WRITTEN STATEMENT FOR THE RECORD

FOR THE HEARING ENTITLED "MARKUP OF COMMITTEE PRINT, BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS AND H. RES 154"

UNITED STATES HOUSE COMMITTEE ON ENERGY AND COMMERCE

March 8, 2017

BY THE

ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the March 8, 2017 markup of the "American Health Care Act" before the House Committee on Energy and Commerce entitled "Markup of Committee Print, Budget Reconciliation Legislative Recommendations and H. Res 154." APIAHF is a national health justice organization that influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of the over 20 million Asian Americans and nearly 1 million Native Hawaiians and Pacific Islanders (AAs and NHPIs) in the United States. For over 30 years, APIAHF has worked at the federal, state, and local levels to advance sensible policies that reduce health disparities and promote health equity.

Millions of Americans, including AAs and NHPIs, who rely on coverage under the ACA will be worse off under the America Health Care Act (AHCA). Under the guise of flexibility, this plan would end Medicaid as we know it by phasing in per-capita caps. Under the guise of access, the bill would reduce the financial support that is currently allowing millions of low- and moderate-income Americans to afford their monthly premiums. This plan would offer fewer tax credits to individuals and families by restricting eligibility to citizens, nationals and "qualified aliens" under the Personal Responsibility and Work Opportunity Reconciliation Act definition. In contrast, the ACA provides assistance to all lawfully present persons. Limiting tax credits only to persons who are citizens or "qualified aliens" would render many immigrant groups with lawful status ineligible, including Compact of Free Association (COFA) migrants. More than eight in 10 previously uninsured AAs and NHPIs qualify for financial assistance through the ACA. In short, the AHCA not an adequate replacement for the ACA because it does not offer robust, affordable, and comprehensive health insurance.

The ACA Has Expanded Access to Essential Care for AAs and NHPIs

The ACA's coverage expansions reduced the overall rate of uninsured AAs from 15.7 to 7.8 percent and the percentage of NHPIs without insurance fell from 17.4 to 9.9 percent.[1] Health coverage is critical for AAs and NHPIs who experience a number of barriers to accessing affordable health insurance and care. The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. As of 2016, 11% of AAs and 23% of NHPI families live below the poverty line.[2] Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

Eight in 10 AAs and NHPIs qualify for financial assistance under the ACA.[3] Prior to the ACA, high costs caused many AAs and NHPIs to either forgo care entirely or sell everything they had to afford care. People like Trieu, a young adult from Pennsylvania, had to forgo care and hoped he did not get sick until he got coverage thanks to the ACA's financial help.

The ACA's financial assistance saved the life of Jirapon in Georgia. Jirapon is a single mom with three children who works as a cook. Thanks to a local community based organization, she was able to enroll in health care for the first time. She qualified for subsidies as well as Medicaid for her youngest child. After getting covered, Jirapon went for a general screening and was diagnosed with breast cancer. She was able to access affordable surgery, reconstruction, and long-term care because of the ACA.

Falani and his wife, Teuloi, from Utah went uninsured for 15 years prior to the ACA, even though Falani was battling stomach cancer and diabetes. Without coverage, he resorted to home remedies and emergency care when things got really bad. The ACA changed their lives when they realized they could afford a plan for $45 a month and finally get much needed dialysis.

The AHCA does not offer the financial assistance and robust coverage included in the ACA. Trieu, Jirapon, Falani, and Teuloi would likely not be able to afford coverage under the AHCA. The proposed bill puts the the 20 million Americans who gained access under the ACA at risk of losing their coverage with no quality replacement options.[4]

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[1] American Community Survey, 2010 and 2015 Estimates. Table S0201.

[2] Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity, Section 1: Demographics*, Kaiser Family Foundation, June 7, 2016, *available at*: http://kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-1-demographics/.

