Work Needed, Health Affairs Forefront (Sep. 2021) (summarizing multiple studies on the uninsured rate).

[10] Sara R. Collins et al., As the Pandemic Eases, What is the State of Health Care Coverage and Affordability in the U.S.? The Commonwealth Fund (Jul. 2021) (finding that about 6% of working-age adults lost job-based coverage since the pandemic began and that, of these individuals, 25% gained coverage through Medicaid or the marketplaces).

[11] *See e.g.*, Jesse C. Baumgartner et al., Racial and Ethnic Inequities in Health Care Coverage and Access, 2013-2019, The Commonwealth Fund (Jun. 2021); Thomas C. Buchmueller & Helen G. Levy, "The ACA's Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care," *Health Affairs* (2020) 39(3); Samantha Artiga et al., Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018, Kaiser Family Foundation (Mar. 2020); Susan L. Hayes et al., Reducing Racial and Ethnic Disparities in Access to Care: Has the Affordable Care Act Made a Difference? The Commonwealth Fund (Aug. 2017).

[12] Baumgartner et al. *supra* note 11.

[13] *Id.*

Islanders,[14] American Indians and Alaska Natives,[15] and LGBTQ people.[16] Although much more can and must be done, the ACA has helped narrow care and coverage disparities in important ways.

The American Rescue Plan Act Improved Access to Coverage and Affordability

Record-high ACA enrollment has continued thanks to enhancements made by Congress and the Biden administration under the American Rescue Plan Act. This historic law increased the affordability of coverage for millions by extending subsidies to many middle-income people for the first time and increasing subsidies for those with lower incomes for 2021 and 2022. Among many other changes, the American Rescue Plan Act also fully subsidized COBRA continuation coverage for laid-off workers through September 30, 2021 and included new incentives for states that have not yet expanded their Medicaid programs.

These investments in affordable coverage have already had a significant impact. As of January 15, 2022, a record 14.5 million people had enrolled in marketplace coverage, including many new consumers.[17] Overall, 5.8 million people have newly gained coverage since 2021, including 2.8 million people who enrolled during the Biden administration's six-month COVID-19 special enrollment period and 3 million people who enrolled during the 2022 open enrollment period.[18] This is a significant reversal of marketplace enrollment trends: after previously peaking at 12.7 million people for 2016, enrollment largely stagnated under the Trump administration.[19]

Record enrollment is driven in large part by the availability of enhanced subsidies under the American Rescue Plan Act. Under the new law, consumers that use HealthCare.gov saw average monthly premiums fall by 23%, and 32% of HealthCare.gov consumers selected a plan for $10 per month or less.[20] Consumer out-of-pocket costs have also dropped: more generous premium tax credits mean consumers can opt to enroll in a more generous plan with lower out-of-pocket

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[14] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage Changes: Asian Americans and Pacific Islanders, HP-2021-11 (May 2021). This analysis suggests that Asian Americans and Pacific Islanders (AAPIs) experienced the largest improvement in coverage rates among any racial or ethnic group between 2013 and 2019, although considerable variation remains by AAPI subgroup.

[15] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges, HP-2021-18 (Jul. 2021).

[16] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Coverage and Access to Care for LGBTQ+ Individuals: Current Trends and Key Challenges, HP-2021-14 (Jun. 2021).

[17] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Marketplace 2022 Open Enrollment Period Report: Final National Snapshot (Jan. 27, 2022).

[18] U.S. Department of Health and Human Services, Biden-Harris Administration Announces 14.5 Million Americans Signed Up for Affordable Health Care During Historic Open Enrollment Period (Jan. 27, 2022).

[19] Enrollment for 2022 is higher by about 2.5 million people than for 2021—and about 1.8 million more people than the prior enrollment record from the 2016 plan year. *See* Kaiser Family Foundation, Marketplace Enrollment, 2014-2021 (last visited Feb. 2022).

