SENATE FINANCE COMMITTEE

"HEALTH INSURANCE COVERAGE IN AMERICA: CURRENT AND FUTURE ROLE OF FEDERAL PROGRAMS"

OCTOBER 20, 2021 – 10:00 AM

OVERVIEW

On Wednesday, October 20, the Senate Finance Committee held a hearing to examine the current status and future role of federal programs that support health insurance coverage in the U.S.

Members asked about, among other things, the biggest gaps in Medicare; economic implications of the Build Back Better Act; Affordable Care Act; American Rescue Plan Act; expanded insurance subsidies; prescription drug pricing; non-interference clause; international reference pricing; House proposals to address drug pricing; illegal immigration; Medicaid expansion; home and community based services; special enrollment periods; Medicare insolvency; public option; the Hyde Amendment; treatment for substance use disorder; the Medicare Coverage of Innovative Technology (MCIT) and Definition of 'Reasonable and Necessary' final rule; and expansion of Medicare benefits to include dental, hearing, and vision.

The witnesses all agreed that as we look toward the future of our healthcare system, we must focus on increasing affordability, enhancing quality of care, and improving access to innovative, lifesaving medications, treatments, and therapies. Drs. Blumberg and Collins as well as Mr. Isasi advocated for making the temporary American Rescue Plan Act (ARPA) marketplace subsidies permanent; touched upon how some of the policies under consideration in the reconciliation package can address existing barriers to improving coverage and access; and urged passage of the Build Back Better Act. Additionally, Mr. Isasi and Dr. Blumberg discussed the need to streamline Medicaid redetermination and enrollment and suggested making sure all children automatically have continuous eligibility for 12 months once the COVID-19 public health emergency ends and also consider extending that to adults.

Dr. Holtz-Eakin recommended that the federal government should focus on maximizing spending power and improving the value of existing programs to ensure sustainable and high-quality healthcare. He also expressed support for placing a cap on out of pocket expenses for Medicare beneficiaries in Part D; requiring drug manufacturers to pay rebates during the catastrophic phase; and restructuring the benefit design of Medicare Part D in a way that realigns incentives away from high-cost, high-rebate drugs.

OPENING STATEMENTS

- Chairman Ron Wyden (D-OR)
- Ranking Member Mike Crapo (R-ID)

WITNESS PANEL

- The Honorable Raphael Warnock – United States Senator, Georgia
- The Honorable Rick Scott – United States Senator, Florida
- Linda Blumberg, Ph.D – Institute Fellow, Urban Institute
- Sara Collins, Ph.D. – Vice President for Health Care Coverage and Access, The Commonwealth Fund
- Douglas Holtz-Eakin, Ph.D. – President, American Action Forum
- Frederick Isasi, J.D., M.P.H. – Executive Director, Families USA

QUESTION AND ANSWER SUMMARY

Sen. Debbie Stabenow (D-MI) – What are the biggest gaps in the Medicare program and what should we be doing about them?

Mr. Isasi – Right now, the biggest crisis in healthcare coverage is price. We cannot currently negotiate fair drug prices. We have to tackle the abuses of drug companies. 90% of Americans want this across the political spectrum. Second, Medicare does not cover essential services such as dental, vision, and hearing benefits, which are critical for seniors. Finally, I agree strongly with Dr. Holtz-Eakin in that the way we are currently paying for healthcare incentivizes waste and margin high profit services over actual health. We have to change the way we pay for healthcare. Medicare Advantage (MA) is not the answer. Under MA payments, what we see is just traditional fee for service, volume-based payments. We have to make sure the new payments are actually reaching hospitals, doctors, and nurses. We also have to make sure that the people who are actually improving health, maintaining health, and solving health problems do well under the system, while people who are just driving towards volume and high price fail.

Sen. Mike Crapo (R-ID) – Can you discuss the macroeconomic implications of the President's Build Back Better plan?

Dr. Holtz-Eakin – We heard during the course of the campaign for the presidency about the Build Back Better plan so in the aftermath of the election, we commissioned this study so it was done by some scholars at Rice University using some models that are essentially identical to the Joint Committee on Taxation's macro models. The basic findings are that imposing trillions of dollars in new taxes is a severe headwind to economic growth and would diminish it considerably. There was a lot of consensus on that. We heard from the other side that the spending programs are going to be so effective that they're going to outweigh that and we'll get better economic growth. We had the scholars model that by taking all of the money and spending it entirely on productive infrastructure and research and development and the net effect was negative for the economy over 10 years. If you compare that modeling exercise with what is actually in the legislation, the spending is far less targeted on productive infrastructure and research and development so the impacts are going to be even more negative than our modeling indicated.