[3] Minh Wendt, et al., *Eligible Uninsured Asian Americans, Native Hawaiians, and Pacific Islanders: 8 in 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid, or CHIP*, HSS ASPE Research Brief, March 18, 2014, *available at*: https://aspe.hhs.gov/sites/default/files/pdf/180311/rb_UninsuredAANHPI.pdf.

[4] Bowen Garrett, *Who Gained Health Insurance Coverage Under the ACA and Where Do They Live*, Urban Institute, December 2016, *available at*: http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf.

Medicaid Serves Our Most Vulnerable Members of Society

The ACHA would effectively end the ACA's Medicaid expansion by repealing the guaranteed federal funding associated with it. As proposed, the ACHA would also end Medicaid's guarantee as a safety net to the poor, elderly and disabled, capping Medicaid funding to the states. Both of these actions would have a devastating effect on consumers, particularly low-income AAs & NHPIs.

Medicaid represents a vital piece of our country's health care system and is the sole source of health insurance for many AAs and NHPIs. Since 1965, it has served as the safety net for those in need of help, including persons with disabilities, those in poverty and older Americans. The ACA expanded Medicaid to cover poor, childless adults for the first time.

Access to health insurance is a critical part of ensuring a strong public health infrastructure. Medicaid and the Children's Health Insurance Program (CHIP) provide essential health coverage to 78 million people, about half of whom are children.[5] Medicaid also serves as a vital resource to seniors. As our country ages, many families struggle to find care for aging parents. Medicaid is the primary payer for more than half of long-term services and supports.[6] Medicaid is also critically important to providing reproductive and maternal healthcare to women. Together with CHIP, Medicaid covers nearly half of births across the country.[7]

Medicaid represents an important part of our country's ability to minimize harm at times of growing poverty rates and increasing need. Medicaid's recent growth as a share of insurance coverage represents this design. In addition to the eligibility expansion under the ACA, much of that growth is a reflection of greater need, corresponding with higher poverty rates for children, seniors and adults.[8] Yet, Medicaid's ability to serve the nation's needs are severely restricted under this legislation.

Medicaid Plays an Important Role for AAs and NHPIs

AAs and NHPIs are among the fastest growing racial groups in the United States. Between 2014 and 2015, the AA population grew by 3.4 percent, more than any other group, while NHPIs

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[5] Centers for Medicare and Medicaid Services, *Medicaid & CHIP: August 2016 Monthly Applications, Eligibility Determinations and Enrollment Report*, 2016, *available at*: https://www.medicaid.gov/medicaid/program-information/downloads/august-2016-enrollment-report.pdf.

[6] ca L. Reaves & MaryBeth Musumeci, *Medicaid and Long-Term Services and Supports: A Primer.* Kaiser Family Foundation, 2015, *available at*: http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/.

[7] Markus, A., Andres, E., West, K., Garro, N., & Pellegrini, C., *Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform*. Women's Health Issues, *23*(5), e273-e280, 2013.

[8] Bradley et al, *Strengthening Medicaid as a Critical Lever in Building a Culture of Health*, National Academy of Social Insurance, 2017, *available at*: https://www.nasi.org/sites/default/files/research/Strengthening_Medicaid_as_a_Critical_Lever_Low_Res.pdf

grew 2.4 percent, following only mixed race individuals.[9] Any bill that attempts to cut Medicaid, particularly in the longer term, must take the needs of AA & NHPI communities into account. Like many Americans, health care ranks as one of the top issues of importance to AA families. This is reflected in polling showing that among AAs, healthcare was mentioned as the second most important issue affecting voters personally. In addition, 60 percent of AAs voters have said they support the ACA.[10]

The importance of Medicaid to AA & NHPI communities is emphasized by the 17 percent of AAs and 34 percent of NHPIs who are enrolled.[11] NHPIs match American Indians as the racial community with the highest percent of its population on Medicaid. Twelve percent of AAs live in poverty, as do 17.3 percent of NHPIs.[12] Medicaid's roll in covering the nation's most vulnerable populations, whom are disproportionately people of color, means that any cuts to Medicaid will hurt efforts to improve health equity.

