Central Penn Business Journal Health Care Symposium Remarks
July 18, 2017

Good morning, and thank you to the Central Penn Business Journal for the opportunity to begin today's event. Although our health care landscape is constantly growing and changing – especially with current conversations happening at the federal level – it is important that we continue to engage together to adapt to these changes and better serve the people we work with every day. Our goal should always be to ensure that Pennsylvanians can access the medical care and services they need. Governor Wolf, his administration, and the Pennsylvania Insurance Department remain committed to this goal, and we hope you will work towards it with us no matter what happens in Congress.

As we all know, our health care landscape changed significantly in March 2010 with the passage of the Affordable Care Act. The rules were rewritten and the populations we serve grew, but our common missions remained the same: Helping people access and afford the care they need to lead healthy and productive lives.

When the Obama Administration and Congress were drafting the Affordable Care Act, they did so to address problems with our country's health insurance system. For many people who did not receive health insurance from their employer, insurance available through the individual market often provided limited coverage at a lower monthly premium, leading to extremely high out-of-pocket costs for people with chronic health needs. If a person had a pre-existing condition, coverage was often denied for services related to that condition if they were able to get insurance at all, and people with chronic and catastrophic health needs faced annual and lifetime limits on covered benefits. To put it simply, there was much that needed to be done to ensure that our health care system was working effectively for all Americans, regardless of how they receive their insurance.

The Affordable Care Act addressed these problems through various changes to the playing field, the biggest of which being guaranteed issue, more commonly known as the ban on refusing coverage for pre-existing conditions. The ACA established a "three-legged stool" to help balance the added risk for insurers. Insurers were no longer to allowed to rate based on a person's health status, but the individual mandate was enacted to bring more people into the risk pool while the final leg, financial assistance for qualifying individuals and families, made this coverage more affordable. The law also ended annual and lifetime limits for covered benefits and established essential health benefit requirements and required access to certain preventive care services in order to assure that enrollees saw value in coverage for their premium dollars.

Pennsylvania has seen the positive impacts of these reforms. 5.4 million Pennsylvanians can no longer be denied coverage due to a pre-existing condition, 4.5 million Pennsylvanians no longer have to worry about large bills due to a pre-existing condition, and 6.1 million Pennsylvanians benefit from access to free preventive care services. Overall, reforms to the individual market and Governor Wolf's decision to accept the Medicaid expansion have brought Pennsylvania's uninsured rate down to 6.4 percent – the commonwealth's lowest ever.

The Affordable Care Act and Governor Wolf's decision to accept the Medicaid expansion has also helped reduce the burden that uncompensated care puts on hospitals around the commonwealth. In 2016, hospitals in Pennsylvania experienced a $129 million decline in uncompensated care due to coverage improvements from the Medicaid expansion and individual market, allowing them to invest this money into technology and improving the quality of care for their patients.

But just as the Affordable Care Act worked to address problems in our country's health insurance system and certainly made progress from where we were when the law was passed seven years ago, new problems were created both through how the law was drafted and how Congress and the executive branch – both under the Obama Administration and the Trump Administration – have handled implementation of certain features.

We now hear politicians from around the country at all levels of state and federal government saying that the Affordable Care Act is failing or "in a death spiral." That is not accurate. In fact, a recent report by the Kaiser Family Foundation found that insurers are doing better than they were before the federal and state governments opened the marketplaces in 2014. The ACA is not perfect and significant improvements are needed to ensure that it is working properly for consumers, insurers, and providers, but it is certainly not failing on its own accord.

We also need to establish what exactly is being referred to when we talk about the law failing. In Pennsylvania, the individual market – the market politicians say is failing – encompasses just five percent of our coverage landscape. This is 506,000 Pennsylvanians, with roughly 426,000 of them purchasing coverage that is eligible for financial assistance from Healthcare.gov. This is a relatively small piece compared to the number of people who are insured through their employer or a government program like Medicare or Medicaid. We should still ensure that this market is functioning properly and provides options for consumers who use it, but it is also important to understand which market needs improvements.

Pennsylvania's individual market is no stranger to the law's challenges. Last year, we saw two insurers – both national carriers – exit our individual market. Losing Aetna and United Healthcare in the individual market was unfortunate, but I am thankful that their exit did not leave us with significant gaps and "empty" counties around the commonwealth. We did, however, almost find ourselves in this situation at the end of last summer.

Individual market carriers across the country have voiced frustrations regarding the failure of the federal government to make risk corridor payments owed to insurers that experienced higher than expected claims resulting in significant financial losses from the 2014 and 2015 plan years. A report released in November 2016 by the Center for Consumer Information and Insurance Oversight estimated that the federal government owes insurers more than $8 billion in risk corridor payments based on 2014 and 2015 experience. These payments have been delayed due to a provision passed by Congress in 2014 to make the program budget-neutral – after insurers had already offered policies rated with the assumption that the payments would be made.

