Statement before the House Democratic Policy Committee

The Effects of an ACA Repeal

Presented by:

Jessica Altman, Chief of Staff

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Good morning Chairman Sturla and Members of the House Democratic Policy Committee. My name is Jessica Altman. I am Insurance Commissioner Teresa Miller's Chief of Staff. Thank you for the opportunity to be here today to speak about an issue of such significance to residents of the Commonwealth. Thank you also to Representative Frankel for hosting today's hearing.

I applaud the Committee's efforts to shed light on such an important topic. As we begin to talk about the many impacts repeal and replacement of the Affordable Care Act (ACA) would have on Pennsylvanians, we should first recognize the impact that the ACA itself has had on Pennsylvanians. And, that begins with remembering what our health care system was like prior to the ACA's enactment. Before the ACA, sick people couldn't get health insurance due to a pre-existing condition, or if they were able to pay the expensive cost for the coverage, often their pre-existing condition would not be covered under the policy. Individuals with chronic medical issues or anyone who underwent a costly procedure like a transplant could face annual and lifetime limits that left consumers in financially devastating circumstances. Women would see higher coverage costs than men and perhaps not have contraception or maternity care covered. Other critical services like mental health and substance use disorder treatment services and prescription drugs were often difficult if not impossible to find coverage for. Most importantly, more than 10 percent of Pennsylvanians went uninsured.

Since the ACA's passage, Pennsylvania's uninsured rate has dropped to 6.4 percent – the lowest it's ever been. Over 1.1 million Pennsylvanians have accessed coverage only available because of the ACA, and that coverage is much more comprehensive than before the ACA. 5.4 million Pennsylvanians cannot be denied health insurance coverage due to their pre-existing conditions, 4.5 million Pennsylvanians no longer have to worry about large bills due to annual or lifetime limits on benefits, and 6.1 million Pennsylvanians benefit from access to free preventive care services. Additionally, more than 175,000 Pennsylvanians have been able to access substance use disorder treatment services through their exchange and Medicaid expansion coverage. This is critical as our Commonwealth strives to combat the overwhelming impact of the opioid crisis.

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With all of that being said, the ACA does have room for improvement. Last year, two health insurers left Pennsylvania's exchange and our Department had to approve significant rate increases to ensure consumers in every county in Pennsylvania continued to have access to subsidized coverage through the exchange. We should be talking about how to stabilize this market, how to make sure the market works better for consumers, and how we can ensure this is a market insurers want to continue to offer products in for the long-term. But, that is not the conversation currently happening in DC.

There have been plenty of discussions about replacing the ACA with a variety of different alternatives, and earlier this month, members of the U.S. House of Representatives released the American Health Care Act (AHCA) as their first repeal and replace plan. I would like to offer the Department's thoughts on a few aspects of this proposal.

Removing Minimum Cost-Sharing Standards to Lower Premium Costs

The current proposal intends to address premium costs by removing requirements that insurance companies offer plans with certain levels of cost-sharing. Allowing plans with higher levels of cost-sharing may make coverage less expensive at face value, but it does nothing to address the true issue of rising health care costs. Instead, costs will shift from monthly premiums to out-of-pocket costs like deductibles, copays, and co-insurance that consumers face when the need to access care – something we all need to do at some point. These plans could resemble bronze plans sold today, which have annual deductibles that can reach $7,000 for an individual and $14,000 for families. In addition, it will be harder to compare the likely out-of-pocket expenses under these plans. The law also proposes expanded use of Health Savings Accounts to help with the additional upfront costs. This sounds good, but while it may be good for wealthier individuals, we worry that low and middle-income consumers will not be able to afford putting extra money into an HSA when they need to balance such spending with everyday needs like food, clothing, and shelter. Shifting costs to point-of-care, and making those costs harder to compare when shopping for coverage, will only put more burden on consumers. We are concerned that we will see a return to the pre-ACA world where more people struggle to pay medical bills or opt to go without care because they're driven away by the costs.

Tax Credits in Place of Subsidies

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Under the AHCA, subsidies that help lower monthly premiums and other out-of-pocket costs would be replaced by tax credits based on a person's age. Additional assistance that currently helps lower income Pennsylvanians pay for their out-of-pocket costs like co-pays and deductibles would go away all together. Low and middle-income Pennsylvanians will almost certainly fare worse under this plan because financial assistance will not be varied based on a person's need. When coupled with the shift to out-of-pocket costs, this could render some individuals completely unable to afford care. The GOP proposal also permits an "age tax" that would allow older Pennsylvanians to be charged up to five times what a younger person would pay. Although the tax credit will be highest for seniors, it likely will not be enough to make up for the higher premiums. According to an Insurance Department analysis, a 60 year-old Lancaster County resident earning $20,000 annually would pay $8,654 more for the cheapest silver plan under the GOP proposal *based on current premiums*, up from $816 to $9,380. That is, the AHCA would have this 60-year old paying half of their income on health insurance premiums alone, not even counting out-of-pocket expenses, or the increased premiums due to the "age tax". Individuals in rural areas like Pennsylvania's "T" (lower central Pennsylvania and the northern tier) would also be harder hit by this tax credit proposal since health care costs tend to be higher in rural communities and the AHCA's tax credits would be a fixed amount rather than a percent of premium. For example, a 45 year-old making $30,000 in Columbia County would pay roughly $4,000 under the GOP proposal *based on current premiums*, whereas the same person in Pittsburgh would pay only about $644.