Sen. Crapo – What impact would the House drug pricing proposals have on healthcare access and quality? What type of policies do you see as the right ones?

Dr. Holtz-Eakin – I'm quite concerned about the proposals that were in H.R. 3 and are now in the Ways and Means-passed legislation. International reference price is a price control. The supposed negotiation with the Secretary of HHS is not a negotiation when the threat is a 95% sales tax on domestic sales. The Secretary would be in the position of being judge and jury and demanding what he/she wants. We know from looking at other countries that while prices are lower, access to medicines are much more limited. In many cases, innovative therapies don't arrive for two to three years, if they arrive at all. In the U.S., 90% of innovative therapies are on the market within three months. The reforms that I outlined on Part D would be a very good starting point. They're bipartisan in nature; they've been in legislation proposed by Democrats, Republicans, and presidents; they would improve the negotiation incentives in Part D, resulting in lower prices across the board that spill over into commercial markets as well. This would also protect seniors from catastrophic costs, which is overdue. That's a good place to start, it doesn't threaten innovation in the system, and promises high quality drugs for seniors.

Sen. Ron Wyden (D-OR) – Would proposals like a public option or a dental, vision, and hearing benefit in Medicare Part B have a negative impact on the Medicare Part A trust fund?

Dr. Collins – No, they would not because they're financed out of other revenue sources so the trust fund would not be affected. The Affordable Care Act had a very positive effect by extending the Medicare trust fund solvency, reducing the scheduled updates to Part A providers, reducing the disproportionate share hospital (DSH) payments, and increasing the payroll tax for upper income households.

Sen. Wyden – How did Medicaid and the ACA premium tax credits for insurance coverage meet the needs of American families during the pandemic?

Dr. Blumberg - This recession related to the COVID-19 pandemic is the first test of the safety net that was enhanced and strengthened by the ACA and the American Rescue Plan Act (ARPA) subsidies just enhanced that further. It was the first time in a recession in memory where the number of uninsured did not increase. The only places where the number of adults without health insurance increased are states that did not expand Medicaid under the ACA. While employer-sponsored insurance did fall significantly as it has in every prior recession on record, the number of uninsured nationally stayed constant because some people moved into marketplace coverage while others who lost much more income were enrolled into Medicaid. Without it, we would have seen a significant increase in uninsured. The ARPA subsidies made insurance coverage even more affordable to people during this crisis.

Sen. Chuck Grassley (R-IA) – For decades, the Congressional Budget Office (CBO) has said government drug price dictation does not save money unless you restrict access to patients through limiting formulary. Is that correct?

Dr. Holtz-Eakin – Yes, that's correct.

Sen. Grassley – Is government drug pricing negotiation a real negotiation or is the government dictating prices?

Dr. Holtz-Eakin – The government is dictating prices. You can't do a real negotiation unless you have a restriction of access in some way or in this instance, another lever, which is a 95% tax on sales in the U.S. market.

Sen. Grassley – Can you save money if you do not limit access like restricting the formulary or dictating prices based on domestic or international reference pricing?

Dr. Holtz-Eakin – No. Every CBO Director since the Medicare Modernization Act has passed has come to the conclusion that there is no additional, genuine negotiating lever that the Secretary of HHS would have. Prescription drug plans have lots of beneficiaries so they have market shares and formularies, which they can offer as the way to expand their sales and that's how you get a lower price.

Sen. Grassley – Can you expand on how patients will be hurt by the proposed government drug pricing dictation policy?

Dr. Holtz-Eakin – The spirit of these proposals has always been to look to other countries as the reference price and starting point of dictating prices. If you look at the experiences in those countries, the way prices are lower is because governments say no to any drugs and they are not available to their citizens. There is not a general drug pricing problem. We have high prices for some specialty drugs on patent, largely oncology drugs, which are the most innovative and most effective modern treatments. These proposals would be telling our citizens that we don't want them to have the best care.

Sen. Grassley – If we disincentivize the private sector to produce cures, will we give up our status as the world's leading research and development country?

Dr. Holtz-Eakin – Yes. We are the leading biopharmaceutical innovator in the globe but that's not a God-given right. It's due to the incentives that are in the system. If we went ahead with these proposals, there will be less incentives for venture capitalists to fund startups that have generated these advances. Those startups often then sell them to biopharmaceutical companies who would not be interested in buying them because there would be no return on investment. Innovation would dry up. It's a real threat.

Sen. Grassley – Should we be pursuing policies that would produce fewer cures?

Dr. Holtz-Eakin – No. Directionally, everyone agrees there would be fewer cures. The only debate is over how many and how innovative they might be.