The Pennsylvania Insurance Department firmly believes that this is wrong and that insurers should be made whole under the rules they agreed to when entering the market in 2014. Last year, we filed an amicus brief in Highmark's suit against the federal government for the more than $200 million it is owed. It is critical that Congress authorizes these payments and helps create a stable playing field for insurers. The ACA rewrote the rules of the individual market, but left insurers to adapt to how to price these new plans based on experience they did not have yet. Risk corridors, risk adjustment, and reinsurance provisions in the ACA were designed to help insurers deal with the adjustment and the potential losses that could come as they gained experience with the new market. Without this safety net, insurers might not have entered the market to begin with. Congress must make good on the language included in the Affordable Care Act when it was passed and make insurers whole.

Indecision from Congress and the history of losses in the initial years of the newly configured market has contributed to the notion that the Affordable Care Act is failing, and my department has worked closely with our remaining insurers to ensure that they continue to view Pennsylvania's market as a viable place to do business. It has not always been easy, and unfortunately bringing our plans to a place of stability has resulted in larger rate increases than we hoped, but we are getting there.

This year, our insurers requested a statewide average increase of 8.8 percent – significantly different from the experiences we're hearing from other states and the narrative at the federal level. According to an analysis from Oliver Wyman, annual trend in care costs account for five to eight percent of requested premium increases, and an additional three percent comes from a federal health insurance tax. Given this, our increases are very close to below trend. Why is it that Pennsylvania is differing so greatly from other states? Well, I can only speak for Pennsylvania, but there is a common theme in the concerns we hear in conversations with our insurers and what we're hearing in statements from other states and their insurers: cost-sharing reductions and the individual mandate.

In July 2014, the U.S. House of Representatives, led by then-Speaker John Boehner, sued the Secretary of Health & Human Services over cost-sharing reductions, which help low-income individual market consumers with incomes ranging from 100-250 percent of the federal poverty line by limiting the consumers' out-of-pocket costs and making corresponding payments directly to insurers. The House's lawsuit alleges that cost-sharing reduction payments are illegal because they have not been specifically appropriated, and a judge ruled in favor of the House in 2016. The Obama Administration appealed, and since taking office, Secretary Price has not dropped the lawsuit. However, the Trump Administration has done little to demonstrate its commitment to protecting cost-sharing reductions by seeing the appeal through.

Despite calls from Republicans in Congress for these payments to be made, President Trump and Secretary Price have only committed to maintaining these payments on a short-term basis. Commissioner Miller and the CEOs from Pennsylvania's five individual market health insurers echoed these calls in a letter to Secretary Price sent in April. Our insurers need more than a short-term or month-to-month commitment that these payments will continue. As many of you know better than anyone, the insurance business thrives on predictability. If there continues to be uncertainty surrounding the future of cost-sharing reductions that insecurity will be reflected in a carrier's rate filings. I will touch more on that momentarily.

We have also seen concerns surrounding the enforcement of the individual mandate. From the ACA's beginning, the individual mandate was not a popular provision, but it was necessary to maintain the careful balance of the law's three-legged stool. Under the Obama Administration, there was criticism that the penalty associated with the individual mandate was not strong enough to encourage healthy people who may not qualify for financial assistance to choose coverage over paying a fine. Unfortunately, at the same time, the previous administration was also not doing enough to enforce limitations on special enrollment periods outside of open enrollment, leading to cases of adverse selection that the individual mandate was designed to mitigate.

The Centers for Medicare and Medicaid Services, under the direction of Secretary Price, issued a proposed rule earlier this year that would, among other things, strengthen enforcement of special enrollment periods. I think that is a positive step, but I worry that CMS now seems to favor an even more relaxed approach to the individual mandate. If congressional action does not nullify it completely, I

worry that failing to enforce the penalty will result in fewer people enrolling in coverage and what this will mean for our insurers and consumers remaining in the market.

According to the Oliver Wyman findings I mentioned earlier, non-enforcement of the individual mandate accounts for an estimated 9 percent of requested premium increases, though they note that some carriers could request up to 20 percent increases if the mandate is not enforced. They also estimate that failing to fund cost-sharing reductions would result in additional increases of 11 to 20 percent. Mind you – these numbers are in addition to annual increases for medical trend and the federal health insurance tax.

When our insurers filed plans for 2018, they indicated that changes to both cost-sharing reductions and the individual mandate would require them to request as much as a 36 percent increase due to added risk – compared to the much more reasonable 8.8 percent increase requested without those changes. This is not the Affordable Care Act failing on its own accord or being in a death spiral. These are actions that Congress and the Trump Administration have control over.

