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# American Health Care Act

Mr. SMITH of New Jersey… Mr. Speaker, while the Affordable Care Act has been in effect since 2010, it has only provided actual access to health insurance benefits through the exchange and Medicaid expansion for a little over 3 years—beginning in 2014.

In that short period of time, however, serious problems and flaws have been exposed, yet in recent months the law's systemic problems have been trivialized or ignored by many.

Today, buying an insurance policy on the exchanges with high premiums, high copays, and most importantly, exceedingly high deductibles make the actual utilization of health benefits far costlier than originally advertised.

Americans were told repeatedly that the ACA would save up to $2,500 in premium payments per family per year. President Obama said: ''I will sign a universal health care bill into law by the end of my first term as president that will cover every American and cut the cost of a typical family's premium by up to $2,500 a year.''

That didn't happen—not even close. Nationwide, since 2016, gross premiums before subsidies in the Bronze-priced tier rose a whopping 27 percent, silver 24 percent and gold 32 percent.

That should come as no surprise. As early as August 2012, Politifact found President Obama's promise to be untrue and labeled the statement a ''promise broken'' in a Politifact report entitled: NO cut in premiums for typical family.

Health insurance consumers were promised they could keep their insurance plan if they liked it and keep their trusted doctors as well.

That didn't happen either.

As a matter of fact, several million were kicked off insurance plans they were very satisfied with—like my wife and I—only to be forced into an Obamacare plan that we didn't want and was more expensive.

Also, in New Jersey—like much of the nation—insurance companies are pulling out of the exchanges. Insurers continue to exit the individual market and the exchange has experienced a net loss of 88 insurers. Today, five states only have one insurer option. At home, last year five insurance carriers offered plans on the New Jersey exchange, today only two remain. The exodus of insurance companies from the individual market is an unsustainable and ominous trend.

Mr. Speaker, almost twice as many Americans have paid the financial penalty—pursuant to what is euphemistically called the ''individual mandate''—for not buying a health insurance plan—or have received an exemption from the individual mandate as those who have actually purchased a plan through the exchange. By the numbers that means 19.2 million taxpayers either paid the individual mandate penalty or claimed

an exemption, compared to 10.3 million individuals who paid for plans on the Obamacare exchanges.

Obamacare also increased taxes by about one trillion dollars. For example, beginning in 2020, a new 40% excise tax on employer provided comprehensive health insurance plans is scheduled to take effect. Any plan provided by an employer exceeding $10,200 for individuals and $27,500 for families will be taxed at 40 percent for each dollar above those numbers.

According to the Kaiser Family Foundation this so-called Cadillac tax will hit 26 percent of employers by 2020.

According to the IRS, approximately 10 million families took advantage of the chronic care tax deduction which is now been redefined out of reach for many. New taxes combined with skyrocketing premiums, copays and deductibles underscores the need for serious review, reevaluation and reform.

That said Mr. Speaker, I remain deeply concerned—and will vote no today—largely because the pending bill cuts Medicaid funding by an estimated $839 billion over ten years according to the Congressional Budget Office (CBO), rolls back Medicaid expansion, cancels essential health benefits such as maternity and newborn care, hospitalization, pediatric services, and mental health and substance use treatment, and includes ''per capita caps''—all of which will likely hurt disabled persons, the elderly and the working poor.

For years, I have supported Medicaid expansion as a meaningful way of providing access to health care for struggling individuals and families living above the poverty line but still poor despite being employed—80 percent of all Medicaid enrollees in New Jersey are families with at least one working adult in 2017.

Although more than 800,000 children are served by Medicaid in my state, the bulk of Medicaid funds are spent assisting the disabled and the elderly. In New Jersey approximately 74 percent of all Medicaid spending goes directly to assist persons with disabilities and senior citizens. Two out of every five people in nursing homes are on Medicaid.

According to the New Jersey Department of Human Services, in New Jersey total enrollment in Medicaid in February 2017 was 1.77 million people. Of that a significant number are newly enrolled under Medicaid expansion— 663,523 ''newly eligible.''

These people are in need and deserve our support. Current law provides states that opted to embrace Medicaid Expansion—like New Jersey—95 percent of the costs for the ''newly enrolled.'' The federal share drops to 90 percent by 2020.

The proposed American Health Care Act continues Medicaid expansion however only until 2020. Those enrolled before December 31, 2019 would be grandfathered in at the 90 percent match rate but the federal-state match formula would then be reduced to a range between 75 percent–25 percent to 50 percent– 50 percent or any new enrollee.

What does that mean?

The United State Conference of Catholic Bishops wrote each of us on March 17th: ''. . . it is our assessment that some provisions are commendable (and they reference the pro-life safeguards and other noteworthy provisions in the bill) . . . while others present grave challenges that must be addressed before passage . . . millions of people who would be eligible for Medicaid under current law will be negatively impacted due to reduced funding from the per capita cap system proposed in the legislation, according to the CBO.

Those struggling families who currently receive Medicaid coverage from the recent expansion will see dramatic changes through the AHCA as well, without clear indication of affordable, adequate coverage to replace their current options. Many states begin their legislative sessions every cycle by attempting to overcome major deficits. State and local resources are unlikely to be sufficient to cover the gaps that will be created in the health care system as financial responsibility is further shifted to the states. Congress must rework the Medicaid-related provisions of the AHCA to fix these problems and ensure access for all, and especially for those most in need.''

A letter led by the Consortium For Citizens with Disabilities, and signed by over 60 organizations states: ''Dramatic reductions in federal support for Medicaid will force states to cut services and/or eligibility that puts the health and wellbeing of people with disabilities at significant risk. In fact, people with disabilities are particularly at risk because so many waiver and home- and community-based services are optional Medicaid services and will likely be the first services cut when states are addressing budgetary shortfalls. The health, functioning, independence, and wellbeing of 10 million

enrollees living with disabilities and, often, their families, depends on funding the services that Medicaid provides. Likewise, Medicaid Expansion provides coverage for millions of people with disabilities and their caregivers who previously fell into healthcare coverage gaps. For many people with disabilities, being able to access timely, needed care is a life or death matter. The drastic cuts to Medicaid that will result from per capita caps and the ultimate elimination of Medicaid Expansion will endanger millions.''

Autism Speaks, a leading autism awareness, science, and advocacy group, further articulated another concern, that ''the choice of 2016 as a baseline year for per capita caps may prevent states from addressing the needs of children with autism. In July 2014 the Center for Medicaid and CHIP Services issued an informational bulletin clarifying Medicaid coverage of services to children with autism, including benefit requirements for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Although EPSDT is a mandatory Medicaid program, few states in 2016 funded autism services at the required standard of care. Locking in 2016 as a baseline year can only perpetuate this historic underfunding of EPSDT benefits.''