Through Medicaid, AA & NHPI populations who are low-income and working can access treatment for conditions that disproportionately impact these communities, such as liver and stomach cancers, hepatitis and diabetes.[13] AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention. AAs are 25 percent more likely to be diagnosed with diabetes than Whites, while NHPIs are 3 times more likely.[14] AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.[15] Certain AA and NHPI subpopulations suffer from even greater health disparities. Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.[16] Vietnamese women have cervical cancer rates five times higher than White women.[17]

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[9] Lam. Charles, *Asians Remain Fastest-Growing US Group as Pacific Islanders, Mixed-Race Numbers Grow*: Census. NBC News, 2016, *available at*: http://www.nbcnews.com/news/asian-america/asians-remain-fastest-growing-us-group-pacific-islanders-mixed-race-n597711

[10] Karthick Ramakrishnan, *Asian American Voices in the 2016 Election*, APIA Vote, Oct 2016, *available at*: www.naasurvey.com/wp-content/uploads/2016/10/NAAS2016-Oct5-report.pdf

[11] National Health Interview Survey, United States Centers for Disease Control, 2015, *available at*: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2015_SHS_Table_P-11.pdf

[12] American Community Survey One Year Estimates, 2015, Table S0201.

[13] *Asian American & Pacific Islander Health Disparities Compared to Non-Hispanic Whites*, Families USA, 2014, *available at*: http://familiesusa.org/product/asian-american-pacific-islander-health-disparities-compared-non-hispanic-whites

[14] Asian and Pacific Islander American Health Forum, *Native Hawaiian and Pacific Islander Health Disparities*, 2010, *available at*: www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf

[15] Heron, Melonie, *Deaths: Leading Causes for 2014. National Vital Statistics Reports* Volume 65, Number 5. United States Centers for Disease Control, 2016.

[16] Spanakis, Elias and Sherita Hill Golden, *Race/Ethnic Difference in Diabetes and Diabetic Complications*. Curr Diab Rep. 13(6), 2013, *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/

[17] Miller BA et al., *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992*, 1996, *available at*: https://seer.cancer.gov/archive/publications/ethnicity/

The ACHA's cuts to Medicaid would Decimate the Program

According to the Center on Budget and Policy Priorities, the ACHA's Medicaid cuts would shift $370 billion in Medicaid costs to states over the next ten years. State governments already face tight fiscal situations and likely would not be able to maintain current eligibility and/or benefit levels under such a shift. The Medicaid expansion has played an important role in expanding the number of AAs and NHPIs with health insurance, and repealing will set the nation backwards. While payment at the enhanced rate would continue for beneficiaries as of 2020, Medicaid populations tend to have less stable incomes and fluctuate in coverage. For example, a Medicare beneficiary may gain a new job and lose Medicaid eligibility, only in turn to lose the job not too long after and return to the program. Under the AHCA, states would lose the enhanced FMAP for the expansion population and would further restrict state funding by not allowing states to account for that churn.

Turning Medicaid into a per capita cap would restrict the program's ability to meet increased need. The program would be tied to a single inflationary value for the whole country and would not account for differences between states or across time. If an expensive new drug is released or a state faces a public health outbreak, such as the current opioid crisis or Zika virus, states can easily run out of federal matching funding for the Medicaid population when health costs spike. Additionally, as the senior population ages within its cap, costs will likely rise for that population.

As Congress debates the future of Medicaid and the health care system, we urge policymakers to take into consideration the needs of AA and NHPI communities, many of whom would have to forgo health care if Medicaid was cut or eligibility was further restricted. Medicaid must remain a strong source of health insurance for the most vulnerable Americans.

