



Testimony before the United States Senate Committee on Health,
Education, Labor, and Pensions

**Stabilizing Premiums and Helping Individuals in the
Individual Insurance Market for 2018: State Insurance
Commissioners**

Presented by:

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Good morning Chairman Alexander, Ranking Member Murray, and members of the U.S. Senate Committee on Health, Education, Labor, and Pensions. Thank you for the opportunity to be here today to speak about an issue that is so critical for residents of the Commonwealth of Pennsylvania.

I am pleased to have been recently chosen by Governor Wolf to serve as acting secretary for the Pennsylvania Department of Human Services after having been Insurance Commissioner since shortly after Gov. Wolf took office in 2015.

Gov. Wolf has been an active participant in a group of governors working to ensure Congress's approach to health care reform is completed in a bi-partisan manner that strengthens our nation's health insurance system. Additionally, the governors urge Congress to take steps to make coverage more affordable and stable in the interim.

Both Gov. Wolf and I applaud the committee's efforts to work towards a solution on this important issue. As we begin to talk about the importance of stabilizing our individual health insurance markets under the Affordable Care Act (ACA), we should first recognize the impact that the ACA itself has had on Pennsylvanians and why it is imperative that we fix the law rather than undoing the progress we have made. 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 financially devastating annual and lifetime limits. Women could see higher monthly premiums 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 through the ACA, and that coverage is much more comprehensive than what was previously available. There are 12.7 million Pennsylvanians, and more than 40 percent of them – 5.4 million – have pre-existing conditions and cannot be denied health insurance coverage due to the ACA. Today, 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. In addition to this, more than 175,000 Pennsylvanians have also been able to access substance use disorder treatment services through their exchange and Medicaid expansion coverage. These services are critical as our commonwealth and other states around the country strive to combat the overwhelming impact of the opioid epidemic.

The positive impact of the governor's efforts to expand Medicaid and help Pennsylvanians access treatment services for substance use disorder have become even more evident to me as I've taken the helm at the Department of Human Services. These are expansions that are making a significant difference in people's lives.

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 really impact. The ACA has had minimal impact on 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 see problems, is a very small market relative to these others, covering only about 5 percent of Pennsylvanians. However, this market is very important 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 market is heavily subsidized because of the ACA. About 80 percent of Pennsylvanians who purchase their coverage through the exchange receive tax credits to help pay their premiums. Because of the way the tax credits are structured based on income, these consumers do not feel the full impact of premium increases. Currently more than half of Pennsylvania consumers who enroll in the exchanges are also eligible for cost-sharing reductions, additional financial



assistance that helps them pay for their out-of-pocket costs like deductibles and co-pays. The payments the federal government makes to insurers to cover the costs of this additional financial assistance are in jeopardy because President Trump has not committed to making them longer than a month-to-month basis. I am seriously concerned about the destabilizing effect failing to commit to these payments could have on both Pennsylvania's market and others around the country and how this will impact premiums for people in the individual market, but I will address this at length later in this testimony.

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. We still have a serious affordability problem in the individual market, especially for the 1-2 percent of Pennsylvanians who rely on the individual market for coverage but are not eligible for financial assistance and those facing rising deductibles. Their concerns are legitimate and must be addressed, but starting over or moving backwards will not better serve Pennsylvanians or Americans throughout the nation. I applaud this committee's efforts to work together to strengthen this law so it may better serve everyone rather than undoing the good it has accomplished around the country. With that context, I would like to offer Pennsylvania's thoughts on the issues we currently face and what reasonable bipartisan solutions that would improve the ACA for all could look like.

Guaranteeing Payments for Cost-Sharing Reductions

While the individual market is facing issues, in some states more than in others, I can tell you that Pennsylvania's market is on a path to stability and will not implode unless the federal government takes adverse action. Our market saw some issues last year and lost two carriers, but 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 filed for a statewide average increase of just 8.8 percent, assuming no changes come from the federal level. An analysis on 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 finally seeing improved experience with this market and that is reflected in the rate increases they filed, but I am very



concerned that this stability is on fragile ground because of all the uncertainty here in Washington.