Sen. Ben Cardin (D-MD) – Can you give us additional tools that we can use to reach those in underserved and minority communities to make sure they have adequate third-party coverage? What recommendations can you make for us to deal with that gap that we have in our system today?

Dr. Collins – The ACA had a very significant impact on reducing disparities and coverage across racial and ethnic groups. That happened in all states but the states that saw the biggest improvements in coverage and biggest decreases in disparities were in Medicaid expansion states. Expanding coverage in all states would help further reduce those disparities that have been endemic to our system. On the underinsurance side, this is an ongoing chronic problem in employer coverage and in individual market plans for people who are outside the cost sharing subsidy threshold. Extending the cost sharing reductions in marketplace plans further up the income scale would further reduce deductibles in marketplace plans. Also, allowing more people in employer plans to access those enhanced protections in the marketplaces would also address the underinsurance issues that we see growing over time.

Sen. Cardin – Can you discuss the impact of the coming Medicaid redeterminations at the end of the public health emergency? How can Congress support individuals and states to prevent significant disruption and coverage loss?

Mr. Isasi **–** Many folks may be surprised to know that currently, because of the public health emergency, states are under the maintenance of effort requirement, which means that they can't disenroll people from Medicaid because we're in a public health emergency. Right now, it was just extended until January 2022 but when that ends, states will have to go through a redetermination process. What we know from history is that when that happens, millions of people who are eligible for Medicaid end up losing coverage because it's a paperwork and administrative burden. They may have moved, they may have a language barrier, or they may not have access to the internet in order to maintain their enrollment. It's really important that as we move into this period where redeterminations will be made, that we do so thoughtfully and carefully. One of the things we can do for children is make sure they have continuous eligibility. It's currently an option for states. We should make sure all children automatically have continuous eligibility for 12 months once the public health emergency ends and also consider extending that to adults.

Sen. John Cornyn (R-TX) – Illegal immigration creates a crisis like we're seeing at the border right now. The number of people detained since the Biden Administration came into being is 1.7 million migrants. That's the most since 1986. The more undocumented or illegal migrants that come into the U.S., the worse our uninsured population is. Do you agree with that?

Dr. Holtz-Eakin – That's correct.

Sen. Cornyn – The policies of the Biden Administration are making the problem worse, not better.

Dr. Holtz-Eakin – Certainly. 1.7 million is an extraordinary flow.

Sen. Cornyn – Would you agree that things that have been proposed by the Biden Administration like cash tax credits, additional healthcare coverage benefits, and other welfare benefits are part of the pull factors that encourage people to come to the U.S. by other than legal means?

Dr. Holtz-Eakin – Certainly a pursuit of a better standard of living whether it be through illegal employment or benefits from the government are a big part of the pull factor.

Sen. Cornyn – Do you believe our current level of debt that has resulted from the pandemic is unsustainable and that additional deficit, spending, or debt is not a great idea?

Dr. Holtz-Eakin – I am concerned about that. We entered the pandemic with a structural deficit that puts the U.S. on an unsustainable fiscal trajectory. We have added an enormous amount of debt that exceeds the economy during the pandemic and the proposed legislation would result in a structural deficit that's even larger and accelerates the trajectory that's already so dangerous. That would be a misstep from the viewpoint of macro policy and fiscal policy.

Sen. Cornyn – All of these tax credits are paid to private insurance companies, correct?

Dr. Holtz-Eakin – Yes.

Sen. Cornyn – Private insurance companies benefited enormously from the ACA, correct?

Dr. Holtz-Eakin- They certainly did.

Sen. Cornyn – Are you aware of the fact that of the people that would be covered by the enhanced premium tax credit, 65% of those would have incomes at 400% of the federal poverty level (FPL), 20% would be at 600% of FPL, and 10% would be at 700% of FPL? Would that make our debt problems and fiscal problems worse?

Dr. Holtz-Eakin – Yes. As a whole the proposals have that character. These are large increases in the structural deficit that we already have and are a step in the wrong direction from a fiscal point of view.

Sen. Michael Bennet (D-CO) - Can you share with us how premium supports under the ACA and further expanded under the ARPA have improved coverage and reduced costs?

Dr. Blumberg – By Urban Institute estimates, ARPA subsidy enhancements reduced household spending on healthcare for families by 23% for those buying in the non-group insurance market. That's about $1140 per enrollee. For low-income enrollees, spending is reduced by 32% on average. This makes insurance more accessible for many people and could decrease the uninsured by over 4 million if made permanent.

Sen. Bennet – Do you agree that the ACA played an essential role in creating a stable and more resilient healthcare system?