The ACHA Would Set New Precedents in Restricting Immigrant Access to Healthcare

The ACHA would severely restrict eligibility to health insurance tax credits on the basis of immigration status. Under the ACA, all persons who are lawfully present, as defined in regulation and guidance, are eligible for tax credits and subsidies. In contrast, the ACHA takes a highly restrictive approach and limits access to tax credits to persons who are citizens, nationals or "qualified aliens" as defined by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This exclusion would thus render many immigrants with lawful status who are currently eligible for and receiving tax credits under the ACA ineligible for assistance under the ACHA, despite paying into the system and being lawfully present.

Among the groups excluded from the category of qualified aliens are individuals present under the Compacts of Free Association (COFA). Since 1986, these compacts have defined the relationship between the United States the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. Under the Compact, in exchange for permitting the U.S. exclusive use and military strategic positioning of 2 million square miles in the Pacific,

the U.S. provides grants to fund education, health care, and infrastructure in these countries. Citizens of COFA parties may freely work, live and travel to the United States without restriction as "non-immigrants" in exchange for military access to their jurisdictions.

Because of the COFA treaties, the U.S. military maintains control of Micronesian lands for key strategic military purposes, such as for military outposts, and as practice targets for the National Missile Defense Program's intercontinental ballistic missile defense system. As such, the islands of the Republic the Marshall Islands, the Federated States of Micronesia and the Republic of Palau support and bolster our national security and are critical allies in the Pacific.

When the 1996 welfare reform law created the qualified alien category, COFA migrants were unintentionally excluded. Since then, despite being taxpayers who pay into the system, COFA migrants have been statutorily excluded from Medicaid. COFA citizens represent the highest per-capita U.S. military enlistment rate than any other U.S. jurisdiction or state. Yet, COFA migrant veterans who have served our country are denied access to the same basic health programs as other Americans.

By limiting tax credits to only immigrants who are "qualified aliens," the AHCA would extend this Medicaid exclusion to tax credits for COFA migrants. Many COFA migrants suffer from chronic diseases and health conditions that can be linked to the medical effects of U.S. nuclear testing in the region. Using restrictive eligibility definitions in ACHA does an injustice to COFA migrants and all other excluded immigrant populations. It also places these communities in an impossible situation where they are ineligible for Medicaid and ineligible for tax credits, increasing the likelihood they will be forced to go without coverage and access to care.

The AHCA Would Reduce the Value of Health Insurance

The AHCA reduces the quality of health insurance. Under the ACA, QHPs have to meet actuarial value standards to ensure that people have quality care and are able to adequately estimate their out-of-pocket expenses. Instead, the AHCA allows insurers to sell catastrophic coverage which dramatically decreases the value of plans.

While the AHCA appears to lower premiums on the surface, it would reduce the actuarial value of QHPs and increase consumer's share of cost-sharing while receiving less value for coverage. The financial burden on older Americans would be especially harsh under the proposed five times age-rating system. It is estimated that the AHCA would drive up the average cost for consumers by $2,409 in 2020 and up to $6,971 in 2020 for older Americans.[18]

[18] David Cutler, et al., *Analysis: GOP Plan to Cost Obamacare Enrollees $1,542 More a Year*, Vox, March 7, 2017, *available at*: http://www.vox.com/the-big-idea/2017/3/7/14843632/aca-republican-health-care-plan-premiums-cost-price

The ACA's consumer protections and financial assistance gave 4.3 million Asian Americans access to free routine preventive care.[19] This is especially important for diagnosing and treating chronic conditions amongst AAs and NHPIs. The risk of diabetes for AAs is 18% higher than for Whites.[20] Additionally, AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.[21] Early routine care is essential for treating these chronic conditions.

Additionally, the AHCA repeals and attempts to codify provisions that would substantially impact women's reproductive health care. The AHCA would repeal the ACA's contraceptive benefit tax, make the Hyde amendment permanent law, and defund the country's largest family planning provider. Together, these three provisions will effectively eliminate access to reproductive health care for many low-income communities, rural communities, and women of color.

