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I thank you for the opportunity to present some comments on the pending changes to PPACA, as related to the conversion to the AHCA, currently under consideration. We are all aware that healthcare is an incredibly complicated and sensitive issue for everyone in this Country; because it impacts everyone either directly or indirectly through our families and friends. I do not claim to have the only solution; or to know the solution. I am extrapolating my almost 16 years of experience of working extensively in the Individual and Small Group health insurance marketplaces on a personal one-to-one basis with Individuals and Business Owners.

My hope is to assist in finding and developing realistic, implementable and manageable options that benefit as many Americans as possible. While PPACA has been a great step in the right direction, we are now starting to see, other than for the expansion of Medicaid eligibility, a rising number of uninsured, health plan costs skyrocketing again, and fewer health plan choices. The shocking part is that even the number of people receiving Subsidies is shrinking rapidly; so, there are issues that needed to be addressed in order to help people.

This document is a list of itemized points, a Summary of key items in the document; and presented in a way that I hope will enhance our personal conversations. We have an opportunity to create positive long-lasting change for the next 2-to-3 decades; if we seize the moment. However, we need to be consciously aware of the political, demographic, and environmental factors that are critical to the process of improving the healthcare "system."

Perspective – The Shifting Healthcare Demographic (Key: 2019-2025)

The focus should be on getting the Baby Boomer population shifted to Medicare, as this will create a significant reduction in the need for Medicaid and Subsidies or Tax Credits. The Gen-X population (~40 million) is about half the size of the Boomers, while the Millennials are about the same size of the Boomers (~80 million), making them the dominant generation, with a median age of ~26, today! The impact on Medical Claims will be significant, as Boomers healthcare costs will shift from the Commercial Marketplace to Medicare, which a whole other issue.

- Baby Boomers – The Elephant in the Room
  - Boomers are age 53 to 71 in 2017; and started enrolling in Medicare in 2011, ~80 million of them!
  - ~40 million (half) are age 56 to 61 today, meaning we must view them in single-year age bands.
  - The 70-year-olds are required to start taking RMDs in 2017 from their Retirement Plans! (Taxed)
  - As they turn 62, due to many being Under/Unemployed, they are collecting Social Security early!
  - Many of them are a large portion of Medicaid and PPACA marketplace enrollment today.

- Important Baby Boomer Shifts
  - Social Security income will make Boomers ineligible for Medicaid, shifting them off Medicaid.
    - If Medicaid funding is held flat, the Boomers shift should free up funds for more people.
  - Pre-Medicare Boomers collecting Social Security, working part-time jobs and withdrawing money from Retirement accounts, *to survive*, will also most likely exceed PPACA subsidy levels; and maybe even the Tax Credit limit, meaning the Exchanges should already be experiencing a reduction in members as Boomers exit and start paying full price, over $8,000/each for health insurance, which is most dramatically felt in dual-income and dependent-based households.

"Giving" Item for Consideration

- The current tax laws and related rules do not allow for helping specific individuals with paying for their health insurance plan and medical expenses, only for direct funding of organizations.
  - There should be consideration given to allow Foundations/Charities/Churches/501c3s to be able to assist Individuals directly, even if payments are made to providers on the individual's behalf.
  - The result should be more private funding for community-based care, and should enhance inter-community relationships, neighbors helping neighbors.

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Ways & Means Committee Document Specific (Document Page Number Noted)

Pages 1 & 2 – Health Plans

The overall message is that Exchanges become "optional" and that PPACA health plans will no longer be able to be sold, similar to how all pre-PPACA plans were not allowed to be sold.

Page 4 and throughout Document – Abortion Coverage

Abortion Coverage is no longer required in all health plans; and in fact, the only reasonable way to offer the coverage is to sell it separately as a carve-out. A carve-out is required; because otherwise, there would be no ability to get a Tax Credit or have health plan portability, including for COBRA. (later in document)

It is important to note that the program will cover complications from any Abortion-related issue, such as an infection, injury, disease, disorder, etc.

Page 5 and in other Sections – Access of Financial Assistance

It is not 100% clear if "Off" and On-Exchange Customers would be able to access Tax Credits in '18 and '19. As I read it, it's written in a way that would allow both PPACA and AHCA to operate at the same time, thereby giving people a choice of Exchange Subsidies or (alternate) Tax Credits in '18 and '19; almost like a transition period.

Page 14 – Individual Mandate

It is important to note that there will be no Tax Penalties for not having health insurance coverage beginning in Tax Year 2016, or this year, 2017. This would allow for people to re-file 2016 Taxes and get their "penalties", for not having coverage reimbursed, although most will not, due to tax preparer filing fees.

The best way to resolve not having a Mandate is to offer low-cost coverage options, such as a Copper Level (50/50) health plan with just the core EHBs. The Mandate is very useful; but those at the lower end of the income level tend to ignore it anyway. The Mandate is a factor for people making enough money to make it a factor; and indirectly hurts families more than individuals.

