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January 4, 2017

The Honorable Kevin McCarthy
Majority Leader
U.S. House of Representatives
2421 Rayburn House Office Building
Washington, DC 20515

The Honorable Kevin Brady
Chairman, House Committee on Ways and Means
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Fred Upton
Member of Congress
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Virginia Foxx
Chairwoman, House Committee on Education and the Workforce
2262 Rayburn House Office Building
Washington, DC 20515

The Honorable Greg Walden
Chairman, House Committee on Energy and Commerce
U.S. House of Representatives
2185 Rayburn House Office Building
Washington, DC 20515

Dear Majority Leader McCarthy, Chairman Brady, Congressman Upton, Chairman Walden and Chairwoman Foxx,

Thank you for your letter requesting feedback on how our current health care system is working for Pennsylvanians and how any substantial changes to that system may impact them. We appreciate your recognition of the critical role that states and state insurance commissioners play in ensuring consumers have access to health care services and security in knowing they will be protected from catastrophic health care costs. We share the vital goals of providing quality, affordable health insurance coverage while stemming the unsustainable growth of health care costs, and I hope that you find my feedback to be constructive in this regard. I am committed to working with you as we continue to strive for these goals, and would welcome any additional opportunities to discuss how we improve our health care system for all Americans.

Before talking about potential changes, it is important to first establish the baseline from which any changes will be made. Today, more people in Pennsylvania and across the country have health insurance than ever before. In our Commonwealth, over 1.1 million people are enrolled in the programs established by the Affordable Care Act (ACA), many of whom are able to access and afford coverage for the first time. A recent study found that one in four adult Americans under age 65 have a pre-existing condition[1]. Those approximately 52 million Americans now feel secure in knowing that they will not be denied access to health insurance. Another study

[1] *An Estimated 52 Million Adults Have Pre-Existing Conditions that Would Make Them Uninsurable Pre-Obamacare.* Kaiser Family Foundation. December 12, 2016.

found that the number of people whose families are struggling to pay medical bills declined by 22% or 13 million people in the last five years[2]. The importance of this financial security for our citizens cannot be emphasized enough.

Further, the ACA has ensured that people are able to access insurance that is robust and comprehensive, where pre-ACA coverage was often limited if not insufficient. ACA coverage guarantees access to preventive health services that can be not only life-saving but also cost-saving, to maternity care that ensures our nation's children are brought into the world safely and with care, and to mental health services, which have become even more critical as our country continues to combat the devastating impact of the opioid addiction crisis. And, these benefits now must be available without the restrictions of lifetime or annual limits, which affected over 4.5 million Pennsylvanians before the ACA[3] and were financially devastating to individuals with catastrophic and chronic health care needs. The ACA is not perfect, but as we talk about changes to this baseline, I ask that you ensure they result in progress, not regress.

To achieve this progress, the most immediate need is to stabilize our markets, particularly the individual markets that have struggled in many states. However, we cannot forget that before the ACA these markets functioned only because they relied on extensive underwriting and excluded many of our most vulnerable citizens. If we want to continue to protect the over 50 million Americans with pre-existing conditions, we must be deliberate in any changes to the market and ensure those changes recognize the fundamentals of how insurance markets work. The ACA approached this problem by creating a delicate balance between three key provisions: guaranteed issue (the prohibition on pre-existing condition exclusions), the individual responsibility requirement (often referred to as the individual mandate), and the affordability provisions that include the premium tax subsidies and cost-sharing reductions. These three provisions are often referred to as a "three-legged stool," because if you cut off one leg, the other two cannot stand on their own. I continue to read in the media that Congress is considering picking and choosing amongst these provisions, making choices like eliminating the individual mandate and its associated penalty while retaining guaranteed issue, preventing payments to insurers under the reinsurance program, or continuing to pursue the lawsuit that would prevent the continued payment of cost-sharing reductions that help millions of Americans pay their deductibles and co-payments when they receive care. I am troubled by these ideas because isolated changes like these are not merely ill-advised; they have the potential to topple the stool. If you take away the individual mandate but retain guaranteed issue, the likely outcome would be healthier individuals choosing to forego coverage, while only those who know they will have expensive health needs continue to buy it. The consequence would be what is known in insurance terms as a death spiral; make no mistake, if you make these decisions, you could quickly collapse individual markets around the country.