Under the ACA, 55 million women gained access to contraceptives with no out of pocket costs.[22] The AHCA repeal of the tax that provides this access will force many women to once again choose between essential medication and paying their bills.

The Hyde amendment has been an annual attachment to the federal budget since 1976.[23] It bars federal funding for abortion care, expect under narrow circumstances, which puts comprehensive reproductive health care out of reach of many low-income women and women of color.[24] Women of color make up over half of those subject to the Hyde amendment rule.[25] Sixteen percent of AAs and twenty-five percent of NHPIs rely on government funded health insurance in 2014.[26] Making the Hyde amendment permanent law in the AHCA would continue a discriminatory policy that has a substantial impact on women of color, including AA and NHPI women.

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[19] *Increased Coverage of Preventive Services with Zero Cost Sharing Under the Affordable Care Act*, HHS ASPE Research Brief, June 27, 2014, *available at*: https://aspe.hhs.gov/pdf-report/increased-coverage-preventive-services-zero-cost-sharing-under-affordable-care-act.

[20] Centers for Disease Control, *National Diabetes Fact Sheet*, 2011, *available at*: https://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf.

[21] Barry A. Miller, et al., *Cancer incidence and mortality patterns among specific Asian and Pacific Islander populations in the U.S.*, November 2007, *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2268721/.

[22] National Women's Law Center, *The Affordable Care Act's Birth Control Benefit is Working for Women*, December 2016, *available at*: http://nwlc.org/wp-content/uploads/2016/06/The-ACAs-Birth-Control-Benefit-1.pdf

[23] All Above All, *Fact Sheet: The Hyde Amendment*, updated January 2017, *available at*: http://allaboveall.org/wp/wp-content/uploads/2015/06/Hyde-Amendment-Fact-Sheet-011717.pdf

[24] All Above All, *Fact Sheet: The Hyde Amendment*, updated January 2017, *available at*: http://allaboveall.org/wp/wp-content/uploads/2015/06/Hyde-Amendment-Fact-Sheet-011717.pdf

[25] All Above All, *Fact Sheet: The Hyde Amendment*, updated January 2017, *available at*: http://allaboveall.org/wp/wp-content/uploads/2015/06/Hyde-Amendment-Fact-Sheet-011717.pdf

[26] Samantha Artiga, et al., *Key Facts on Health and Health Care by Race and Ethnicity, Section 4: Health Coverage*, Kaiser Family Foundation, June 7, 2016, *available at*: http://kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-4-health-coverage/

In addition, defunding the country's largest family planning provider, Planned Parenthood, will create a hole in the family planning safety net that will not otherwise be met. Eliminating funding for Planned Parenthood through Medicaid and other federal funding would put essential and life-saving reproductive health care, including breast cancer exams and STI screening, out of reach for millions of low income people for whom Planned Parenthood clinics are the only accessible provider.

Health Savings Accounts Are Not a Viable Option for Struggling Americans

Health Savings Accounts (HSAs) are not an option for low and moderate income families who often live paycheck to paycheck.[27] They do not have the excess income to store away in a savings account in case of a medical emergency.[28] Also, while the premiums in HSA plans are lower, the consumer pays far more in deductibles.[29] While higher income families can afford to store away money and pay higher deductibles when accessing care, this is nearly impossible for many lower income families. Furthermore, low income families do not make enough to benefit from the tax deductions that are part of HSAs.[30]

The Continuous Coverage Penalty Undermines Access to Coverage

The AHCA attempts to incentivize continuous coverage by charging people a premium plus 30% if they have a gap in coverage. This includes people with preexisting conditions. This will hurt low and moderate income families whose finances fluctuate regularly. A study from 2016 showed that these families had a twenty-five percent income drop for 2.7 months of the year and an income increase for another 2.7 months of the year.[31] Under the AHCA, if these families are forced to drop coverage because of a drop in income, they would face a 30% surcharge to reenroll.