[20] U.S. Department of Health and Human Services, *supra* note 18.

costs.[21] Higher enrollment was also aided by the Biden administration's significant financial investments in marketing and the navigator program, under which 1,500 certified navigators held over 1,800 outreach and education events during the 2022 open enrollment period.[22]

The American Rescue Plan Act has already resulted in significant savings for millions of Americans. But these changes are temporary. Unless Congress extends the American Rescue Plan Act's subsidy enhancements, many consumers will face premium hikes beginning in 2023 and marketplace enrollment could decline. In contrast, making these subsidies permanent would further reduce the number of uninsured people, lower household costs, and reduce premiums.[23]

Protecting Consumers From Non-Comprehensive Insurance Products

Beyond extending the American Rescue Plan Act subsidy enhancements, Congress should protect consumers from the range of non-comprehensive insurance products that fail to offer the protections that patients have come to expect under the ACA. This need to protect consumers, while not new, has been made even more urgent due to the ongoing pandemic.

Non-comprehensive insurance products may include short-term limited duration insurance (STLDI), fixed indemnity plans, other excepted benefits, and health care sharing ministries.[24] These products vary in their design but generally discriminate against people with preexisting medical conditions and do not have to comply with the ACA's other consumer protections—often with devastating medical and financial effects. These products proliferated under the Trump administration, and the media has reported many stories of consumers who unknowingly enrolled in a non-comprehensive product only to learn that their health costs are not covered, leaving them with thousands of dollars in unpaid medical bills.[25]

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[21] Data is not yet available for the 2022 open enrollment period, but the median deductible for new consumers that enrolled during the six-month COVID-19 special enrollment fell from $450 to $50. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Deductibles Among HealthCare.gov Enrollees, 2017-2021, HP-2022-02 (Jan. 2022).

[22] U.S. Department of Health and Human Services, *supra* note 18.

[23] Jessica Banthin et al., What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022, Urban Institute (Apr. 2021).

[24] *See* Christen Linke Young, Taking a Broader View of "Junk Insurance," Brookings Institution (Jul. 2020).

[25] *See, e.g.*, Amy Lotven, "AZ Man Pursues RICO Case Against STLDI Issuers, Charges Broker With Fraud," *Inside Health Policy* (Jan. 28, 2022); Anna Wilde Mathews & Tom McGinty, "Hospital Prices Are Unpredictable. One Type of Health Coverage Often Gets The Worst Rates," *Wall Street Journal* (Dec. 22, 2021); Michelle Andrews, "Think Your Health Care Costs Are Covered? Beware the 'Junk' Insurance Plan," *NPR* (Dec. 3, 2020); Jeremy B. Merrill & Marshall Allen, "'Trumpcare' Does Not Exist. Nevertheless Facebook and Google Cash In On Misleading Ads for 'Garbage' Health Insurance." *ProPublica* (Oct. 20, 2020); Dylan Scott, "How Trump Gave Insurance Companies Free Rein to Sell Bad Health Plans," *Vox* (Jun. 30, 2020); Stephanie Armour, "Shorter-Term Health Plans Force Many to Pay for Lifesaving Treatments, Report Finds," *Wall Street Journal* (Jun. 25, 2020); Ben Conarck, "A Miami Man Who Flew to China Worried He Might Have Coronavirus. He May Owe Thousands," *Miami Herald* (Feb. 24, 2020); Jenny Deam, "A Doctor's Scribbled Note Leads to Patient Losing Health Insurance," *Houston Chronicle* (Nov. 27, 2019); Jenny Deam, "Complaints Against Faith-Based Health Share Ministry Sent to FBI," *Houston Chronicle* (Jul. 12, 2019); Jenny Deam, "Buyer Beware: When Religion, Politics, Health care and Money Collide," *Houston Chronicle* (Jul. 2, 2019); Sarah Gantz, "Villanova Prof

These products are inadequate across multiple fronts.[26] STLDI products, for instance, can and often do exclude entire categories of benefits (such as prescription drugs, maternity care, and mental health care);[27] deny coverage or benefits to those with preexisting conditions;[28] discriminate against women;[29] engage in medical underwriting;[30] require much higher cost sharing than ACA products;[31] and lead to exorbitant out-of-pocket costs for those who become ill.[32] Some STLDI does not cover even routine preventive care or injuries,[33] and many of these policies do not cover treatment for COVID-19[34] or have a provider network, putting enrollees at risk of significant balance bills.[35] As a result, those who purchase these plans risk (often unknowingly) catastrophic medical bills that can lead to financial instability and uncompensated care for hospitals and other providers. These and other gaps were documented in an extensive investigation of STLDI by the Democratic staff of the U.S. House of Representatives Energy and Commerce Committee.[36]

