Testimony before the U.S. House Democratic Steering and Policy Committee

ACA Marketplace Stabilization—Urgent Action Needed

Presented by:

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Good morning Leader Pelosi and members of the House Democratic Steering and 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 and to stress the urgency of the need for certainty and stability as we strive to make our health care system and our health insurance markets work for all who need them. I know there have been proposals circulating in Congress that would repeal or repeal and replace the Affordable Care Act (ACA), but those proposals may have stagnated due to significant and justified concerns about their impact on consumers and their ability to access and afford care. I also know that the goal of this hearing is to talk about what we do next, and it is a privilege to be here today to offer my thoughts and ideas as we strive to move our markets to stability. While these Congressional proposals may not be moving forward, that does not mean there are not things that need to be done, things that I believe can be done in a thoughtful and bi-partisan way.

Before talking about how we move forward in greater detail, I first want to talk about how far we have come under the ACA and what we need to make sure to protect as we deliberate on the next steps for our health care system. 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 such as 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 has ever been. More

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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.

The narrative I continue to hear from Republicans in Washington is that the ACA is failing. 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 has 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 see problems, is a very small market relative to these others, covering only about 5 percent of Pennsylvanians. However, it is 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.

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 (HHS) 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 lower-income 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 to low-income consumers 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

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those who are not eligible for financial assistance, which is about 1-2 percent of Pennsylvanians.

I believe we need to build upon the foundation of the health care system we have and make targeted, common sense changes that will improve the ACA and make it work better for the people it is not working perfectly for today. Starting over, or even moving backwards as I believe the proposals we've seen from the House and Senate will do, will not better serve Pennsylvanians or Americans throughout the nation. With that context, I would like to offer my department's thoughts on the issues we currently face, how proposals considered by Congressional Republicans will impact these problems, and what a reasonable bipartisan solution that would improve the ACA for all could look like.

Guaranteeing Payments for Cost-Sharing Reductions

While the individual market has had its issues, in some states more than in others, in many places across the country these markets are stabilizing. I can tell you that in Pennsylvania, our market is on a path to stability and will not implode unless the federal government takes adverse action. While our market saw some issues last year and lost two carriers, I worked closely with our remaining insurers to ensure that we did not have any bare counties for 2017. For 2018, our individual market insurers are seeking a statewide average increase of just 8.8 percent, assuming no changes come from the federal level. An analysis of the drivers of 2018 premium increases puts our requests at or below what we would expect based on trends in annual medical costs and a federal tax on health insurance plans that comes into effect for the 2018 plan year. I am very happy that our insurers are seeing a better experience with this market and that is reflected in our rates, but I am very concerned that the stability is on fragile ground because of all the uncertainty here in Washington.

When filing rates, I also asked our insurers to provide information on what they would need to request if cost-sharing reductions payments were not made or if the individual mandate was not enforced. The differences are stark. If cost-sharing reductions are not paid, they would need to request a statewide average increase of 20.3 percent. If the individual mandate is not enforced, they say they would seek a 23.3 percent increase. If both changes occur, our insurers estimate

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that they would seek an increase of 36.3 percent, assuming they continue to participate in the market at all.

I'd be lying if I said these numbers didn't scare me, especially as we move closer to when we need to finalize rates. In April, I co-signed a letter to Secretary Tom 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. I reiterated this urgent need for stability in an answer to a request for information on how to stabilize the individual market issued by the Centers for Medicare and Medicaid Services in June. Yet here we are, roughly a month out from when states need to send final rates for 2018 to HHS, and the Trump Administration still refuses to make anything longer than a month-to-month commitment on these payments.

I cannot stress enough how difficult this uncertainty is on our insurers. These payments have a significant impact on insurer's rates, and failing to make a long-term commitment will do nothing but drive up prices for consumers in the market. This will especially hurt the 1 to 2 percent who do not receive subsidies – if their company stayed in the market at all - as those who do receive subsidies would be shielded from most of the increases. The closer we get to rates being due, the more critical this need for certainty becomes. At the end of the day, rates have to be made based on finite assumptions and insurers will sign contracts to participate on the exchange, or they won't. If you asked me what the single, most important step the federal government could take to stabilize the market is, the answer is easy: commit to making CSR payments on an ongoing basis and commit to it now. I fear what the impact will be otherwise.

Preserving the Individual Mandate

Proposals put forth over the past few months from Congress would also do little to nothing to address the current instability we see in the market, and they would all result in increased instability to some extent. Both the American Health Care Act (AHCA) and the Better Care Reconciliation Act (BCRA) would end the individual mandate, which would do nothing but exacerbate the stability issues we currently face.

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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 AHCA, 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 specific need for coverage. People who 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. This problem would only be made worse under the Senate's BCRA, which completely repeals the individual and employer mandates but does not offer a continuous coverage requirement. And, the Cruz-Lee amendment added to BCRA would provide even less incentive for healthy individuals to join the risk pool by providing an alternative market of plans not subject to the ACA's protections.

Rather than repealing the individual mandate or failing to enforce it, we need to strengthen it. I know that the individual mandate is not popular, but it is also necessary to provide adequate incentive to bring everyone into the market and ensure universal coverage. I have long worried that the penalty was not strong enough to encourage individuals to regularly pay for coverage rather than paying the penalty. In order for the individual mandate to truly balance the risk pool as it was intended, it needs to be strengthened to encourage more people to opt for coverage. Over time, this could help stabilize and even lower premiums as more young and healthy people enter the market and balance the risk pool with those who purchase coverage because they know they will need it.