I further worry that the change in administration has created a sense of uncertainty that is currently permeating the health care system and has the potential to undermine our markets before changes can even be decided upon. If we want our insurance companies to continue

[2] *Problems Paying Medical Bills Among Persons Under Age 65: Early Release of Estimates From the National Health Interview Survey, 2011-June 2016.* National Center for Health Statistics. November, 2016.
[3] *Impact of the Affordable Care Act in Pennsylvania*. U.S. Department of Health & Human Services. December 13, 2016.

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offering products to our consumers, they must be given certainty so that they know the rules and can make informed business decisions. Whatever changes you decide to make, timing, advance notice, and the ability to provide definitive answers that align with the existing timelines for preparing products for sale, are critical. If this certainty cannot be given, I fear that insurance companies will be unwilling to risk continued participation in these markets. If this happens, markets around the country could collapse and millions of Americans could lose their health insurance coverage as you continue to deliberate and negotiate in Washington.

As insurance commissioner, I have a responsibility to the citizens of the Commonwealth of Pennsylvania to do everything in my power to maintain vibrant and competitive markets, provide them with affordable and quality health insurance coverage options, and protect them from harm. I am committed to collaborating with you on positive change, but I cannot overstate the need for stability in our individual market and the potential for devastating consequences if great care is not taken to consider the potential impacts on our citizens of any changes you may make to the ACA.

I have provided extensive responses to each of your detailed questions in the included attachment. If you have additional questions about our comments, please reach out to my Legislative Director, Kristen Erway, at any time. She can be reached by email at krerway@pa.gov or by phone at (717) 783 -3501. Thank you again for your interest in my feedback and the feedback of all states. I look forward to further discussions.

Sincerely,

Teresa D. Miller
Pennsylvania Insurance Commissioner

cc: The Honorable Mike Kelly, Member of Congress, Pennsylvania's 3rd District
The Honorable Scott Perry, Member of Congress, Pennsylvania's 4th District
The Honorable Glenn W. Thompson, Member of Congress, Pennsylvania's 5th District
The Honorable Ryan Costello, Member of Congress, Pennsylvania's 6th District
The Honorable Pat Meehan, Member of Congress, Pennsylvania's 7th District
The Honorable Brian Fitzpatrick, Member of Congress, Pennsylvania's 8th District
The Honorable Bill Shuster, Member of Congress, Pennsylvania's 9th District
The Honorable Tom Marino, Member of Congress, Pennsylvania's 10th District
The Honorable Lou Barletta, Member of Congress, Pennsylvania's 11th District
The Honorable Keith Rothfus, Member of Congress, Pennsylvania's 12th District
The Honorable Charles W. Dent, Member of Congress, Pennsylvania's 15th District
The Honorable Lloyd Smucker, Member of Congress, Pennsylvania's 16th District
The Honorable Tim Murphy, Member of Congress, Pennsylvania's 18th District

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1. **What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choice and lower premiums?**

I am a strong proponent of states as the primary regulator of their health care systems and health insurance markets. Steps to increase state flexibility, such as a streamlined §1332 innovation waiver application and greater willingness of the federal government to accommodate unique state needs in the execution of their federal responsibilities related to health care, are welcome. For example, the current administration has not been willing to provide states flexibility on some key elements, such as how subsidies are paid and the functionality available through the heathcare.gov platform. State governments know their markets best and flexibility such as this enables them to better serve their residents, regulate their markets, and facilitate innovation in state health care systems.