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[27] Linda J. Blumberg, *Health Savings Accounts and High Deductible Health Insurance Plans*, Urban Institute, January 2009, *available at*: http://www.urban.org/sites/default/files/publication/30106/411833-Health-Savings-Accounts-and-High-Deductible-Health-Insurance-Plans.PDF

[28] Linda J. Blumberg, *Health Savings Accounts and High Deductible Health Insurance Plans*, Urban Institute, January 2009, *available at*: http://www.urban.org/sites/default/files/publication/30106/411833-Health-Savings-Accounts-and-High-Deductible-Health-Insurance-Plans.PDF

[29] Catherine Hoffman, *Health Savings Accounts and High Deductible Health Insurance Plans: Are They an Option for Low-Income Families?*, Kaiser Family Foundation, October 2006, *available at*: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7568.pdf

[30] Catherine Hoffman, *Health Savings Accounts and High Deductible Health Insurance Plans: Are They an Option for Low-Income Families?,* Kaiser Family Foundation, October 2006, *available at*: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7568.pdf

[31] Julia B. Isaacs, et al., *Stabilizing Children's Lives when Family Income Fluctuates from Month to Month*, Urban Institute, December 8, 2016, *available at*: http://www.urban.org/urban-wire/stabilizing-childrens-lives-when-family-income-fluctuates-month-month.

Repealing the ACA's Prevention Fund Threatens the Nation's Public Health

The ACA included a major step forward in addressing preventive care by creating the Prevention and Public Health Fund set up to fund grants and initiatives that have been working to make families and communities healthier. ACHA would repeal that fund, and as a result, end successful programs that are helping consumers avoid chronic conditions and reducing the cost of healthcare in the process. Repealing the fund would lead to a 12 percent cut of the Center for Disease Control's budget alone.

The Racial and Ethnic Approaches to Community Health (REACH) program, operated by the CDC, is financed by the prevention fund and has been a critical tool to help community based organizations address disparities in healthcare. This important program serves as the nation's only community-based, culturally relevant and multi-disciplinary program dedicated to the elimination of racial and ethnic health disparities. Many communities based organizations working to improve the health of AA & NHPI communities have received REACH grants to set up walking trails and healthy eating programs. APIAHF and the NYU Center for the Study of Asian American Health are just one example of the type of organizations who have received REACH funding. APIAHF was awarded a five-year REACH grant to support 15 organizations for $3 million in 10 states and Guam to implement projects to increase physical activity and improve nutrition. The project, known as Strategies to Reach and Implement the Vision of Health Equity (STRIVE) [32], took a three-pronged approach leveraging high-impact, population-wide, evidence-based strategies to combat obesity among AAs and NHPIs—a condition that costs the U.S. $147 billion each year. Eliminating the prevention fund would result in eliminating critical programs like REACH.

In addition, repealing the prevention fund's investment would cripple the nation's ability to respond to disease outbreaks, such as Zika and Ebola, putting our security at risk.

Committees Should Not Proceed Without a Congressional Budget Office Score

This legislation is being considered by the committee without a publically released report by the Congressional Budget Office (CBO). A CBO report would provide information to the public, as well as to all members of Congress, about the cost of ACHA as well as how many people would lose coverage under its provisions. A CBO report would help identify which populations in particular would be most impacted by the legislation, and without that data we are only able to speculate about the costs and cuts consumers are facing. We urge the committee to postpone any vote until an official CBO is released.

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[32] Patel S et al. *Using evidence-based policy, systems, and environmental strategies to increase access to healthy food and opportunities for physical activity among Asian Americans, Native Hawaiians, and Pacific Islanders.* Am J Public Health (2015 Jul;105), *available at*: https://www.ncbi.nlm.nih.gov/pubmed/25905839

In conclusion, the AHCA is not an adequate replacement for the ACA. It does not combine real financial assistance with comprehensive quality health care and as such APIAHF opposes the bill.