Instead of addressing the very obvious problems of affordability that our market still faces, Affordable Care Act repeal and replacement plans from both chambers of Congress do little to address this issue at all. While these proposals maintain some portions of the ACA's consumer protections, a return to less comprehensive plans would disproportionately hurt consumers with pre-existing and chronic health care needs.

Estimates from the Congressional Budget Office and other offices indicate that the proposals put forth would result in significant increases to the country's uninsured population and could seriously destabilize individual insurance markets. Under an amendment put forward by Senators Ted Cruz and Mike Lee, states would have the opportunity to offer low premium, slim coverage plans so long as they also offer one plan that complies with ACA requirements. I want to echo the concerns voiced by America's Health Insurance Plans and the Blue Cross Blue Shield Association – this alleged "consumer freedom option" will do nothing but create a segregated market that will significantly drive up premiums for our most vulnerable populations.

The Affordable Care Act tried to create a more balanced risk pool by requiring everyone to buy the same type of insurance. Clearly that has not worked as it was intended, but segregating the risk pool by essentially creating plans for healthy people and plans for sick people will only exacerbate this problem. Comprehensive health care for those who need it most will likely become unaffordable at most income levels, and people who purchase the skinnier plans could find themselves in catastrophic financial situations if they get sick or have some type of medical accident that requires extensive care.

I am deeply concerned about the legislative process both chambers of Congress have used thus far while considering health care reform. In January, Commissioner Miller responded to a request for information from U.S. House Majority Leader Kevin McCarthy on how the Affordable Care Act has worked in our state. In the majority leader's request, it was stated that regulators would have the opportunity to discuss our experiences at an in-person meeting in Washington in early 2017. To date, that meeting has not even been scheduled, and leadership in both chambers of Congress have made little effort to engage with regulators and industry stakeholders that work with these markets every day. I'm sure I speak for many of you when I say that we are more than willing to help. We understand these markets. We know the problems we face, and we have potential solutions to these problems.

So how do we move forward? First, we need to understand the problems we actually face. The Affordable Care Act tried to solve the problems of people with on-going or pre-existing conditions being able to access quality and comprehensive medical coverage at an affordable price. The law's ban on rating based on health status and requirements for essential health benefits and free preventive care were an important step towards this, but we are not there yet. We still have substantial affordability issues when it comes to health insurance, and we need to work together to find ways to tackle the issue of rising costs.

The Pennsylvania Insurance Department is working to address this in a few areas. Market instability is one of the greatest contributors to rising costs. As I discussed previously, ending uncertainty around certain portions of the Affordable Care Act is an easy way to create a more stable playing field for our insurers. Last month, we responded to a request for information issued by the Centers for Medicare and Medicaid Services looking for ways to stabilize the market. Although the timing of this request was a bit late considering most states had already received rate filings for 2018, we wrote about the feedback we received from our insurers on how frequently changing positions on the law's enforcement has real impacts on the rates insurers request. Creating a stable and predictable set of rules for insurers will result in less uncertainty and lower rates for consumers.

Improving how we pay for, deliver, and coordinate health care services is a priority of the Wolf Administration's Government That Works initiative. In order to help accomplish this, Governor Wolf included $2 million in his 2017-2018 budget proposal to fund an All Payer Claims Database. This database would allow the Pennsylvania Health Care Cost Containment Council to bring further transparency on health care costs to Pennsylvanians. In Pennsylvania, health care spending is growing at 5.4 percent annually and our costs are 13 percent higher than the national average. An APCD would help consumers understand where their money is going and empower them to knowledgeably take greater financial responsibility when making health care decisions. On the industry side, an APCD would allow stakeholders to identify opportunities for cost containment that could be used in future plan design.

Unfortunately the funding for an APCD was not included in the final budget that Governor Wolf allowed to go into law last week, but the Wolf Administration continues to view an All Payer Claims Database as an important tool for cost containment and will continue to explore it in the future.

These are important steps, but there is more to be done. We need a commitment from the Trump Administration and Congress to truly work together to address the real problems we face in constructive ways. It cannot be the insurance industry, hospitals, and consumer groups on one side and government on the other.

At some point in our lives, we will all need to use health care. Comprehensive coverage cannot be treated as a luxury. We need to come together and build upon the progress started by the Affordable Care Act and make the necessary adjustments to ensure all consumers have access to high quality health care at an affordable price regardless of their income or health status. That was the promise President Trump made when running for president, and I believe that we can reach that goal together. I hope you all will join me in using our expertise to keep the best interests of the people we serve at the forefront as the health reform debate continues.

Thank you again for allowing me to speak this morning. I will now be happy to answer any questions.