When rates were initially filed, I asked our insurers to provide information on what they would need to request if cost-sharing reduction payments were not made or if the individual mandate was not enforced. The differences are stark. If cost-sharing reductions are not paid, they estimated that they would need to request a statewide average increase of 20.3 percent. If the individual mandate is not enforced, they said they would seek an estimated 23.3 percent increase. If both changes occur, our insurers estimated that they would seek an estimated 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 worry me, especially as we prepare to finalize rates. At this point, we have no more certainty on cost-sharing reductions than we had in April when I, along with executives from all five of Pennsylvania's on-exchange insurers, first wrote to Secretary Tom Price on this issue.

What's most frustrating about the situation we are in is that it is entirely avoidable. I have sent multiple letters to Secretary Price asking the administration to not take steps to undermine the progress we have made and the pathway to stability that we 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. Governor Wolf and a bi-partisan group of governors have asked Congressional leaders to address stability, too. And, yet here we are, two weeks out from when states need to send final rates for 2018 to the Department of Health and Human Services (HHS) – a deadline that was already extended – 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 their rates, and failing to make a long-term commitment will do nothing but drive up prices for consumers in the individual market. This will further hurt the 1 to 2 percent of Pennsylvanians – roughly 125,000 people – who do not receive subsidies as those who do receive subsidies would be shielded from most of the increases – if their insurer stayed in the market at all. At the end of the day, rates have to be finalized based on finite assumptions and



insurers will sign contracts to participate on the exchange or they won't participate at all. Pennsylvania consumers will be left to bear the burden of premium increases or lessened choices necessitated by this instability.

Failing to make payments for cost-sharing reductions does not serve any goal aside from trying to make markets fail. According to the Congressional Budget Office's analysis on the matter, doing so would result in higher premiums, more counties without individual market coverage options for 2018, and would increase the federal deficit by \$194 billion through 2026 due to the payment of additional premium subsidies because of higher premiums. The Congressional Budget Office further estimates that premiums would rise an additional 20 percent in 2018. This will undoubtedly create more problems, especially for individual market consumers who are not eligible for financial assistance.

If the Trump Administration is not going to do the right thing for consumers and stabilize the law, Congress should allocate funds to ensure payments for cost-sharing reductions continue for 2018. Making these payments is the simplest way to "fix" the ACA that I can offer. I fear that it will very soon be too late to avoid rate increases for 2018, so Congress must act quickly.

Supporting Opportunities for State Innovation

Under Section 1332 of ACA, states have the opportunity to obtain waivers on portions of the law as long as they do not increase the federal deficit, reduce affordability or quality of coverage sold in the state, or have a negative quantitative impact on the state's insured population. States currently must offer a public notice and comment period, hold public hearings, and pass legislation outlining the state's intent to pursue and implement a Section 1332 waiver. Governor Wolf and I join the sentiments outlined in the bipartisan plan presented by Governors Hickenlooper and Kasich to streamline the waiver process in order to improve state flexibility.

Changes that permit states to easily build upon waivers obtained and successfully implemented by other states, coordinating the waiver submission and approval process, and easing the process of applying for waiver extensions would be viewed favorably. We would value the ability to pursue a waiver without requiring action from our state's legislature. If states are making small, targeted changes to stabilize the market like what is needed now, the current process can



be too long and cumbersome when you consider a state's budget cycle and legislative process. An extensive process should be in place if states were to make significant changes to the structure of their market, but streamlining the current process would allow states to use Section 1332 waivers to make incremental changes as issues arise. The Wolf Administration would also look favorably on the opportunity to combine multiple waivers into a coordinated effort and consider deficit neutrality across the comprehensive plan.

However, we strongly believe that the baseline coverage improvements that must be maintained during the waiver process must be preserved. Eliminating these provisions – often called “guardrails” would likely result in a race to the bottom. Insurance companies would sell plans that offer less comprehensive coverage at a lower monthly cost, leaving consumers vulnerable to large out-of-pocket costs when care is accessed – something we all do at some point. These protections exist to ensure that Americans around the country have access to equitable, quality coverage regardless of the state in which they reside. The baseline protections contained in the ACA and the coverage improvements that have resulted should not be jeopardized as we consider opportunities for greater state flexibility.

Preserving the Individual Mandate

Since the ACA was passed, the individual mandate has historically been an unpopular feature of the law. However, it is imperative to making sure the law functions as it was intended.

