Testimony before the U.S. Senate Democratic Policy and Communication Committee

America Speaks Out: The High Costs of Trumpcare for Families

Presented by:

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Good morning Chairwoman Stabenow and members of the Senate Democratic Policy Committee. Thank you for the opportunity to be here today to speak about an issue of such significance to residents of the Commonwealth of Pennsylvania.

I applaud the committee's efforts to shed light on such an important topic. As we begin to talk about the many impacts repealing the Affordable Care Act (ACA) and replacing it with the American Health Care Act (AHCA) would have in Pennsylvania, we should first recognize the impact that the ACA itself has had on Pennsylvanians. Before the ACA, sick people often couldn't get health insurance due to a pre-existing condition. If they were able to get coverage, they often paid significantly more for it than someone without a pre-existing condition. In some cases, these individuals would be offered a policy, but it would not include coverage for their pre-existing condition. Individuals with chronic medical issues or anyone who underwent a costly procedure like a transplant could face annual and lifetime limits that were often financially devastating. 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 and 16 percent of Americans nationwide went uninsured.

Since the ACA's passage, the national uninsured rate has fallen to 8.6 percent and Pennsylvania's uninsured rate has dropped to 6.4 percent – the lowest it's ever been. More than 1.1 million Pennsylvanians have accessed coverage only available because of the ACA, and that coverage is much more comprehensive than what was previously available. There are 12.7 million Pennsylvanians, and more than 40% of them - 5.4 million – with pre-existing conditions cannot be denied health insurance coverage due to the ACA. 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. More than 175,000 Pennsylvanians have also been able to access substance use disorder treatment services through their exchange and Medicaid expansion coverage. This is critical as our commonwealth and other states around the country strive to combat the overwhelming impact of the opioid crisis.

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The narrative I continue to hear from Republicans in Washington is that the ACA is imploding and that unless Congress takes action, it will in fact implode. While the ACA has not been perfect, it is critical that we level set and talk about the issues that exist and who those issues are really impacting. The ACA has had minimal impact to the Medicare program and enhanced the already very popular Medicaid program by expanding access to millions more around the country. Further, since the passage of the ACA, the employer markets where small and large businesses can purchase insurance products for their employees have been stable and even seen costs grow at a slower pace than before the ACA. The individual market, where we are seeing problems, is a very small market relative to these others, covering only about 5 percent of Pennsylvanians. It is also a very important market, because it is where individuals and families who do not have access to coverage through their employer or public programs go to purchase insurance. But, this is also the market that is heavily subsidized through the ACA. About 80 percent of Pennsylvanians who receive their coverage through the exchange receive tax credits to help pay their premiums. In fact, the Department of Health and Human Services estimated that 3 in 4 returning marketplace consumers could find a plan for less than $100 per month in 2017. And, because of the way the tax credits are structured based on income, these consumers do not feel the full impact of premium increases. Further, more than half of consumers who enroll in the exchanges are eligible for cost-sharing reductions, additional financial assistance that helps them pay for their out-of-pocket costs like deductibles and co-pays. However, the people who this market may not be serving well are those that are not eligible for financial assistance, which is about 1-2 percent of Pennsylvanians.

While the individual market is facing issues, in some states more than in others, in Pennsylvania I can tell you that our market will not implode unless the federal government takes adverse action, like refusing payment for cost-sharing reductions, that would cause it to implode. Last month, I co-signed a letter to Secretary Price with executives representing each of the five health insurance companies remaining on Pennsylvania's exchange asking the administration to not take steps to undermine the progress we have made and the pathway to stability that we have put our market on.

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Because we are on that path, I believe we need to build upon the foundation of the health care system we have and make targeted, common sense changes that will make it work better for the people it is not working for today. Starting over, or even moving backwards as I believe the AHCA will do, will not better serve Pennsylvanians, nor do I believe it will better serve Americans throughout the nation. With that context, I would like to offer my department's thoughts on a few specific aspects of this bill.

Coverage for Individuals with Significant Health Needs

The American Health Care Act raises serious concerns 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 bill that passed the House last week, the individual mandate would 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. People that go without insurance for a period of time will face a temporary penalty in the form of a higher first-year 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.