Dr. Blumberg – Absolutely. Prior to the ACA, when people lost their employer-sponsored insurance coverage, very few of them would be eligible for financial assistance for other coverage and this time it was there through Medicaid and marketplace coverage.

Dr. Collins – I would agree with Dr. Blumberg.

Sen. Bill Cassidy (R-LA) – You point out that it's not just about paying for care but it's about lowering the cost and having better quality of care because otherwise it is not sustainable. There has to be sustainability built into whatever we do to expand access. Is that correct?

Dr. Holtz-Eakin – That's right.

Sen. Cassidy – Is it a fair analysis to say that in the ACA, there was a big effort to put on the Cadillac tax to otherwise restrain the amount of subsidized healthcare because we knew that subsidies drive demand, which drives up overall cost?

Dr. Holtz-Eakin – Yes.

Sen. Cassidy – You are speaking about how we need to further subsidize healthcare. That seems to go against the principal that subsidies drive demand, which drives up the overall cost. Yes, you lower the out of pocket cost to the individual but for society you drive up the cost, which calls into question sustainability, unless you have unlimited dollars. How would you respond to that?

Dr. Collins – The new data out from the Healthcare Cost Institute really does show that prices, not utilization are driving our cost problem in commercial insurance.

Sen. Cassidy – Is it fair to say that totally immunizing someone from the cost of healthcare indeed increases utilization and therefore would increase demand and total expense?

Dr. Collins – None of our health insurance plans except for very low-income people have zero cost sharing.

Sen. Cassidy – In the silverization of the ACA exchange policies, there are those who do not have any cost sharing whatsoever. At some point, cost sharing becomes so significant for people that it impacts their behavior, correct?

Dr. Collins – It does but we know that high cost sharing really discourages people from getting needed care.

Sen. Cassidy – I'm not talking about high cost sharing. I'm talking about the general principle that the more healthcare is subsidized, the more demand is generated, and the more people become cost insensitive to a higher price. The more people are cost sensitized, the more it is for total global cost. Is that a fair statement?

Dr. Collins – Cost sharing is an important part of health policy, particularly for care that is necessary. However, we want to make sure people have the right incentives to get the care they need.

Sen. Rob Portman (R-OH) – How would a new proposal in the reconciliation bill to force states, that have not expanded Medicaid, to partake in a federally funded and federally run Medicaid program, inhibit the ability of states to innovate?

Dr. Holtz-Eakin – This is a dramatic change to Medicaid. The program has always been a federal-state partnership and states have always been responsible for the business model they want to pursue in their state. There's an enormous track record of success in moving into managed care organizations as a central plank of Medicaid. Competition among them is even better. That gives the opportunity of having a basic approach to capitated payment for cost incentives and quality metrics to make sure we get high value care. To my eye, there is no guarantee of that strategy in what is being proposed in the reconciliation bill.

Sen. Portman - Do you agree that states like mine would be unfairly penalized by this proposal?

Dr. Holtz-Eakin – There is clear mistreatment with federal taxpayers picking up the entire tab.

Sen. Portman – What is going to be the impact of the Build Back Better Act on inflation?

Dr. Holtz-Eakin – We've heard in the discussions about the structure of the plan is to frontload all of the spending and leave in permanent tax increases. The $1.9 trillion back in March was poorly timed. The economy was growing at 6% and it was way too big for any macroeconomic problem we faced and it was poorly designed. This would be a repeat of exactly that exercise.

Sen. Portman – Do you anticipate that all states will be able to take advantage of enhanced funding to bolster the home and community based services (HCBS) program given the new requirements that they would place on home-based care?

Dr. Holtz-Eakin – I think that's a real concern. To create a high-value system you have to allow the flexibility to innovate and find cheaper ways to find quality outcomes. Getting a whole bunch of money with restrictions is at odds with that approach.

Sen. Sherrod Brown (D-OH) – If Congress permanently extended the enhanced subsidies from ARPA and expanded them to lower income Americans in non-expansion states, how many Americans stand to benefit?

Dr. Blumberg – Estimates by my colleagues at the Urban Institute show that an additional 7 million people would have coverage.

Sen. Brown – Would permanently extending funding for CHIP help ensure coverage for the children of working families for years to come?

Mr. Isasi – Absolutely.

Sen. Brown – Would providing continuous eligibility for kids and postpartum individuals in Medicaid and CHIP help new moms and their kids stay healthier, reduce disparities, and improve the continuity of their coverage?

Mr. Isasi – Yes.