Page 14 – Employer Mandate

This is an important positive change, mainly due to the 'unspoken' reality of what has happened in the Employer-based health plan marketplace over the last 4 years. Unfortunately, to avoid the penalties, most companies started offering low-cost very basic high deductible health plans that cost the "Individual-only" a price that makes them and, unfortunately their families, ineligible for any Subsidies on the Exchanges, only Medicaid-eligible.

- *(Needs Fixing!)* The Unresolved Family Issue between Individual Subsidies and Employer-Based Plans
    - If one family member is offered "affordable" employer-based coverage for themselves, the entire family is excluded from getting any help on a PPACA Exchange! This has been devastating for families; and it is seldom spoken about today. *(More later, a fix on page 47)*

Page 18 – Repeal Increase of Income Threshold for Medical Care Deduction on Taxes

This is a good change; because so many people are now paying Non-Covered Medical Expenses due to the propagation of health plans with limited provider networks and limited prescription drug coverage.

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Pages 20 to 29 – Tax Credit Program

These pages detail the new program and how the assistance would be provided and calculated; and since it gets fairly technical, I'll stick to highlighting key points, comparing it to PPACA.

- Monthly Income changes are extremely difficult to track and manage from a logistical perspective on a real-time basis; and have been a major issue for PPACA Subsidy's too. If there is going to be a tack-back of the Tax Credit, maybe consider only going-forward changes and options. For example, if someone was ineligible for a Tax Credit, after-the-fact, maybe legitimately due to a year-end bonus, then 'reduce' the Tax Credit amount on a going-forward basis, maybe at a 50% rate for 12 months, then reset.

- In the proposal, there are five (5) age-based Tax Credit Levels; and I would suggest that whatever the final resolution turns out to be, that the number of 'Levels" equal the allowed premium pricing levels' therefore, if plans are priced at a 5-to-1 Ratio for Age-Bands, then the Tax Credit should be five (5) levels.
    - Note that there is no Tax Credit band for under age 21; and this could be a potential issue, if the pricing model is similar to today, where those under age 21 pay 2/3rd's of the age 21 rate.

- It appears that the Tax Credit is 'per-person' and that one could get the aggregate of the five (5) oldest family members, not to exceed a maximum of $14,000 per year in Tax Credits. This is more comprehensive than PPACA; ***however***, it is important to note that kids are no longer forced into CHIP. It appears, later in document, that parents will have the 'choice' of enrolling their kids in Medicaid/CHIP or they keep their kids on their own health plan.
    - This change is very beneficial for many families, especially larger families, and families with kids under 27 living around the Country; such as college age students, or young adults in transition.
    - It is important to note that we force many young adults onto Medicaid; and if they travel or go to college in another State, their coverage is limited to Emergency-only coverage when out-of-State.

- Veterans should have the options of being enrolled in "Both" Programs, with assistance, as dual-eligible.
    - Many Veterans live far from a VA; or wait forever to see the VA. (Page 28)

- It appears that Legal Aliens will not be required to be legal residents for a minimum of six (6) months in order to be eligible for a Tax Credit; unlike PPACA, which is a six (6) month waiting period.

- It appears that Tax Credits can also be used for COBRA coverage offered by Employers. This is a positive change as many employer-based plans have better healthcare coverage than Individual plans. In today's Individual marketplace, few, if any, health plans offer national provider networks and few cover very expensive prescription medications, such as injectable drugs.

Page 30 – Married Couples Tax Filing Requirement

This is a MAJOR ISSUE!! It is and was a significant issue with PPACA too! There are far too many reasons that "requiring" all couples to file joint returns can be impossible; but also, immoral. As a frame of reference, what if a spouse has fled the home due to domestic abuse, under fear for their life, and they 'can't' get a divorce in a timely manner? What about estranged spouses, who've just skipped out on their partners?

There is no easy way to address this item. However, since we are considering a "flat" Tax Credit program; why not meet people half way and allow them an option versus no, reasonable, option? My initial suggestion, trying to be middle of the road, and not to entice people to file separately, is to offer Married couples filing separately a "reduced" income maximum. For example, if couples can get the Tax Credit up-to $150,000, then for Married Filing Separately, then set their Single Income limit to 75% of the $75,000, $56,250 in this case, for 'each' spouse.

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Page 32 – Small Employer HRA

The concerns around the HRA program should be that we do not create an option in which an Employer is better served by not offering health insurance to their employees; because they can reimburse the employees for what they pay to buy their own Individual health insurance plans in the health insurance marketplace. This has been a contentious issue in the employer market, even though it has not received the attention it should have received, considering it can lead to the destabilization of the Employer-based group health insurance marketplaces.

One option, combined with notes below for Page 38 – Employer-offered coverage, is to set a limit as to how much a business can reimburse an employee for the employee's purchase of an Individual health insurance plan. If one looks at this holistically; and accounts for the tax implications, then the limit an employer should be able to reimburse an employee for purchasing their own health insurance plan, for themselves and their families, on the Individual health insurance marketplace, should be between 'one-third' and 'one-half' of the available Tax Credit. We want to make sure we do not create financial issues for families, similar to PPACAs.