Despite predictions that STLDI would evolve to offer more comprehensive benefits under a Trump administration rule that allowed these products to be sold for up to 364 days and renewed for up to three years, 12-month STLDI continues to deny coverage based on health status, exclude major benefit categories, exclude coverage for preexisting conditions, and impose low

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Contracted Sepsis and Needed an Amputation—And Her Health Plan Wouldn't Pay," *Philadelphia Inquirer* (Apr. 5, 2019); Zeke Faux et al., "Health Insurance That Doesn't Cover the Bills Has Flooded the Market Under Trump," *Bloomberg* (Sep. 17, 2019); Noam N. Levey, "Skimpy Health Plans Touted by Trump Bring Back Familiar Woes for Consumers," *Los Angeles Times* (Apr. 2, 2019); Reed Abelson, "Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans," *New York Times* (Nov. 30, 2017); Erik Larson & Zachary Tracer, "The Health Plans Trump Backs Have a Long History of Disputes," *Bloomberg* (Oct. 16, 2017).

[26] *See* Leukemia & Lymphoma Society et al., Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed (Mar. 2021); *see also* Linke Young, *supra* note 24.

[27] Karen Pollitz et al., Understanding Short-Term Limited Duration Health Insurance, Kaiser Family Foundation (Apr. 2018).

[28] *See* American Cancer Society Cancer Action Network, Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans (May 2019).

[29] *See, e.g.*, JoAnn Volk et al., Trump Administration Promotes Coverage That Fails to Adequately Cover Women's Key Health Care Needs, The Commonwealth Fund (Oct. 2020).

[30] Pollitz et al., *supra* note 27; American Cancer Society Cancer Action Network, *supra* note 28.

[31] Dania Palanker et al., New Executive Order: Expanding Access to Short-Term Health Plans is Bad for Consumers and the Individual Market, The Commonwealth Fund (Oct. 2017).

[32] Dane Hansen & Gabriela Diguez, The Impact of Short-Term Limited Duration Policy Expansion on Patients and the ACA Individual Market, Milliman (Feb. 2020).

[33] Cheryl Fish-Parcham, Seven Reasons the Trump Administration's Short-Term Health Plans Are Harmful to Families, Families USA (Aug. 2018), (finding STLDI exclusions for sports injuries and tonsillectomies).

[34] *See* Emily Curran et al., In the Age of COVID-19, Short-Term Plans Fall Short for Consumers, The Commonwealth Fund (May 2020).

[35] Dania Palanker & Kevin Lucia, Opportunities to Better Protect Consumers and Markets from the Negative Impact of Short-Term Plans, The Commonwealth Fund (Jan. 2021).

[36] U.S. House of Representatives, Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk (Jun. 2020), [hereinafter *Shortchanged*].

dollar limits on care.[37] These gaps, researchers concluded, show that the STLDI market "continues to place enrollees at huge risk."[38] Given the concerns raised by STLDI, it is unsurprising that there is broad support among Americans of all political stripes to require these products to comply with the same rules as traditional health insurance.[39]

Other products, such as association health plans and similar group purchasing arrangements, are not regulated under the same rules that apply to the individual and small group markets, leading to discrimination through eligibility rules, rating practices, and benefit design.[40] This can lead to risk segmentation and higher premiums in the traditional individual and small group markets.[41] These arrangements are also plagued by a long history of fraud, scams, and insolvency.[42] Some entities have tried more creative ways to evade state insurance regulation and much of the ACA by arguing that their coverage arrangements with non-employees qualify as a single-employer self-insured group health plan under the Employee Retirement Income Security Act.[43]

Although much focus has been given to STLDI and association health plans, similar concerns extend to a range of other products that are exempt from the ACA's consumer protections but often masquerade (and are marketed) as comprehensive coverage.

Health care sharing ministries, for instance, can be designed and marketed to mimic insurance. Yet these products do not guarantee to reimburse members for medical expenses and do not have to meet financial or other standards that ensure they can cover members' medical needs.[44] As enrollment in ministries has increased, at least some members have been left with significant unpaid medical bills or forced into debt collection over even small bills that go unpaid.[45] Concerns that some health care sharing ministries are operating as unlicensed insurers has led

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[37] Dania Palanker et al., Limitations of Short-Term Health Plans Persist Despite Predictions That They'd Evolve, The Commonwealth Fund (Jul. 2020).