I spoke earlier in my letter about the baseline of where we are today, and the progress the ACA has made in terms of increased access to health insurance and to comprehensive health care benefits. So, while I certainly support increased flexibility, to fully answer this question I must know what the baseline is from which states will be allowed flexibility. The immediate changes I would like to see for Pennsylvania are incremental, and would require the maintenance of core aspects of how our market functions, including the federal health insurance exchange, Medicaid expansion, and subsidies for middle income Americans. So, my question to you is, will you give Pennsylvania the flexibility to keep much of what we have today? If not, you will not be giving my state flexibility; you will be taking it away.

Finally, inherent in the value of state flexibility is the ability of states to be the primary regulator of our insurance markets. This is how we ensure any changes are to the benefit of our consumers and that insurance companies are providing all of the benefits guaranteed to them by law and regulation. I continue to hear discussions of allowing the sale of insurance across state lines. Today, states already have the ability to allow insurance products approved by other states to be sold in their state or to enter into compacts with other states to facilitate cross-border sales. In fact, multiple states have passed legislation to allow for one or both of these ideas. Interestingly, no insurance companies have opted to sell products across state lines in these states, likely reflecting the geographically specific nature of health insurance because of the need for local provider networks and rates that reflect local variation in health care costs. That being said, I would support any federal effort to support or encourage states to pursue such agreements or take other actions that could incentivize increased participation in their insurance markets and therefore increase competition, particularly in rural areas that currently struggle to attract new market entrants. However, I am concerned by indications that Congress may instead pursue a model that would force states to allow insurance products approved by other states to be sold in theirs. This would fundamentally undermine the principles of state-based regulation, and prevent state insurance departments from adequately exercising our regulatory responsibilities to protect our consumers and regulate our markets. Pennsylvania's General Assembly has also decided that certain benefits, such as coverage for autism, should be covered by most plans sold in the Commonwealth. Products approved by other states may not have these same benefits, undermining the will of our legislative body. If you want to provide states

more flexibility and support state-based regulation, you will allow each state to make its own decision about which products can be sold to its consumers.

2. **What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?**

   The ACA is not perfect, and there have been flaws in its implementation that have contributed to some of the instability and significant rate increases we are seeing in many individual health insurance markets today. In Pennsylvania, this past year saw two companies exit our health insurance exchange market and I had to approve significant rate increases to ensure the continued participation of the remaining companies in our market. We worked closely with the outgoing administration to ensure this continued participation, and I believe we put our market on a path to stabilization by doing so. There are some changes that if pursued, would continue and support this pathway to stabilization, including increased enforcement of special enrollment periods to prevent adverse selection into the market, payment of the monies owed to our health insurers under the risk corridor program, and other changes that will encourage the growth and stability of enrollment, and therefore of the risk pool.

   However, I believe what will contribute most to the stabilization of state individual markets, is the stabilization of the rules governing state individual markets. Perhaps the greatest implementation error made by the outgoing administration was to continue to make significant changes to the federal rules for these markets every year. While these ongoing changes may have been well intended, they also prevented insurers from knowing the rules in advance, from investing in long-term strategies, and from fully understanding what they were getting into every year they continued to offer products. As I mentioned earlier in my letter, the change in administration has created a sense of uncertainty that has permeated the health care system, and particularly the health insurance industry. They fear the constant change will continue, if not drastically increase, and they need certainty to make informed decisions for their businesses. The best change you could make for this market is to stop the changes, and provide reassurance to the industry and to states that they can move forward understanding the rules of the market.

3. **What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?**

   In order to best answer this question, I coordinated with Pennsylvania's Secretary of Human Services, whose Department administers both the Medicaid and CHIP programs in Pennsylvania. He provided the following response:

   As a key administrative change, Pennsylvania would like to see the Centers for Medicare & Medicaid Services (CMS) reform its approach to review of state plan amendments, state waiver programs, and state contracts and rates. CMS review of these materials has become a bureaucratic process that is protracted, without official standards or criteria by which the review is based. In some cases, these reviews have resulted in revisiting previously

reviewed and approved materials and creating new standards and tests for which the states must demonstrate compliance to the current CMS reviewer. A better state-federal partnership would be grounded in objective rules, applied consistently and affording states the flexibility and control over those matters that are appropriate for state oversight. Pennsylvania also encourages aligning eligibility and verification requirements. Currently, eligibility information received from the federal hub (established under the ACA) and state electronic data sources cannot be utilized for the Supplemental Nutrition Assistance Program (SNAP), Cash Assistance, or Low-Income Home Energy Assistance Program (LIHEAP) benefits. Individuals applying for one of these benefit programs and Medicaid need to provide additional documentation that would not be required if the Pennsylvania Department of Human Services (PA DHS) could use the federal hub or other data sources. A tri-agency agreement between CMS, Food and Nutrition Services (FNS), and PA DHS would allow use of shared information which would streamline eligibility verification for all benefit programs.

Regarding regulatory or legislative changes, I offer several recommendations:
On August 2, 2016, a bipartisan group of 29 United States senators submitted a letter to the Acting CMS Administrator, Andy Slavitt, regarding the changes to the Institutions for Mental Disease (IMD) payment prohibitions made in CMS-2390F, the Managed Care Final Rule. New regulations in the Managed Care Final Rule prevent states from claiming federal match on capitation payments to managed care organizations (MCOs) for beneficiaries residing in an IMD for more than 15 days in a month. The senators expressed concern that 15 days of treatment in a month was not sufficient in light of the nationwide opioid epidemic. In the preamble to CMS-2390F, CMS acknowledged that many comments to the Managed Care Proposed Rule (CMS-2390P) called for a complete repeal of the IMD exclusion. CMS responded that the IMD exclusion is statutory and would require Congressional action for complete elimination. In light of this explanation by CMS, a complete repeal of the IMD exclusion by Congress would allow Pennsylvania to combat the opioid epidemic in a patient-centered and cost effective way. Should the regulation not be repealed in full, substance use disorder admissions should be explicitly excluded from the provision.

The enactment of the ACA provider enrollment and screening requirements has put undue administrative, regulatory, and financial burden on Pennsylvania. Requirements such as revalidating every five years, site visits, background checks, and mandatory enrollment of all ordering, referring, and prescribing providers were implemented to reduce fraud and abuse, but do not serve to improve quality of care or health outcomes of Medicaid beneficiaries. While trying to generalize these provisions and their implementation across the Medicare and Medicaid programs, failure to recognize the statutory differences among providers who participate in these programs has created additional confusion and tensions for providers and states. Repeal of these mandates would return control to the states to target integrity efforts and resources in a manner that addresses the health care issues specific to the state and the Medicaid program.

Pennsylvania has realized over $3.9 billion in total Medicaid federal rebate return on managed care covered drug claims as a result of the ACA. It is imperative to maintain the mandate of Medicaid federal rebates on outpatient covered drugs paid for by the MCOs. It is

also important to maintain the federal rebate percentages mandated by the ACA to control drug spending in Medicaid. Additionally, continued enhanced federal match for individuals newly eligible for Medicaid under the ACA would be beneficial.

From Pennsylvania's perspective, the Covered Outpatient Drug Rule (CODR) increases state and federal costs but is not correlated in any way to improving health outcomes or access to care. In contrast, other states that have been reimbursing at levels significantly greater than acquisition cost will have significant savings as a result of the CODR. This is another example of an area where returning control to states or allowing more flexibility would be beneficial for both state and federal governments.

Continuous Medicaid eligibility for children should be ensured. Currently a renewal for eligibility is completed every 12 months and states must have procedures in place to affect Medicaid benefits if reported changes between the renewals would impact eligibility. Per Section 1902(e) (12) of the Social Security Act, states can implement continuous eligibility for children under 19 years of age. Continuous eligibility would maintain annual renewals but children would remain eligible for the 12-month period in most circumstances. Pennsylvania is currently considering implementation of this option for children 0-3 years. Implementation of continuous eligibility will decrease administrative burden and associated costs, reduce churn of Medicaid eligible children, and allow for continuity of care of children for healthier outcomes.