Sen. Brown – Could adding a public option to the ACA or allowing older Americans to buy in voluntarily to Medicare before 65 help reduce disparities and give Americans more health coverage options that they can afford?

Mr. Isasi – Absolutely. The options provide real financial security and also allow the government to finally start addressing the pricing abuses that we're dealing with.

Sen. Brown – Would addressing ACA's provision to allow children to remain on their parents' health insurance policies until age 26 to CHAMPVA enrollees' help to ensure children of disabled veterans have stronger coverage options?

Mr. Isasi – Absolutely.

Sen. Brown – Would fixing the so-called family glitch in the ACA give working families more affordable coverage options?

Mr. Isasi – Absolutely. It would ensure families are not being unfairly penalized and held to an individual standard instead of their family standard. This is really important.

Sen. Brown – Would extending guarantee issue protections to Medigap policies provide seniors and individuals with disabilities with more coverage options and greater out of pocket protections?

Mr. Isasi – 100%. It would ensure you can't be denied coverage for preexisting conditions in Medigap. That should be the law of the land in this country.

Sen. Patrick Toomey (R-PA) – What is the true cost of Medicare expansion?

Dr. Holtz-Eakin – The expectation is that this benefit will be available indefinitely so the $80 billion over 10 years is the correct estimate of the cost -- $800 billion.

Sen. Toomey – Why do you suppose it's being phased in gradually?

Dr. Holtz-Eakin – That's a standard way to make it appear cheaper and make it into some sort of budgetary restriction.

Sen. Toomey – Is it your view that these Medicare expansion benefits are going to go to people with substantial income and alternative ways of obtaining insurance?

Dr. Holtz-Eakin – This is an unsurprising finding. The proposals to get rid of the cap at 400% of FPL means it's targeted to people who are relatively affluent and this is what CBO is saying.

Sen. Toomey – Does it sound like a good idea to you that a program that is on the highway towards insolvency and is running a massive deficit should be expanded to people whose income is many multiples of the poverty line?

Dr. Holtz-Eakin – Targeting all of these proposals much more carefully to low-income and needy populations would be a step in the right direction.

Sen. John Thune (R-SD) – What drives the shift away from private coverage and into plans heavily subsidized by the federal government? What does it mean for the long-term?

Dr. Holtz-Eakin – This has been a concern since the ACA passed. If you ran the numbers, the subsidies were already so rich that for people up to 300% of FPL, employers could stop offering coverage, put the individual into the exchange, give them a raise, and make more money. There was so much money on the table in the exchanges that it was in the incentive of employers to stop offering coverage. This is an increase in those premium tax credits and we're just seeing the same behavior in the CBO estimates. There are clear incentives for employers to stop offering insurance and in the process pay their employers more money and make more money simultaneously.

Sen. Thune – Does Democrats' proposal to make the expanded ACA tax subsidies permanent include anything to prevent exchange premiums from increasing?

Dr. Holtz-Eakin – Yes. That's how these subsidies are calculated. In the end, insurance is a financial product to shift the medical bill around. The national medical bill is too big and delivers too low quality care. Getting control of the bill allows you to keep insurance premiums down directly and doesn't require as much taxpayer subsidy. This is right where the sustainability issue raised by Sen. Cassidy hits.

Sen. Thune – Is it correct that these expanded taxpayer funded subsidies could fund plans to cover elective abortions?

Dr. Holtz-Eakin – Yes.

Sen. Thune – This year the Administration allowed special enrollment periods (SEPs) on the exchanges that lasted more than six months. Democrats are now proposing to create a continuous enrollment period for individuals at certain income thresholds through 2024. For years, we've heard about issues with adverse selection in the insurance market so what has changed?

Dr. Holtz-Eakin – Nothing. Our analysis indicates that the SEPs were raised because of the adverse selection issue and that will make this program more expensive on top of everything else.

Sen. Thune – Can you provide some context to the recent CBO report about federal revenues hitting $4 trillion for the first time and increasing individual income taxes and corporate income taxes. With revenues coming in at historically high levels, what would be the fiscal or economic impacts of raising taxes on American workers and businesses?

Dr. Holtz-Eakin – The impacts on the economy are decidedly negative. We're recovering well from the near-term losses due to the pandemic. We still have a long-term growth problem. The proposals that are on the table would inhibit the accumulation of intellectual property, capital, and other productivity-enhancing investments, which would be negative over the long-term for productivity, real wages, and the standard of living.

Sen. Bob Casey (D-PA) – How have Medicaid expansion and marketplace policies both lowered cost to help families save money?

Dr. Collins – There is a considerable body of research as Mr. Isasi's testimony indicated showing that the expansions led to huge increases in people's ability to access care, lowering the financial barriers to healthcare, lowering out of pocket costs across the population, and improving the financial protection for low income families.