[38] *Id.*

[39] Leukemia & Lymphoma Society, U.S. Adults Widely Agree It's Time to Protect Consumers from Short-Term, Limited-Duration Health Plans (Jan. 2022).

[40] *See, e.g.*, Christina Lechner Goe, Non-ACA-Compliant Plans and the Risk of Market Segmentation: Considerations for State Insurance Regulators (Mar. 2018). The Trump administration finalized a rule in 2018 to dramatically alter the regulation of association health plans; however, the rule's most significant changes were set aside by a federal district court in March 2019. *See* Timothy S. Jost, The Past and Future of Association Health Plans, The Commonwealth Fund (May 2019).

[41] Goe, *supra* note 40.

[42] *Id.*

[43] *See* Katie Keith, CSR Litigation, New Non-ACA Plan Decision, Health Affairs Forefront (Oct. 2020). In litigation over this arrangement (known as the Data Marketing Partnership arrangement) before the Fifth Circuit Court of Appeals, amicus briefs were filed in support of the Department of Labor by the National Association of Insurance Commissioners, individual state insurance commissioners, patient advocates, consumer advocates, insurer associations, and state attorneys general.

[44] JoAnn Volk et al., Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets? The Commonwealth Fund (Aug. 2018).

[45] *See, e.g.*, Jenna Carlesso, "'I'm Relying on Prayer.' Complaints Pile Up Against Health Care Sharing Ministries As State Mounts a Defense," *CT Mirror* (Mar. 2, 2020); Reed Abelson, "It Looks Like Health Insurance, But It's Not. 'Just Trust God,' Buyers Are Told," *New York Times* (Jan. 2, 2020).

several state insurance departments and attorneys general to shutter or otherwise warn consumers about these products.[46]

Fixed and hospital indemnity products raise similar concerns. While comprehensive data is not available, anecdotal evidence and research suggests that the fixed and hospital indemnity market has evolved from a form of income replacement (where consumers receive a fixed payment amount per day of illness or hospitalization) to more complex products with provider networks and payment amounts that vary based on an enrollee's specific health care needs.[47] These more complex products mimic traditional health insurance but are exempt from major consumer protections and thus can discriminate based on preexisting conditions, refuse to cover the essential benefits, and have very low annual limits.[48] As a result, these products may not cover enrollee health needs or costs.

Non-comprehensive products are also being offered as a primary form of coverage in the group market, raising serious concerns for workers and their families.[49] For instance, a 36-year-old man in Texas paid $130 per month for what he thought was a major medical plan through his employer—until he received $67,000 in hospital bills following a heart attack and learned that his fixed indemnity plan would only pay out $400 towards his hospital bills.[50] In response to these types of concerns, the Committee on Education and Labor and this Subcommittee have requested information from federal regulators on complaints received, enforcement actions taken, and efforts to protect workers from noncompliant fixed indemnity and other products.[51]

The significant gaps associated with non-comprehensive products are especially pernicious given the aggressive and misleading tactics used to market these products. Investigations and studies have shown that insurers, agents and brokers, and sales representatives misrepresent coverage to consumers, urge consumers to purchase plans over the phone without written information, or fail to disclose major coverage limitations.[52] Some deliberately design and sell these products to

[46] *See, e.g.*, Samantha Liss, "Healthcare Sharing Ministry 'Sham' Faces Suit for Allegedly Defrauding Consumers in California," *Healthcare Dive* (Jan. 13, 2022); Liuan Huska, "Health Care Sharing Ministries Fight for Legitimacy Amid Lawsuits," *Christianity Today* (Oct. 21, 2020); Reed Abelson, "Christian Health Sharing Group is Target of Customer Lawsuits," *New York Times* (Apr. 21, 2020).

[47] Christen Linke Young & Kathleen Hannick, Fixed Indemnity Health Coverage is a Problematic Form of "Junk Insurance," Brookings Institution (Aug. 2020).

[48] *Id.*

[49] *Id.*; *see also* Linke Young, *supra* note 24.

[50] *See* Jaie Avila, "Show Me Your Bill Helps Wipe Out $70k in Charges After Heart Attack," *News 4 San Antonio* (Oct. 10, 2019).

