pennsylvania
INSURANCE DEPARTMENT

January 13, 2017

Senator Lamar Alexander
Chairman, Senate Committee on Health, Education, Labor and Pensions
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Alexander,

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 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

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

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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 deliberative 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. I appreciate your comments about moving forward in a step-by-step manner, and am encouraged by your promise of a deliberate and thoughtful process. If we want our insurance companies to continue 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.

[3] *Impact of the Affordable Care Act in Pennsylvania*. U.S. Department of Health & Human Services. December 13, 2016.

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
Insurance Commissioner

cc: Senator Patrick Toomey
Senator Robert Casey

1. **What legislative and administrative actions do you recommend be taken in order to stabilize the individual and group insurance markets for the 2017, 2018, and 2019 plan years? In what timeframe would such actions need to be taken in order to stabilize the market?**

   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.

As far as timing, you should be very cognizant of 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.

2. What steps can be taken to improve the health of risk pools and ensure that high costs incurred by some do not lead to substantial premium increases for others in the pool?

To improve the health of risk pools, you must improve the health of those in the risk pool. Many believe that the incentives established by the ACA for individuals to obtain coverage, the individual mandate in particular, have not been strong enough to generate the robust risk pool anticipated by the law. This has resulted in many healthier and younger people staying out of the market and choosing to forego coverage. We need to bring those people into the market, and create the right incentives to do so. Additionally, the marketplaces have seen individuals enrolling only when they need significant care, or only enrolling for a partial year to avoid the penalty while concentrating all of their utilization into the months they are covered. We must improve the integrity of these programs to ensure the risk pools can function as intended.

We must also ensure that programs meant to stabilize markets, like risk adjustment programs, are functioning and spreading risk in the way they are intended. Of the three risk stabilization programs in the ACA, the one that was implemented most smoothly was the reinsurance program, which will now be phased out in 2017. Reinsurance is a mechanism to cover the costs of extremely high cost enrollees aimed to moderate premiums for enrollees with low or average annual health care costs. 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 like a high risk pool.

Before the ACA, a number of states had such 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, and I would caution a return to this model. 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.

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.

3. How would your state define "Essential Health Benefits" if it were given the freedom to define those requirements?

Essential health benefits were deemed "essential" because they were meant to be the services every person with health insurance coverage deserves to have access to. When I look at the list of services, I have to say I agree. Do we want health plans that don't contain emergency services, or hospital services? What about preventive services or pediatric services for our children? Health insurance is only as valuable as what it covers and the ACA's gains in coverage for things like mental health services, maternity services, and preventive health services cannot be undervalued for those that need them. I do not believe we should look to reducing benefits as a way to tackle cost issues; this isn't paying less for more, it is simply paying less for less.

Assuming we retain these critical broad categories for essential health benefits, the question becomes how we define required services within those categories. The current approach is to allow states to select a plan from among the most popular health plans in their state, then use that plan as a benchmark for the benefits to be covered by all other plans in the individual

and small group market. This is a market-based approach that allows the benchmark to reflect a product that insurers want to sell in a given state, and that consumers want to buy. To me, this seems a logical and fair process.

I also recognize that there may be states that want to go further or tailor the required benefits in a certain way. I would welcome states being granted the flexibility to do this, but would also recommend retaining a default option like the one we have today.

4. **Do you view the Section 1332 State Innovation Waivers as a workable option for providing state flexibility? If not, what changes in the law and regulations would you recommend? How long would it take your state to implement a Section 1332 Waiver?**

I am a strong proponent of state flexibility and states as the primary regulator of their health care systems and health insurance markets. While Pennsylvania does not have plans to pursue a §1332 waiver at this time, the 1332 Waiver process does provide significant flexibility to make changes that make sense for their markets and their residents, but more flexibility is always 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. However, because we have no plans to implement a Waiver nor do we know what such a Waiver would contain for Pennsylvania, I cannot comment on how long it would take to implement. I can say that if a Waiver is necessary, it will take significant time and resources to develop and even more so to implement.

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.

5. **What is your vision of a modern private health insurance market in your state? What would you do to lower health care costs, provide more individualized plan choices, and innovate, and what additional authorities would the states need from Congress to do so?**

First, we need to focus on the consumers who buy health insurance and the patients who use it. When I talk to consumers about their health insurance, about what they like and don't like about it, what they want is clear. They want health insurance that they can afford and rely on to cover what they think it covers when they need it most. Where our system currently falls short for these consumers is when they go to the doctor expecting their services to be covered, only to find out they're not. This can happen for a number of reasons, such as the consumer not understanding how their deductible works, a doctor beginning to charge a new fee when they become affiliated with a larger facility, or a so-called "surprise bill" that occurs when a consumer seeks care from an in-network doctor or facility, and inadvertently receives a service from an out-of-network provider only to receive a significant bill for that service. In my vision of health insurance, this shouldn't happen. Health insurance should be understandable, useable, and reliable. Tackling these consumer issues is the first step to get here, and a number of states have already taken actions to fix these problems for their residents. Our health care system should work for consumers, consumers shouldn't have to work to understand it.

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.

Beyond this critical consumer agenda, we need to focus on what is driving costs increases. 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.

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.

We also need to focus on the fastest rising cost in the health care system: the cost of prescription drugs. 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. This is one area where states are limited in their ability to tackle the problem; the Federal government must take this issue on if we want to see these costs curbed and prescription drugs become more affordable for all.