I also worry about some steps the Trump administration has taken that could further erode the risk pool: shortening the open enrollment period and ending CMS's contracts to support outreach and enrollment efforts for the Marketplace. I worry that both of these decisions will

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result in fewer people enrolling and relatively fewer healthy people enrolling, exacerbating the issues that already exist in the risk pool.

If we want a robust individual market and prices to come down as both sides say they do, we need to focus on encouraging enrollment through proactive outreach and a stronger mandate that will mitigate adverse selection in the market. Anything else will only result in further instability that could sabotage the market completely.

Adequately Funding Reinsurance Programs

When the ACA was passed, it contained three premium stabilization programs to help insurers experiencing higher than anticipated claims as they adjusted to the new market. Two of these programs – risk corridors and reinsurance – were designed to be temporary and have expired, but many insurers around the country, including those in Pennsylvania, are still owed significant risk corridor payments. Last year, Highmark sued the HHS for these payments, and my department filed an amicus brief in support of their suit.

Although the program has expired, it is still extremely important that insurers be made whole for the payments they were anticipating. Many of these insurers experienced significant losses in the first few years, and making these payments would be a good way to demonstrate good faith and a long-term commitment to this market.

Of the three premium stabilization programs, the one that was an unquestionable success was the reinsurance program. While this program has now been phased out as the ACA intended, when it was in effect, the ACA's reinsurance program successfully mitigated the impact of extremely high cost patients and claims and measurably moderated premiums. In the first year of the program, premiums were estimated to be10-14% lower than they would have been otherwise. Because of this success and the need for stability, a number of states have now begun to leverage the ACA's state innovation waiver program to implement state-based reinsurance mechanisms, and even the republican proposals circulated in Congress recognized the value and beneficial impact a reinsurance mechanism could have. Both the AHCA and BCRA include funding for a reinsurance program.

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A robust reinsurance program in the context of a careful, bipartisan approach to improving our health care system would be something I would view favorably, especially if the individual mandate were strengthened and outreach was boosted to improve enrollment in individual market plans. These could be an effective way to scale back the premiums we currently see. Increasing participation in the individual market would create a more stable, healthy risk pool, while the reinsurance program would help off-set enrollees with abnormally high claims costs. Together, these steps would moderate premiums for all while retaining the critical protections and robust benefits required by the ACA.

Addressing Underlying Costs of Health Care

Balancing the individual market is an important first step to addressing cost concerns we hear from consumers, but we still need to get to the root of what really drives insurance costs: the cost of health care. To put it simply, insurance is expensive because the health care it pays for is expensive. And, unfortunately, it gets more and more expensive every year, which means premiums will continue to rise every year even if there are no detrimental changes to the market.

The AHCA and BCRA purport to save consumers money by lowering premiums, but they are really only shifting the costs from the monthly premium 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. Plans under these proposals 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. The republican proposals also point to expanding use of health savings accounts as a way to help with the additional upfront costs. This sounds good, but while it may be good for wealthier individuals, I worry that low and middle-income consumers will not be able to afford putting extra money into a health savings account 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. I am 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. These proposals do nothing to address the underlying cost of care; they simply shift the cost of health care from insurers to consumers.

We need to have a serious national conversation about how we can moderate the unsustainable growth in health care costs, especially in areas experiencing astronomical growth in cost like we are seeing with pharmaceutical costs right now. There is no silver bullet to these questions and the conversations are not easy, but they are unquestionably necessary as we look to the future and the long-term viability of our health care system. We continue to look for solutions to these problems at the state level, but these are national problems that I believe merit national solutions. So, I am hoping all of you and your colleagues in Congress want to work alongside the states in tackling this complex and multifaceted issue.

The Need for Bi-Partisanship

While the health reform debate has without question been partisan, the goals we are trying to achieve are not, and neither should recognition of the real problems that exist in our health care system. My hope is that if conversations about repealing or replacing the ACA stagnate, we can begin talking about health care differently as a nation. We all want Americans to have access to the care they need and be able to afford that care. We also want them to have choices, and that means supporting a competitive health insurance marketplace that can provide those choices. Let's start by recognizing where consumers may not have that access or affordability, and let's understand where we are not supporting the competitive market we need. Then, let's look for solutions that can solve those problems, both in the short-term and in the long-term.

As my testimony outlines, I believe some of those strategies in the short-term are to provide clarity and stability of the rules in the market by continuing the payment of cost-sharing reductions and ensuring robust enforcement, if not enhancement, of the individual mandate to get more healthy people into the market and improve the risk pool. A reinsurance program would also contribute to stability and the moderation of premiums. In the long-term, it is imperative that we begin to look for ways to moderate the growth of health care costs to ensure our health care system is sustainable and will meet the needs of those that need it now as well

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as those that will need to rely on it in the future. I am hopeful that we can move away from drastic proposals that would jeopardize the health and financial security of millions of Americans, and focus on solving real problems with common sense solutions like these.

Again, thank you for allowing me to speak with you today. I would be happy to take any questions that you might have.