Medicare enrollment should be required as a condition of Medicaid eligibility for Qualified Medicare Beneficiaries (QMBs). Medicare enrollment for someone who is eligible for Medicare is not a condition of eligibility for Medicaid in Pennsylvania. The state is responsible for paying 100% of the individual's medical costs when the individual could be receiving Medicare. Medicaid should be the payer of last resort. This change would be for QMBs only because there would be no increased costs for the individual as the state pays their Part B premium and Medicare deductibles/copays. This change would improve enrollment in the Medicare Savings Program, increase savings for the state, and allow for better coordination of benefits between Medicare and Medicaid.

4. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?

The ACA did little to fundamentally change the employer-sponsored insurance system, and employer-based insurance continues to provide coverage for more Americans than any other type of coverage. In recent years, premiums for employer-based coverage have been relatively stable and most Americans in these plans continue to enjoy robust benefits and services. That being said, the employer-based insurance market is feeling the impact of rapidly rising health care costs as much as other types of insurance coverage, and tackling these underlying costs is critical to the future of our health care system. I will provide some specific suggestions on how we can begin to do this in my response to the next question.

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5. What key long-term reforms would improve affordability for patients?

Insurance coverage is expensive because the underlying costs of health care are expensive. The average per capita health care spending in the United States is almost $10,000, far more than the average American can afford to pay for their care. If we want to improve the affordability of insurance products, we need to tackle the root causes and empower consumers to navigate the health care system in an efficient way. And, we need to do this without sacrificing access to critical services, especially those that can save lives and health care dollars in the long-term. Three strategies that can begin to address these critical problems are: changing the way we pay for care to incentivize value over volume, increasing transparency in our health care system to give consumers the information they need to make informed decisions about their care, and beginning to tackle the fastest growing costs in our health care system: the costs of pharmaceutical drugs.

For decades, our health care system has been based on fee-for-service payments that incentivized over-utilization of health care. As a nation, we have begun the transformative shift away from these pay-for-volume structures, to payments that encourage high quality, necessary care. While many of these investments have been made at the federal level through the Medicare program, states, insurance companies, hospitals and other health care providers have also made significant investments in payment reform efforts that are tailored to their health care ecosystems. These investments should be protected and expanded, so that we can continue on the path to creating the right incentives in our health care system and ultimately reining in health care costs.

Your letter talks about empowering individuals and I agree this is absolutely critical. Our health care system is convoluted and opaque, so much so that consumers do not have the tools they need to make informed decisions today. We must give consumers the information they need to make good health care decisions and we need to give it to them in a format that is understandable, accurate, and actionable. Taking steps to make information on cost, quality, and access more readily available and comprehensible is what will enable consumers to do this. A number of states have taken steps to provide consumers with this information, from providing quality data on hospitals and providers to collecting insurance claims information into state-based databases that can be used to provide cost and utilization information to the public. If you want to empower consumers, support states and work with them to understand how the federal government can be a partner in these efforts.

National prescription drug spending is projected to have grown by 8.1% in 2015, after rising over 12% in 2014. But that will not be the end; prescription drug prices are projected to continue to grow year over year for the foreseeable future. And, they are growing at a rate faster than any other area of health care spending. In a nation with the highest health care costs in the world, where health care spending is expected to exceed 20% of GDP within the next decade, this trend cannot continue and must be moderated. Drug costs also represent over 20% of the claims insurance companies pay on behalf of their enrollees in Pennsylvania, so driving down the cost of these drugs would have a significant impact on the cost of insurance for consumers as well as on state and federal budgets through Medicare, Medicaid, CHIP, and other health programs funded with public dollars.