Page 37 – Administration of the Tax Credit Program

The AHCA program proposes the option of allowing Third-Party Administrators to assist in managing the Tax Credit program. This is a great idea, as most TPAs only charge a few dollars per month per employee to administer multiple programs for employers. In 2012, I proposed the idea of the Exchanges as being able to offer the Individual and SHOP Exchange plans as a package to Employers and their employees; and to allow a single bill to be sent to the employer. The employer could also payroll deduct the employee's payments for their individual health insurance plans, and then submit the payments to the carriers through the Exchanges.

With the TPA model; and considering TPAs process multiple payroll deductions and third-party payments today, I foresee a very efficient model for handling the Tax Credit program. However, I would add the caveat that there needs to be a pre-set limit that can be charged by the TPAs for handling the Tax Credit program. TPAs should compete on service; and additional bundled services that they already provide to employers and their employees.

Page 38 – Employer Offered Coverage (Needs a Standard)

One item we often forget when discussing what people will pay for health insurance is that most people are covered by an employer-based health plan; AND, they are paying $100 to $300 per month for their share of an Individual Only health plan. When discussing what people are paying to purchase health plans through the Exchanges, most people forget that income is not always taken into consideration when the employer offers coverage. Under PPACA, people purchasing with Subsidies, in some cases, are paying less than they would have paid, making the same income, if they were working full time and offered employer-based coverage.

There should be serious consideration to creating a strong and incentivized employer-based group health insurance marketplace, considering it is the foundation for our entire healthcare system. If employer-based coverage fails, the system fails. Along these lines, I believe it is time to set "new standards" for what should be deemed 'minimum employer-offered financial assistance'; and set it at an amount that makes sense, relative to the Tax Credit program. We want employers to offer 'reasonable' options to employees; and with no employer mandate, the options should be reasonable, or they should just not offer employer-based coverage.

One of the issues, related to affordability and Subsidies or Tax Credits, is how employer-offered coverage can make employees, and their families, unable to receive a Subsidy or Tax Credit in the Individual health insurance marketplace. Employers do this by offering an inexpensive base plan, on which the employer contribution is based; and employees wanting better health insurance then buy-up to the better plans, by paying 100% of the price difference for themselves, and their families. The offering of a base-plan with a buy-up strategy needs to be eliminated, as it hurts families. This is still an issue with PPACA, and could continue to be an issue with AHCA.

(continued)

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Page 38 – continued…

I believe that in setting a new standard for 'minimal employer-offered financial assistance' for an employee's purchase of a health plan offered by an employer, we should make sure that it correlates to the proposed Tax Credit program. In addition, as per earlier in the HRA section, the tax implications of the health plan premium payments need to be taken into consideration when determining the employer contribution to any health plans that are offered by the employer to the employees and their families.

- For example; If an employer offers employer-based coverage, the employer must offer financial assistance that is the equivalent of 1.5 times of the available Tax Credit, inclusive of HRA funds, or higher, as financial assistance to the employee, for the employee to be able to purchase the employer-based Individual-only health plan; and assuming 2 things: 1) The employer must provide employees with three (3) health plan options to pick from, and one must be a Silver level health plan; and 2) The spouse and children are still eligible for the Tax Credit in the Individual health insurance marketplaces, if still eligible based on family income. (Similar to a Defined Contribution Arrangement)

Page 45 – Children's Eligibility for CHIP (Non-Mandatory)

In this section of the AHCA, it appears that participation in CHIP will be on a voluntary basis. If this is the case, will the kids still be eligible for the Tax Credit, if their parents purchase Individual health plans on the Individual health insurance marketplaces? This is very critical and very important to understand, especially as it relates to implications across programs, meaning both the Tax Credit program for the Individual health plan purchase, and with regards to Medicaid funding and its availability.

My personal experience in enrolling 100s of families in PPACA plans, myself, is that many parents were extremely upset that they did not have a choice, as it was Husky/Medicaid or pay full price. They were not very happy conversations; and many people wanted to pay to have their kids on the same health plans as themselves. If the parents were on Husky/Medicaid, there was no issue with enrolling the kids in Husky/Medicaid. Parents preferred to have all family member on the same plan; and spitting the family up became an issue in many cases.

Page 47 – Family Issue

Within the Coordination of Coverage paragraphs, that begin on Page 47, it appears that this is how the existing issue of family members losing access to Subsidies or Tax Credits is resolved, in the case of an employer offering an employee an affordable employee-only health plan. The issue being that if an employer offers 'affordable' coverage to an employee, PPACA only takes into consideration what it costs the employee for the 'cheapest' available employee-only health plan option offered to the employee, by calculating the affordability of the health plan cost based on employee-only coverage. If the plan is considered affordable for the cheapest employee-only plan, then the family is ineligible for financial assistance, a Subsidy on the Exchange.

In consideration that many employers contribute far less for family coverage, as a percentage of premium, than they contribute for the employee-only plan; the situation created is that the family is unable to get help for purchasing a health insurance plan. The reality is that many employees purchase the employer-plan for the whole family, many even purchase a buy-up plan option, and the cost for the employee can easily be in the range of $100 to $200 "per week", meaning $400 to $800 per month, for the entire family's health insurance coverage.