Coverage for Individuals with Significant Health Needs

This proposal also raises concern for individuals with significant health needs. The ACA's "three-legged stool" – the individual mandate, non-discrimination requirements for people with pre-existing conditions, and subsidies and cost-sharing reductions – was designed to help insurers balance the added risk of individuals with pre-existing conditions while avoiding the risk of adverse selection where people only enter the market when they are sick and need care. Under the current proposal, the individual mandate will be replaced by a continuous coverage requirement, which may prompt typically healthy people to delay entering the market until they have a particular need for coverage. And, people that go without insurance for a period of time will face a penalty in the form of a higher premium when they choose to get coverage, which may deter healthy people from getting insurance even when they decide they should. This

means that the people who seek coverage during the open enrollment period will likely be a less healthy population, thus driving up premiums for those who need coverage the most.

Market Stability

The biggest issues the ACA currently faces center around market stability. Between changing market rules from the previous administration, lawsuits over payment of the cost-sharing reductions, relaxed enforcement of Special Enrollment Periods, and outstanding risk corridor payments, there have been decisions made in Washington, both by the Obama administration and by Congress, that have undermined the stability of the individual market. We should be talking about how to address these issues so that the market can work as it was always intended to. Instead, rather than tackling these issues, the AHCA could create even more instability. By getting rid of the individual and employer mandates and replacing it with a surcharge for those who try to get insurance after a period without continuous coverage, there is less incentive for young, healthy people to enter the market. Without low-cost policyholders to balance against the policyholders who require more health care, premiums will only rise for those who remain in the market. Additionally, as currently drafted, there is a gap between when the mandates sunset and when the continuous coverage requirements take effect. It is hard to say what might happen to the market during this period, but we worry that the impact on the risk pool would be significant.

Selling Insurance Across State Lines

While the AHCA does not address cross-state sales, this continues to be a policy proposal on the table in Washington and I would be remiss to not mention the potential negative impacts and risks of such a proposal. There is no question that competition is good, and we need to look for ways to bring more competition to health insurance markets across the country, particularly in rural areas. But, allowing sales across state lines is just not the way to get there.

Allowing states to participate in cross-border sales is already explicitly allowed under the ACA if states pass laws allowing plans approved by other states to be sold in their state without additional regulation. Three states have passed laws to allow for this, and a handful of other states have passed legislation to authorize their state to enter into a compact with neighboring

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states that would facilitate cross-border sales. Interestingly, no insurer has chosen to sell products approved by another state in the states that allow them to and no states have actually entered into the interstate compacts allowed by the ACA.

There are two reasons for this: first, health insurance is inherently local. Health plans today are built around local provider networks, which can take time to build. In building those networks, insurers require market power to negotiate favorable discounts for reimbursement that can result in competitive premiums. Generally, we hear from health insurers that the reason health plans don't often enter new markets is not regulation: it is network construction. Without this local network, plans from other states wouldn't make sense for our consumers because Pennsylvanians don't see doctors in Georgia or Oregon or Hawaii: they see doctors in their own communities. Second, health insurance rates are also geographically specific and reflect how underlying costs vary by region. So, the actuarially accurate price of a plan sold to consumers in Georgia or Oregon or Hawaii wouldn't make sense for a consumer accessing care in Pennsylvania, because the cost of receiving that care can vary greatly.

States also, for very good reasons, have different rules for the plans sold to their residents. For example, Pennsylvania's General Assembly has decided that certain benefits should be guaranteed for many consumers in our Commonwealth, such as mental health and substance use disorder treatment and services for children with autism. If we allow products approved by other states to be sold in Pennsylvania, they may not have these same benefits. Insurers could choose to file plans and sell out of a state with more flexible regulations than those mandated by the General Assembly, and Pennsylvania's consumers could lose access to benefits you have decided they deserve. This undermines our Commonwealth's legislative authority.

Finally, consumer protection is the number one priority of our department and what we strive to provide to consumers each and every day. Consumer protection goes hand in hand with state-based regulation. We protect our consumers through our regulatory authority in licensing and monitoring the solvency of insurance companies and in approving products and the rates at which they will be sold. If a Pennsylvanian has a health plan approved by Georgia or Oregon or Hawaii or any other state, and that health plan isn't doing what they should, Commissioner Miller and the department would have limited ability to intervene or take action against the

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company. So, would we rely on another state to provide that service to our consumers, to your constituents? Because of this dynamic, we fear cross-state sales could result in a "race to the bottom," where plans will be approved by the states with the least stringent and most loosely enforced regulation, and consumers would bear the consequences.

Conclusion

The ACA isn't perfect. Instead of targeting what plans cover or granting tax credits instead of need-based subsidies, we need to talk about common sense changes that can stabilize markets and focus on what consumers want and need, like lower deductibles and protections from surprise health care bills. The CBO score that came out a few weeks ago demonstrates how the AHCA would not achieve these goals, but would instead be a significant step backwards.14 million and eventually 24 million more Americans would be uninsured compared to today. Premiums would initially go up, not down, and eventually only be 10% cheaper than under the ACA, while plans would get significantly less generous in their benefit structures. And, the Center on Budget and Policy Priorities estimates that the AHCA would shift $370 billion back on to state budgets.

Our hope is that Washington keeps the needs of consumers at the forefront of their minds as they continue to deliberate. This is about Americans accessing and affording care that is vital to their health and well-being. We cannot return to a place where people are forced to make a choice between their finances or their health. Again, thank you for allowing me to speak with you today. I would be happy to take any questions that you might have.