[51] Rep. Robert C. "Bobby" Scott & Rep. Frederica S. Wilson, Letter to U.S. Department of Labor (Oct. 2020).

[52] *See, e.g.*, Dania Palanker & JoAnn Volk, Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period, Georgetown University Health Policy Institute Center on Health Insurance Reforms (Oct. 2021); *Shortchanged* at 29-41; Linke Young & Hannick, *supra* note 47; U.S. Government Accountability Office, Private Health Coverage: Results of Covert Testing for Selected Offerings, GAO-20-634R (Aug. 2020); Christen Linke Young & Kathleen Hannick, Misleading Marketing of Short-Term Health Plans Amid

mimic ACA-compliant plans, or target consumers searching for comprehensive coverage, promising coverage for specific medical conditions without disclosing exclusions.[53]

Rising concerns about deceptive and misleading marketing recently led state insurance regulators to establish a new formal working group at the National Association of Insurance Commissioners—the Improper Marketing of Health Insurance (D) Working Group—devoted entirely to monitoring improper marketing, coordinating enforcement, and addressing the use of lead generators.[54] Federal and multi-state efforts are critical as insurers increasingly use out-of-state associations to circumvent state restrictions on the sale of these products.[55]

A comprehensive approach from Congress and the Biden administration is needed to protect consumers from non-comprehensive products. Federal policymakers can close gaps in how federal law defines individual and group coverage and clarify key terms such as excepted benefits. Congress can also improve regulatory standards for employer health plans, such as requiring job-based plans to cover essential health benefits at a minimum actuarial value.

Additional Policies to Improve Access to Affordable, High-Quality Coverage

In addition to extending the American Rescue Plan Act's subsidy enhancements and addressing non-comprehensive insurance products, more work remains. The uninsured rate remained stable during the pandemic but is still high. An estimated 31 million people were uninsured in 2021.[56] Worse, more coverage losses could be on the horizon as states resume Medicaid eligibility redeterminations at the end of the declared public health emergency.[57] Up to 15 million people, including 6 million children, could lose coverage.[58]

To further reduce the uninsured rate, Congress should 1) extend the American Rescue Plan Act's subsidy enhancements; 2) provide a coverage option for low-income adults in states that have not

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COVID-19, Brookings Institution (Mar. 2020); Office of Senator Bob Casey, Health Care Sabotage Online: A Warning to Consumers (Oct. 2019); Sabrina Corlette et al., The Marketing of Short-Term Health Plans, Robert Wood Johnson Foundation (Jan. 2019).

[53] *Shortchanged* at 29-41; *see also* U.S. Government Accountability Office, *supra* note 52.

[54] *See* National Association of Insurance Commissioners, New Working Group Formed on Improper Marketing of Health Plans (Aug. 2021) ("The working group will address the deceptive marketing of health plans and other products that lead consumers to believe they are purchasing comprehensive health coverage when they are really purchasing coverage that does not cover all pre-existing conditions or hospital care.").

[55] *See* Emily Curran et al., Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections, The Commonwealth Fund (Jan. 2019); *Shortchanged* at 25.

[56] Robin A. Cohen et al., Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2021, National Center for Health Statistics (Nov. 2021); *see also* Collins et al., *supra* note 10.

[57] *See, e.g.*, Sara Rosenbaum et al., Winding Down Continuous Enrollment for Medicaid Beneficiaries When the Public Health Emergency Ends, The Commonwealth Fund (Jan. 2021).

[58] Matthew Buettgens & Andrew Green, What Will Happen to Unprecedented High Medicaid Enrollment After the Public Health Emergency? Urban Institute (Sep. 2021).

expanded their Medicaid program; and 3) support aggressive outreach and enrollment efforts and streamlined Medicaid redetermination and enrollment processes.[59]

Over the long-term, Congress should address high health care spending by commercial insurance plans.[60] High provider prices are increasingly a challenge for workers with job-based coverage. By one measure, the average annual health care spending for people with job-based coverage increased to an all-time high of $6,001 in 2019, up by 21.8% from 2015.[61] Other studies have documented just how much more commercial insurers pay for health care services than public programs like Medicare or Medicaid.[62] For instance, employers and commercial plans paid hospitals an average of 247% of what Medicare would have paid in 2018 for the same services at the same facilities, a level that has risen over time and varies significantly by and within states.[63] Insurers often pay these high prices even though the prices far exceed hospitals' costs.[64]