Sen. Casey – What are the current barriers to HCBS and how would investments in these services help Americans?

Mr. Isasi – HCBS are the key services that allow Americans who are aging, disabled, and have chronic conditions to stay in the community and not end up in an institutional setting like a nursing home. They allow people to be independent, work, and be close to their family. Right now, 800,000 people are on waiting lists all over the country to get access to these services. As a result, we have people who are languishing and people who are in institutions. We need to make investments in these services.

Sen. Sheldon Whitehouse (D-RI) – As we're designing the public option, what's the population that we should make sure we're attending to?

Mr. Isasi – There are a few groups from my perspective. One is individuals who are self-employed and can't get access to high-quality coverage depending on where they live.

Sen. Whitehouse – Where should the public option be offered and how should it be administered?

Mr. Isasi – The honest answer to that question is how can we get it through the Senate and through the Congress and have it enacted. The bottom line is it needs to have several dimensions: be available to everyone, actually provide high quality affordable coverage that provides financial security, and has to be available in all communities.

Dr. Blumberg – By our analysis, the places where the public option would have the greatest impact are those areas that have few insurers offering coverage and/or have very highly consolidated providers so that the prices for obtaining care are higher and as a consequence, premiums are higher.

Sen. Whitehouse – What should we be looking at to maximize these proven cost-reducing, quality-improving, better outcomes for Americans strategies?

Dr. Collins – Innovation is happening on this issue in states across the country. Rhode Island has empowered their insurance commissioner to review premium rates and hospital rates. Taking an active stance on this pricing problem is an indication of what states are experimenting with. Washington state on the public option and Montana is implementing changes to its state employment benefits program on hospital pricing. Lots of states are innovating in this space.

Sen. Maggie Hassan (D-NH) – What has it meant for families to be able to access needed healthcare services during the pandemic?

Dr. Collins – We know that the majority of people who are unvaccinated don't have insurance coverage. It's not because you need health insurance to get the vaccine but because people don't have a relationship with the health system that insurance coverage affords them so that they're not getting the information they need. It's been very important in terms of access to healthcare, particularly for people who did get sick with COVID and being able to get the care they need. It has also been important for ensuring access to the usual care people get.

Sen. Hassan – Can you speak to the important role that Medicaid coverage has played in expanding access to treatment for substance use disorder and improving health outcomes?

Dr. Collins – Medicaid has been so important for substance use issues as well as mental health generally across the population. States that haven't expanded Medicaid have denied this access to their residents. It has been a critical part of our ability to address this crisis that we're seeing with substance abuse and drug overdose deaths. The marketplaces have also required plans to cover substance abuse and mental health services so they have also been a critical part of this fight.

Sen. Hassan - Can you speak to how expanded health coverage has helped pregnant women and new parents impacted by substance use disorders as well as their children through innovative programs such as Moms in Recovery and other avenues?

Dr. Blumberg – Having insurance coverage either through Medicaid or private coverage has a very positive impact on mothers, not only on their own health but the health of their children. There is a great deal of research that supports that. That is also a reason why a lot of folks are looking at continuing care postpartum, not just for birth-related care but also for general healthcare.

Sen. Steve Daines (R-MT) – Is it accurate to say the Hyde Amendment would not apply to the new federal health entitlement under Democrats' tax and spending plan and therefore abortions would be paid for and covered by federal taxpayers under this program?

Dr. Holtz-Eakin – Yes.

Sen. Daines – Would Democrats' tax and spending plan increase federal spending and grow the federal government's role in everyday Americans?

Dr. Holtz-Eakin – The simplest presentation of the budgetary impacts is by having each of the programs be made permanent and look at them over 10 years. That's clearly the intent in the end. That's about $5.5 to $6 trillion in new spending and the taxes are about $2 trillion, so that's a huge structural deficit being added to the existing structural deficit driven by the existing entitlements, Social Security and Medicare. The scale is enormous and the scope is also enormous.

Sen. Daines – A recent CBO analysis found that healthcare policies in Democrats' tax and spend bill will cost at least 2.8 million Americans to lose their job-based coverage. Could you elaborate on this analysis and how it might impact taxpayers?

Dr. Holtz-Eakin – The basic phenomenon is that there is too much money on the table in the exchanges that it is possible for employers to stop offering insurance, use those savings to give their workers a raise, send them off to get coverage through the marketplace, and make more money as a firm. That was true for the original ACA and these are richer subsidies so the same phenomenon is taking place.