The AHCA also gives states the option to return to a pre-ACA world where insurers are able to discriminate against people with pre-existing conditions by charging them more for coverage. States would also be able to opt out of the ACA's Essential Health Benefits requirement, meaning consumers could be paying more for less robust coverage. I do not support allowing insurers in Pennsylvania to rate based on health status, but I also don't think that should be a luxury based on where consumers happen to reside. Americans in every state deserve that fundamental protection. States that receive these waivers would be required to establish high-risk pools to provide coverage for sick people, but historically, high-risk pools have not proved to be an effective way to cover high-cost individuals.

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Pennsylvania did not have a high-risk pool before the Affordable Care Act, but we established a temporary high-risk pool, PA Fair Care, through the Affordable Care Act's Pre-Existing Condition Insurance Plan (PCIP). This was designed to help states provide health insurance to individuals with pre-existing conditions who had spent at least six months without health insurance until full ACA protections took effect in 2014. Enrollees in this program proved more costly than federal funds could support, and enrollment was capped at 6,900. PA Fair Care's enrollees were transitioned to the federal PCIP in July 2013 after the state program ended. As I mentioned earlier, 5.4 million non-elderly adult Pennsylvanians currently have pre-existing conditions. If $160 million in federal funds was not enough to cover just under 7,000 individuals, how much federal funding will Pennsylvania need to provide adequate coverage for the portion of these 5.4 million people who may find themselves purchasing coverage in the individual market at some point in the future? The AHCA provides $8 billion over five years for states that choose to establish high-risk pools. Depending how many states take that step, that amount could prove inadequate very quickly.

The AHCA also includes $100 billion over 9 years to allow state flexibility that could be productive if used to fund a reinsurance program or additional subsidies for low- and middle-income families, but this funding is not without stipulations. Over time, states must put forth a growing percentage of this money, and funding will sunset completely after 2026. This shifts a huge burden on to states to find the money to continue supporting individuals and families that could benefit, and may limit the breadth of programs states establish using the Patient and State Stability Fund. This is on top of the additional burden that will be placed on state budgets through the AHCA's changes to federal funding for the Medicaid program.

Last week, the House passed a version of the American Health Care Act that was even more dangerous than previous versions, and all without seeing an updated score from the Congressional Budget Office. I am disappointed that the House took action on this legislation that could negatively impact millions of people in Pennsylvania and around the nation without even waiting for an estimation of its impact.

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Removing Minimum Cost-Sharing Standards to Lower Premium Costs

The bill passed in the House also 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 they need to access care – something we all need 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. These are dollars that must be spent before a consumer begins to see a real return on their premium. In addition, it will be harder to compare the likely out-of-pocket expenses under these plans. The bill 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

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 House 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

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silver plan under the House 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 House GOP bill *based on current premiums*, whereas the same person in Pittsburgh would pay only about $644.

Market Stability

The biggest issue the ACA currently faces centers around market stability. Between the constantly changing market rules, 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 intended to. Instead, rather than tackling these issues, the AHCA could create even more instability. By getting rid of the individual mandate 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. What our market needs right now is to continue on the pathway to stability and certainty, where the AHCA would only lead to further instability.

Conclusion

The ACA isn't perfect. But, instead of targeting what plans cover or granting age-based tax credits in place 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, and lowering the cost of health care. The AHCA's initial CBO score demonstrated how it would not achieve these goals, but would instead be a significant step backwards. 14 million and eventually 24 million more Americans would be

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uninsured compared to today. Premiums would initially go up, not down, and eventually only be 10 percent cheaper than under the ACA, while plans would be 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. I am extremely disappointed that the House brought this to a vote without an updated score based on amendments made by Representatives MacArthur and Upton. If the initial CBO score for the bill was bad enough to dissuade potential Yes votes, more caution should have been taken given the significant edits.

Our hope is that Washington keeps the needs of consumers at the forefront of their minds as deliberations continue, and that the Senate will take a more thorough and deliberative approach than the House did in evaluating significant changes to our health care system and the potentially devastating impact of those changes on the people that rely on it every day. 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 accept less coverage at an increased cost, and make tough choices 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.