6. **Does your state currently have or plan to enact authority to utilize Section 1332 Waivers for State Innovation beginning January 1, 2017?**

   While Pennsylvania does not have plans to pursue a §1332 waiver at this time, state innovation efforts have benefited immensely as a result of the ACA. Pennsylvania has received over five million dollars in grant awards from the State Innovation Models Design Initiative. This funding has provided the state the ability to engage over two hundred stakeholders in designing the Health Innovation Plan for Pennsylvania. In addition, the state has developed a multi-payer global payment initiative to transform rural hospitals to result in improved health and health care delivery in rural communities across the Commonwealth. The work has been developed in collaboration with the Center for Medicare and Medicaid Innovation (CMMI). Pennsylvania firmly supports the innovation initiatives set forth by the ACA through CMMI. State-led innovation is essential for states to improve quality and lower cost for all residents in Pennsylvania.

7. **As part of returning more choice, control and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?**

   I do not believe a high risk pool is the best mechanism for dealing with the pricing issues and the high costs of individuals with critical health care needs. That being said, I will take any necessary steps available to me to ensure that Pennsylvanians continue to have access to health insurance coverage for life-saving services. So, if a high risk pool is the only option I am given, I will do what I can to protect the consumers with significant health care needs in my state.

   Before the ACA, a number of states had high risk pools meant to provide coverage to those with catastrophic and expensive illnesses who were unable to receive coverage through an employer or purchase it on their own because of a pre-existing condition. There are reasons we moved away from high risk pools as viable mechanisms for covering those with extreme health care needs. First, high risk pools do not actually pool risk; instead, they group together individuals with similar levels of risk. By isolating high-risk individuals rather than spreading costs across the population, the per-enrollee costs in a high risk pool are astronomical and difficult to finance. Second, high risk pools can be difficult to administer and have relatively high administrative costs for the number of people they cover. So, if this is an option Congress chooses to pursue, I ask that you consider what federal funding streams will be made available to states to administer these programs and to subsidize the cost of the coverage to make it affordable for those that need it. Without federal support, high risk pools would be cost prohibitive for states.

   I would suggest consideration of a robust reinsurance mechanism rather than high risk pools. Similar to high risk pools, reinsurance is a mechanism to cover the costs of extremely high cost enrollees and therefore moderate premiums for enrollees with low or average annual health care costs. However, unlike a high risk pool, with reinsurance, high cost enrollees are included in the risk pool with the entire population and the coverage is

administered through health insurance companies, thus both supporting the private market and eliminating the need for an additional administratively burdensome state program.

While I may not believe a high risk pool is the best way to address the impact of individuals with significant health care needs on Pennsylvania's risk pool, other states may believe it makes sense for them. In the spirit of state flexibility, I would encourage you to consider providing states with funding to pursue appropriate steps to stabilize their risk pools and mitigate these high costs, but ultimately letting states determine which of the potential mechanisms would work best for their markets.

8. **What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and rate and form review requirements, should we consider while making changes?**

Pennsylvania's next legislative session runs from January 2017 to November 30, 2018. The budget year for Pennsylvania runs from July 1 through June 30 of the following year. State agencies submit budget requests in the fall to the governor, who must submit a budget proposal on the Tuesday of the first full week of February. The budget must be enacted by July 1, the beginning of the new fiscal year.

For the private insurance markets, the timeline you should be most cognizant of is the process by which health insurance plans are filed, approved, and implemented. Insurance companies are already in the process of developing their plans for the 2018 coverage year. Under the current schedule, plans will be filed by the beginning of June, reviewed through the summer, and approved in August. They will then be marketed in the open enrollment period in the fall, and coverage will begin on January 1, 2018. What this timeline means, most critically, is that if insurers do not know what the rules will be for 2018 well in advance of the June filing deadline, they will not know what to file. Far worse, they may not file at all.

There are two other timelines of which you should be aware. First, under HIPAA, if an insurer withdraws all of its plans from a market (i.e., exits the individual market), the insurer must wait five years before it can offer products in the same market again. Thus, if short-term uncertainties result in many insurers leaving individual markets, it will be five years until they can re-enter the market. Second, if an insurer plans to execute a market withdrawal such as this, they must give 180 days' notice to consumers. This means that for 2018, insurers choosing to leave the market would need to mail letters, potentially to millions of Americans, on July 1, 2017. And, their decisions would be made well in advance of that timeline.