Sen. Maria Cantwell (D-WA) – What can we do to get more people to look at the basic health plan as a way to deal with the very low working class population above the Medicaid rate?

Dr. Blumberg – The basic health plan has had a very positive impact in the state of New York and in Minnesota in terms of lowering costs for private health insurance plans for the very low income people below 200% of FPL but above the Medicaid threshold. This has led to much higher participation and more coverage in those states from the lower premiums. Extending the ARPA subsidies and making them permanent moves towards that direction nationwide without states having to make that jump into the basic health plan. The basic health plan has a lot of positives for consumers but it also unfortunately pulls people out of the risk pool and separates them. Doing so can have impacts on premiums and the attractiveness of the core marketplaces for insurers. There are clearly a lot of positives but it does have downsides as well. There are tradeoffs for sure.

Sen. Cantwell – What proof do you have on that?

Dr. Blumberg – Our analysis looks at the healthcare risk and expected expenditure of individuals who are eligible and enrolled in the marketplaces and how that would change on average when moving individuals who are up to 200% of FPL out into a separate program. Not all those who are under 200% of FPL are high cost or have significant medical needs and are often healthier on average. So, in some states, moving them out of the insurance pool will decrease the marketplace enrollment and could also increase the average healthcare risk of people in the marketplace. By contrast, if you provide those more generous subsidies for those low income people as the ARPA extensions would, then those people stay in the pools and those pools have that strength.

Mr. Isasi – The concerns that my colleague is raising are very important, which is what is the interplay between the insurance coverage and the basic health plan option. However, what we have seen is that both in New York and in Minnesota, we only saw a 2% change in premium costs when that plan was offered. What you're doing is allowing the state to negotiate on behalf of a very large group of people and get very high value coverage at lower costs. That's a homerun. There has to be a way that we can allow that to happen. Our position is that both policies are critically important. Not every state is going to make that kind of investment required to build the basic health plan option and it's really important that every family have access to affordable, high quality health insurance. Underneath all of this, we have to get much more aggressive with our health insurers and demand that they negotiate good prices and that's part of what the basic health plan option does. It gives volume and gives real weight to that negotiation so they can get in there and stop that pricing abuse.

Sen. Catherine Cortez Masto (D-NV) – Can you talk about how tax credits in ARPA might benefit small business owners and their employees who are still in recovery mode from the pandemic? Can you also talk about gig workers and retail and hospitality workers who move from job to job and how these premium tax credits in ARPA might be essential to help them?

Mr. Isasi – As we've heard, there are two main provisions between ARPA and Build Back Better. The first is to provide insurance for small businesses. In that regard, we have to remember that it's the most volatile source of employer sponsored coverage and small businesses often have the hardest time offering coverage. The second piece of this is making sure coverage in the exchanges is affordable. The subsidies have cut premium costs in half for families. That allows for a lot more mobility and economic development as employees change jobs and lose jobs. These are really important provisions that protect employees and employers.

Sen. Cortez Masto – Can you describe how different the rates of uninsurance and underinsurance might have been had Congress not stepped in to support Medicaid programs?

Dr. Blumberg – It's a difficult question to answer. By our estimates, millions more Americans would have been uninsured. We have done estimates of what the implications are of making the changes to the subsidies in ARPA permanent that would extend coverage by about 4 million people. Between the presence of the Medicaid expansion and the enhanced subsidies, you're talking about potentially another 4 million people during the pandemic.

Sen. Todd Young (R-IN) – How will the House Democrats' package raise taxes on people earning less than $400,000 per year?

Dr. Holtz-Eakin – There are two mechanisms in play. First, the direct impact of some of the tax proposals, most notably, taxes on e-cigarettes where buyers will have incomes under $400,000 so they get a direct increase. The second mechanism is the result of the fact that some taxes will be shifted onto workers and they will be in the sub-$400,000 range.

Sen. Young – How could the delay in CMS' coverage and reimbursement process impact innovation of lifesaving diagnostic tools, preventive technologies, and treatments?

Dr. Holtz-Eakin – The Medicare Coverage of Innovative Technology (MCIT) and Definition of 'Reasonable and Necessary' final rule was intended to provide automatic CMS reimbursement for those therapies that got a breakthrough designation by the FDA. In doing so, you would accelerate movement of that product into earning some revenue. That has clear incentives on innovation. If you have innovation that never gets any revenue, you're not going to pursue that. If the revenue is years in the future, you might not be able to survive so you won't undertake that innovation. If you can accelerate the marketability of an innovative technology, pharmaceutical, or a device, that's going to help innovation.

Sen. Young - Do you have any recommendations on how CMS could revise the rule rather than repeal it outright?