High prices mean ever-higher costs for employers *and* employees. The costs of job-based coverage are increasingly passed onto employees and their families through higher premium contributions and deductibles. To keep costs down, employers and commercial plans might also narrow the scope of covered benefits or impose higher cost sharing on key benefits like prescription drugs; high health care costs can also slow the growth of wages for employees.[65]

For 2021, annual premiums for job-based coverage rose to more than $7,700 for single coverage and more than $22,000 for family coverage.[66] The average premium for family coverage has increased 22% over the last five years and 47% over the last 10 years. Similar trends have been observed with deductibles: the average deductible for job-based coverage in 2021 was nearly $1,700 for single coverage, an amount that has increased 13% over the last five years and 68% over the last 10 years.[67]

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[59] *See* Kinda Serafi et al., The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID-19 Public Health Emergency Ends, The Commonwealth Fund (Sep. 2021).

[60] *See* Congressional Budget Office, The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services (Jan. 2022).

[61] *See, e.g.*, Health Care Cost Institute, 2019 Health Care Cost and Utilization Report (Oct. 2021). About two-thirds of this growth has been attributed to increases in service prices, rather than utilization.

[62] *See* Congressional Budget Office, *supra* note 60 at 5; Matthew Fiedler, Capping Prices or Creating A Public Option: How Would They Change What We Pay for Health Care? Brookings Institution (Nov. 2020) (summarizing existing studies on commercial prices as a percentage of Medicare prices).

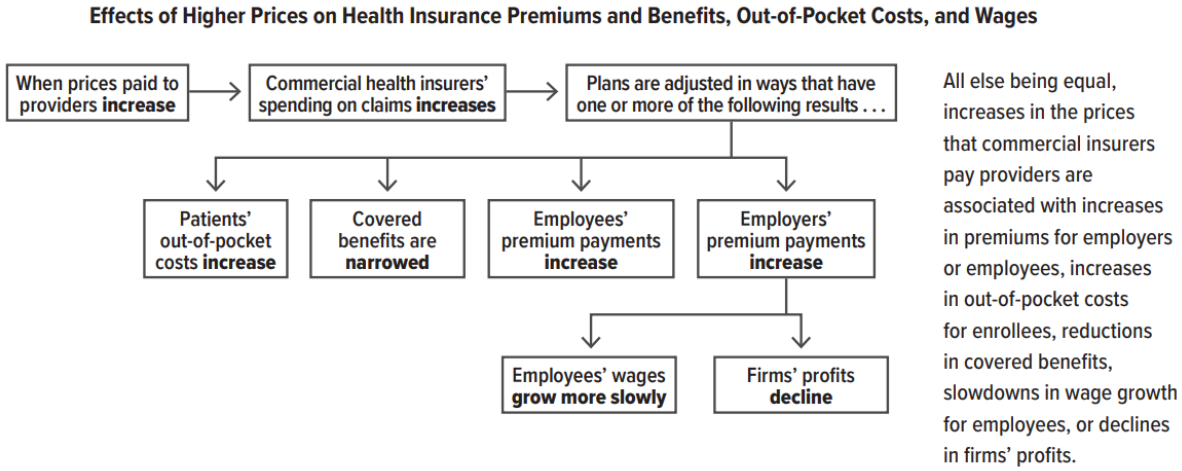
[63] Christopher M. Whaley et al., Nationwide Evaluation of Health Care Prices Paid by Private Health Plans, RAND Corporation (2020).

[64] Congressional Budget Office, *supra* note 60.

[65] *Id.*

[66] Gary Claxton et al., 2021 Employer Health Benefits Survey, Kaiser Family Foundation (Nov. 2021).

[67] *Id.*



Source: Congressional Budget Office, The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services at 9 (Jan. 2022).