The ACA included a “three-legged stool” – the individual mandate, non-discrimination requirements for people with pre-existing conditions, and subsidies and cost-sharing reductions – that helps 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. Proposals to replace the ACA have eliminated the mandate in exchange for a continuous coverage requirement. Because purchasing insurance would no longer be mandatory under a continuous coverage requirement, the people who seek coverage during the open enrollment period will likely be a less healthy population and the risk pool would deteriorate, thus driving up premiums for those who need coverage the most.



I know that the individual mandate is not popular, but we must have adequate incentives to encourage people to purchase coverage and bring healthy people into the market. Over time, this should help stabilize and even lower premiums for everyone as more young and healthy people enter the market and help offset the cost of sicker enrollees.

Adequate Funding for Risk Stabilization 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, one of the Pennsylvania insurers, sued HHS for these payments, and the Pennsylvania Insurance Department filed an amicus brief in support of their suit because insurance companies who entered this market under a set of expectations should be made whole for 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 for the federal government to demonstrate good faith and a long-term commitment to the success of this market.

Both ACA replacement proposals considered by the U.S. House and Senate contained reinsurance programs for 2018. Implementing a reinsurance program would be another effective way to demonstrate a long-term commitment to the health of this market for insurers and consumers who rely on this market for coverage.

A \$15 billion 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 preserved and outreach was boosted to improve enrollment in individual market plans. The ACA's reinsurance program successfully moderated premiums while it was in place and the reintroduction of a long-term reinsurance program 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 the costs of 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.



Continuing Enrollment Outreach Programs

Encouraging people to enroll in this market through active outreach programs is extremely important to ensuring the market's success. The health of any insurance market depends on the strength of its risk pool, and reduced enrollment strains the risk pool and contributes to rising costs for those in it. I worry about some steps the Trump Administration has taken that could further erode the risk pool, such as shortening the open enrollment period and ending HHS's contracts to support outreach and enrollment efforts for the marketplace. In total, the Trump Administration intends to spend \$10 million nationwide on advertising for 2018 open enrollment compared to \$100 million spent last year. The administration also recently announced that funding granted to health insurance navigator organizations to help people enroll was almost halved from levels given under the previous administration. I worry that these decisions will result in fewer people enrolling and relatively fewer healthy people enrolling, exacerbating the issues that already exist in the risk pool.

Pennsylvanians are accustomed to having three months to enroll in coverage. In the past, December 15 has been an important deadline because it was previously the last day to enroll in coverage that was effective January 1, but enrollment still continued for the remaining six weeks of open enrollment. During 2017 open enrollment, more than 130,000 Pennsylvanians enrolled in coverage after the initial December 15 deadline. That is roughly one third of our market. I am extremely concerned that a shortened open enrollment period coupled with low outreach from the federal government will catch consumers off guard and result in people who want or need coverage being left out of the market because they missed the enrollment window.

In Pennsylvania, we are working to ensure that our marketplace population and potential enrollees understand this change through our own insurance outreach program. We are working alongside insurers, health care providers, consumer advocates, and other stakeholders to reach our common goal of increasing covered Pennsylvanians and informing them of important changes to this year's open enrollment period. Encouraging enrollment helps everyone – people have access to coverage, insurers have a more robust risk pool, and providers are more likely to receive compensation for care provided. Overtime, a more robust risk pool should result in lower premiums for consumers. I hope the Trump Administration ultimately sees the value in



this outreach too, but for now Pennsylvania will work to fill the gap created by the Administration.

Addressing Underlying Costs of Health Care

Stabilizing 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. 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.

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 currently see with pharmaceutical costs. There is no silver bullet to reduce the cost of health care and the conversation is not easy, but it is essential 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 will 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 recognizing the real problems that exist in our health care system should not be either. I am very thankful that we are finally moving in the direction of working together, and I am optimistic that the ideas shared today will be a strong foundation moving forward. 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 that choice. 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, taking a lead from Governor Wolf and the group of bipartisan governors, 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 short-term strategies must be to provide clarity and stability of the rules in the market by appropriating funds to ensure payment of cost-sharing reductions and robustly enforcing the individual mandate while enhancing outreach and enrollment efforts to get more healthy people into the market and improve the risk pool. A reinsurance program could also contribute to stability and the moderation of premiums and show insurers that the government wants to work with them for the benefit of consumers – your constituents – to make this market an attractive place to do business. 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 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.