For the Medicaid program, public notice is required with a 30-day comment period for proposed payment changes that may impact continued service access. When there is a change in the methods and standards for setting payment rates, public notice must be published at least one day before the effective date of the methodology change to ensure that providers are aware of changes in the payment methods and standards.

Pennsylvania also provides at least 30 days' written notice to beneficiaries when action is proposed or taken regarding eligibility for Medicaid. Beneficiaries are afforded 30 days from

the mailing date on the notice to appeal the action or decision. With regard to the managed care organizations (MCOs), notice must also be provided to its members and network providers at least 30 days in advance of the changes. Additionally, the Medicaid MCOs must provide the state Medicaid agency 60 days' advance notice when they modify or eliminate any expanded benefits that exceed the benefits provided for under the state Medicaid fee-for-service program. The Medicaid MCOs must also send written notices to members and affected providers at least 30 days prior to the effective date of the change in covered benefits.

PA's DHS estimates that it would take 18-24 months to implement significant regulatory or procedural changes and make the required updates to the eligibility system.

9. Has your state adopted any of the 2010 federal reforms into state law? If so, which ones? What impact would state law have on these state law changes?

Pennsylvania has adopted two of the market reforms into law: expanded rate review authority and the Mental Health Parity and Addiction Equity Act (MHPAEA).

For rate review, Pennsylvania has pre-existing authority to review and approve certain health insurance rates, including all rates for plans sold in the individual market. However, the additional authority adopted to ensure Pennsylvania would be an effective rate review state under the ACA expanded our authority to all plans sold in the small group market. The way this state law is written, if the ACA is repealed, Pennsylvania would lose this expanded authority and my Department would no longer be able to protect small businesses from being charged rates that are excessive, inadequate, or unfairly discriminatory. Rate review is perhaps the most powerful regulatory tool states have to contain health care costs and protect health insurance consumers, and small businesses deserve the same protections as individuals.

MHPAEA preceded the ACA, but the ACA expanded MHPAEA into the individual market where before it only applied to the group markets. Pennsylvania adopted MHPAEA into state law before the ACA passed. Therefore, if the ACA were repealed, MHPAEA protections in Pennsylvania would revert to apply to only the group markets along with federal law. The ACA provided an unprecedented expansion in access to mental health and substance use disorder benefits, through the expansion of MHPAEA but also through other provisions like essential health benefits and preventive health services. MHPAEA has brought equity to our health care coverage system, where for a long time patients with mental health and substance use disorders were significantly disadvantaged by our system. This equity should not be limited by how people receive their health insurance. Also, as you know, our nation is facing a public health crisis as opioid addiction has continued to grow and take lives across the country. In Pennsylvania, access to substance use disorder services has been a vital component of ensuring our residents can get the treatment they need. A repeal of the MHPAEA expansion would be a significant step backwards, one with life-threatening implications.

Finally, it should be recognized that Pennsylvania did not adopt into state law many other critical protections provided by the 2010 market reforms, protections that Pennsylvanians

would lose if the ACA were repealed. Without the ACA, insurers could once again deny coverage to individuals with pre-existing conditions and even rescind coverage for individuals with unexpectedly high health care costs. Health insurance policies could once again contain lifetime or annual limits on coverage, leaving our citizens with the most devastating illnesses without any protections when they need them most. Many consumers will no longer be able to seek an independent external review if a claim is denied, and adult dependent children may no longer be able to remain on their parents' health insurance plan until age 26. Women will once again be charged more than men for their health insurance, and Americans will no longer be guaranteed access to preventive services that are proven to save lives as well as dollars in the long run. Each of these provisions has tremendously impacted how health insurance coverage works, and consumers have gained so much by their implementation. Please think very carefully before you take any of them away from the people who need them.