Given these changes, *under*insurance is on the rise, especially for those in employer plans: in 2018, an estimated 87 million people (45% of non-elderly adults) were underinsured.[68] Being underinsured has implications for access to care and financial stability. Those who are underinsured report cost-related problems getting care and difficulty paying medical bills at higher rates than those with continuous, adequate coverage.[69] This can lead to medical and credit card debt, lower credit scores, loss of savings, and an inability to pay for basic life necessities (like food or rent).[70]

The impact on workers is even clearer when premiums and deductibles are considered together. In 2020, premium contributions and deductibles in job-based coverage accounted for 11.6% of median household income in 2020, up from 9.1% in 2010.[71] Overall, premiums and deductibles amounted to more than 10% of worker median income in 37 states in 2020.[72]

The American Rescue Plan Act helped address some affordability challenges in the individual market, and the No Surprises Act newly protects the privately insured from the most pervasive types of surprise out-of-network bills. But more clearly can be done to improve job-based coverage, which is the primary source of coverage for most of the nation's population.

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[68] Sara R. Collins et al., Health Insurance Coverage Eight Years After the ACA, The Commonwealth Fund (Feb. 2019). Underinsurance refers to people with health insurance but whose plan out-of-pocket costs are at least 5% of household income for low-income people and at least 10% of household income for higher-income people.

[69] *Id.*

[70] Sara R. Collins et al., U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability, The Commonwealth Fund (Aug. 2020).

[71] Sara R. Collins, State Trends in Employer Premiums and Deductibles, 2010-2020, The Commonwealth Fund (Jan. 2022).

[72] *Id.*

Congress could address the high provider prices paid by commercial plans by creating a public option plan.[73] A public health insurance option could achieve cost savings through lower provider and prescription drug payment rates, lower administrative costs, and eliminating the need for a profit margin. Estimated savings vary depending on how a public option would be structured, but recent analyses have suggested potential federal savings between $6 billion and 28 billion.[74] These estimates do not reflect the even greater savings that families and employers would see from reduced premiums and household spending.[75] In general, a public option would have a far greater impact on savings when available to individuals in the nongroup market *and* businesses and employees in the group market.

A public option plan could have other benefits as well. It could offer families and employers an additional, lower-cost choice for comprehensive coverage, while also leading to similar cost reductions among competing private health insurance plans. It could also expand access to coverage for the uninsured and underinsured, lower out-of-pocket costs, and reduce health disparities. The success of a public option in achieving these goals will, however, depend on the specific policies adopted by Congress. Policymakers will want to consider key questions such as how the public option will be administered, who will be eligible, what benefits will be covered, how provider payment rates will be determined, and how quickly the public option would be implemented.[76]

Conclusion

The ACA has resulted in historic coverage gains and played a crucial role in the nation's pandemic response. The American Rescue Plan Act has further cemented these gains by dramatically improving access to affordable marketplace coverage. As the Subcommittee considers the next wave of health reforms, policymakers should extend the American Rescue Plan Act's enhanced subsidies, protect consumers from non-comprehensive insurance products, and lower health care costs with an emphasis on protecting those in job-based coverage. Expanded access to comprehensive health insurance will help improve the health and financial security of families across the country and has never been more important.

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[73] *See, e.g.*, Matthew Fiedler, Designing A Public Option That Would Reduce Health care Provider Prices Brookings Institution (May 2021); John Holahan et al., What Are the Effects of Alternative Public Option Proposals? Urban Institute (Mar. 2021); Fiedler, *supra* note 62; Linda J. Blumberg et al., Comparing Health Insurance Reform Options: From "Building on the ACA" to Single Payer, Commonwealth Fund (Oct. 2019).

[74] *See* John Holahan & Michael Simpson, Introducing a Public Option or Capped Provider Payment Rates Into Private Insurance Markets, Urban Institute (Mar. 2021); Jodi L. Liu et al., Effects of a Public Option on Health Insurance Costs and Coverage, RAND Corporation (2020).

[75] By one estimate, a public option could result in savings for employers of up to $86 billion and household spending could fall by up to $58 billion; savings would be even higher with capped payment rates. Holahan & Simpson, *supra* note 74.

[76] *See, e.g.*, Georgetown University Center on Health Insurance Reforms, Understanding Public Health Insurance Options: Design Considerations (last visited Feb. 2022); Congressional Budget Office, A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications (Apr. 2021); Suhas Gondi & Zirui Song, "Expanding Health Insurance Through a Public Option—Choices and Trade-Offs," *JAMA Health Forum* (2021) 2(3):e210305.