Dr. Holtz-Eakin – The concern that arises is that every therapy that gets a breakthrough designation automatically gets reimbursement and it's not obvious what the appropriate reimbursement is. CMS should have the ability to opt some therapies out if they make the case that it would be too costly or they don't know how to reimburse it.

Sen. James Lankford (R-OK) - What do you see as the key market-based solutions that are not going to be a government controlled healthcare system that can actually bring lower prices and more innovation?

Dr. Holtz-Eakin – The central set of attributes is to have it be highly decentralized so the competition takes place on the ground with recognition of population health statistics. It should involve essentially capitated payments to insurers and managed care organizations to give them strong incentives to manage the costs and not let them become large. With that, there has to be a set of quality metrics that are easy to implement and which allow observation of whether we have high quality outcomes. Then you're essentially moving something that pays for value, does so in a way that's suitable for the population characteristics that might include things that are outside the range of traditional healthcare services, you'll get better health, and you'll have incentives to keep costs down.

Sen. Lankford – Do you see a good example of that currently in our system?

Dr. Holtz-Eakin – There have been attempts at this sort of thing all through the system. You see bundles in traditional Medicare where the idea is to look at a set of services and provide a bundled payment for that. Clearly you have to ensure the quality of the outcome. Medicare Advantage is essentially one big bundle and in the MA Stars Program you have quality metrics. We could improve on that dramatically in the years going forward. With Medicare being such an important player in the system, it's an important determinant of practice patterns. Using MA to drive a high value delivery system that differs across the country is a smart strategy.

Sen. Lankford – From what you have seen in the public arena, how do you think some of the proposals in the reconciliation proposal would affect research and development in the U.S. for future new drugs, treatments, therapies, and procedures?

Dr. Holtz-Eakin – Certainly the new tax proposals would hit a lot of the pharmaceutical firms and that would be a drain on their ability to pursue research and development. Some of the individual proposals on capital gains are likely to affect the venture financing that is such an important part of the biopharmaceutical ecosystem and provides the financing for the startups that have been the leaders in the new oncology drugs in particular. I worry about the impact of these proposals, which are viewed as benign ways to raise money, and what they will do to the culture for investments, innovation, and accumulation of intellectual property in the U.S.

Sen. Wyden – What does it mean for low- and middle-income families when we see the deductibles and out of pocket costs account for a larger and larger share of their income?

Dr. Collins – First of all, spending more on your premiums already burdens households that are already struggling with housing prices, food prices, and childcare prices. Having high deductibles also impacts people's ability to access needed healthcare. The other dynamic that's happening is that high deductibles lead people to be unable to pay their bills and accumulate debt over time. This is a real affordability crisis for lower income people that we do need to address, first by protecting people, and then addressing the high prices in commercial insurance.

Sen. Elizabeth Warren (D-MA) – If all of the remaining states expanded their Medicaid programs, how many of the uninsured people who would become eligible for healthcare coverage have incomes below the poverty line?

Dr. Blumberg – About 3 million of the newly eligible uninsured in those 12 states would have incomes below the poverty line.

Sen. Warren – Do these people have any other coverage opportunities?

Dr. Blumberg – They do not have other opportunities that are adequate and affordable.

Sen. Warren – If the 12 remaining states decided to expand their Medicaid programs tomorrow, how much federal money would the government be able to find to finance these expansions?

Dr. Blumberg – It would cause no increase or need for revenue because it was already covered by the ACA.

Sen. Warren – So, this has already been budgeted for?

Dr. Blumberg – Correct. There is a lot of money left on the table that has not been used by those states.

Sen. Warren – If Congress passed a bill to close the coverage gap and found new money to cover the cost, would Congress be paying twice to cover this same population?

Dr. Blumberg – Yes since it was already funded for the same people and the same benefits.

Sen. Warren – Last year, 9.5 million Medicare beneficiaries said they couldn't access dental, vision, or hearing services that they needed. Can you give us a description about who those people were?

Mr. Isasi – We're talking about three times as many folks who have incomes below $10,000 are having trouble accessing dental, vision, and hearing services that they need as compared to people who are higher income. We are talking about the most vulnerable Medicare recipients. Also, it's many people of color compared to white Medicare beneficiaries. Twice as many black beneficiaries can't see a dentist and one third as many Hispanics. Twice as many black beneficiaries have lost all their teeth as compared to the national average and three times as many Hispanics have tooth decay. This is very much an issue for our most poor, vulnerable, and beneficiaries of color.

Sen. Warren – Would they benefit the most if Medicare were to expand dental, vision, and hearing services?

Mr. Isasi – Without a question.

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