STATEMENT OF

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Mr. Chairman, members of the subcommittee, I appreciate the opportunity to testify before you today on the Affordable Care Act. My testimony reflects more than 30 years of experience—primarily at Georgetown University—exploring how best to address the widely recognized shortcomings of our health insurance system. Over that period, health insurance has become increasingly unaffordable; today an estimated 50 million people are uninsured and unable to afford health care when they need it. An ever-growing body of literature demonstrates that, without health insurance, people get care later, get less care, and are at greater risk of death than people who have health insurance. In short, assuring Americans affordable health insurance matters enormously to the health and well-being of Americans.

Almost exactly a year ago, the Affordable Care Act, or ACA, was enacted to provide that assurance. The law assures most, if not all, Americans essential health insurance coverage by building upon, not replacing, the current health insurance system—securing what works and fixing what doesn't. Put simply, the ACA strengthens the employer-sponsored health insurance that most Americans count on and will cover over 30 million more Americans by making insurance available and affordable to people that today's system leaves uninsured (most of whom are low-wage workers whose employers don't offer health insurance).

Today, about 170 million Americans get health insurance through employment. The Affordable Care Act strengthens job-based health insurance through a combination of consumer protections. The law prohibits annual or lifetime limits on benefits and allows

children up to age 26 to be covered on their parents' policies. It also imposes penalties on employers with more than 50 employees whose employees use newly available tax credits to purchase insurance directly because their employers do not offer affordable coverage. Although the ACA creates new coverage opportunities outside the workplace, estimates of the law's impact by the Congressional Budget Office indicate that in the future, job-based coverage will remain the primary source of health insurance coverage for working Americans, just as it is today.

At the same time the Affordable Care Act secures what works in providing health insurance, it fixes what is generally recognized as broken: the nongroup health insurance market. The overwhelming majority of Americans without health insurance are workers, or in families of workers, whose employers do not offer coverage. Although, in theory, these people can obtain the coverage they need by purchasing health insurance on their own, the nongroup market is not a safety net. On the contrary, insurers survive in this market by assuring they attract consumers when they're healthy and avoid them when they get sick. People with "pre-existing conditions," broadly defined, face enormous difficulties in obtaining coverage in this marketplace—as insurers can deny them coverage, charge exorbitant rates, exclude coverage for specified body parts or systems, and rescind coverage even after it's been awarded.

To address this problem, the Affordable Care Act establishes new rules for private insurance outside the workplace, largely (though not solely) through the states' creation of a new marketplace called an exchange. The rules require insurers to accept all

applicants and provide essential coverage without regard to—or extra charge based on—health status. The law provides tax credits to individuals and some small businesses to make that coverage affordable. And, to assure that health insurance is able to spread risk, the law also requires that everyone able to afford insurance actually buys it.

This set of conditions is often referred to as a "three-legged stool"—without any one leg, the health insurance marketplace simply can't stand. Unless we require health insurers to sell us health insurance, regardless of our health needs, people will be denied coverage for pre-existing conditions. And insurers can only accept all comers if they can count on us to pay premiums when we're healthy, not to wait until we get sick. And, given the high cost of insurance, many of us can only afford to pay these premiums if we get some help, which the ACA provides in the form of tax credits. Requirements on insurers and responsibility—with assistance—for consumers work together in the ACA to fix the broken nongroup health insurance market. The ACA also extend these "fixes"—a new marketplace with new rules and new tax credits—to small businesses, who, like individuals, are currently disadvantaged in the health insurance marketplace.

The Congressional Budget Office estimates that under the ACA, about 19 million people will be covered through exchanges and receive tax credits by 2019. The CBO estimates an increase of roughly 16 million people—on top of coverage projected under pre-ACA law—through Medicaid, with support from another ACA "fix"— a change to federal Medicaid law that currently excludes from coverage low income people who are not aged, blind, disabled, children, or parents of dependent children. The same low-wage

workers whose employers don't offer coverage have been denied public benefits as well, no matter how low their incomes. Fortunately, the ACA brings an end to this discrimination by extending Medicaid—at full federal expense—to all individuals whose incomes fall below 133 percent of the federal poverty level.

Though sorely needed, changes in our health insurance system cannot take place overnight. The ACA is designed to strengthen and extend the health insurance coverage Americans count on, not to disrupt it. The law recognizes that building new marketplaces will take time—and until the full set of new insurance rules and subsidies are in place, people who have inadequate coverage may want to hold on to it, despite its limitations. Therefore, the administration has been willing to grant waivers from some of the law's early requirements, which, if fully imposed, might leave people with nothing. The aim of the law's early requirements and benefits is to make matters better, without making them worse, until the full law goes into effect in 2014. Far from indicating weaknesses in the ACA, these waivers reflect its strength in matching requirements with capacity. It behooves administrators of the ACA to be sensitive to disruptions alongside improvements and to assure a balance that enhances people's protections, as the law intends.

And it behooves overseers of the law's implementation to recognize the "big picture"—the enormous problems that the ACA was enacted to address; its design to strengthen what works, fix what's broken, and avoid unnecessary disruption; and its potential when fully implemented to end discrimination based on pre-existing conditions and assure

most, if not all Americans, access to affordable health insurance coverage. All of us should be working to make sure that we move as quickly and as smoothly as possible to get us from here to there.