



House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Health Care

418 Main Capitol Building – Harrisburg, PA

March 3, 2011

AGENDA

- 10:00 a.m. Welcome and Opening Remarks
- 10:10 a.m. Panel from Pennsylvania Health Access Network:
- Sharon Ward
Executive Director
Pennsylvania Budget and Policy Center
 - Freddi Carlip
Consumer
- 10:40 a.m. Kati Sipp
Executive Vice President
SEIU Healthcare Pennsylvania
- 11:00 a.m. Rev. Amy Reumann
Director
Lutheran Advocacy Ministry in Pennsylvania
- 11:20 a.m. Peter Zurflieh
Staff Attorney
Community Justice Project
- 11:40 a.m. Rev. Jake Waybright
Chair
United Methodist Advocacy in Pennsylvania
- 12:00 p.m. Closing Remarks

TESTIMONY TO THE DEMOCRATIC POLICY COMMITTEE
HEARING ON THE ADULTBASIC INSURANCE PROGRAM
MARCH 3, 2011

Chairman Sturla, members of the Policy Committee, thank you for the invitation to testify today on the adultBasic program. I am Sharon Ward, Director of the Pennsylvania Budget and Policy Center and a member of the Pennsylvania Health Access Network, a coalition representing 2 million health care consumers.

Two days ago, more than 41,000 Pennsylvanians lost health insurance coverage that they have come to rely upon to work, to live their lives and to manage their health conditions. AdultBasic was a smart, forward-thinking and cost effective approach to reducing the ranks of Pennsylvania's uninsured. It was not a perfect program, but it worked for thousands who participated in it.

For the past three months citizens across the Commonwealth have worked to save this program. Thousands of emails have been sent, hundreds of calls have been made. There have been rallies and demonstrations and sing-ins and vigils, and coal deliveries, and valentines and all manner of opportunity to find a solution. None have been successful.

The Corbett Administration has argued, in the end, that the state is broke and there is no funding for adultBasic. That begs the question because adultBasic has never received a dime of state funding. It has been entirely supported by funds from the Tobacco Settlement and Community Health Reinvestment contributions from the Pennsylvanian' Blue Cross insurers.

There are several proposals on the table at the moment that would have temporarily filled in the gap in funding. These include Representative DeLuca's proposal to use the surplus in the Automobile Catastrophic Fund, Senator Stack's proposal to use a portion of leadership accounts, or Representative Clymer's plan to increase the gaming tax and make a portion available for adult insurance. The state is running a small surplus for the year, and funds those funds could have been used to fill the gap. Some policymakers have criticized the program's low premiums, and I am sure that adultBasic users would have contributed their share to making the program whole.

There have been two efforts in recent years to secure permanent funding for adultBasic. The first was in 2007, with the Access to Basic Care program or ABC, part of the Rendell Administration's Prescription for Pennsylvania. The plan would have used Tobacco Settlement, CHR and Tobacco Tax dollars to draw down federal Medicaid funding for ABC would have provide subsidized premiums for small businesses and provided comprehensive health insurance for twice as many Pennsylvanians. That plan passed the House and was not taken up in the Senate, which raised concerns about the Commonwealth's ability to secure a federal waiver, despite a favorable reception by the Centers for Medicare and Medicaid services (CMS) which was reviewing the waiver.

The second was House Bill 2455 which would have made continued the Blues assessment for three years until federal health reform makes affordable plans available in 2014. That legislation was received

coolly in both the House and the Senate. In the end, legislative leaders decided to negotiate a temporary solution to get through the fiscal year and leave the issue to the next Governor. So here we are. On March 1, Pennsylvania achieved not one, but two milestones. AdultBasic has ended. The states non-profit Blue Cross plans appear to have been released, for the first time since at least the mid 1990's, from any meaningful commitment to their statutory charitable mission.

The four Blue Cross plans are "institutions of purely public charity" that qualify for tax exemption under the Pennsylvania Constitution, Article VIII, Sections 2(a)(i) and (a)(vi). To qualify as institutions of purely public charity, they must serve a charitable purpose and render substantial portions of their services for free or at greatly reduced, subsidized prices, relieving the government of some of its burden.¹

Pennsylvania, and other states in similar situations have sought to quantify that charitable obligation. In 1996, the Pennsylvania Department of Insurance required Highmark to contribute 1.25% of its premiums to fulfill its charitable obligation. The Community Health Reinvestment Agreements negotiated by Governor Ed Rendell did not invent this requirement, rather it built on the precedent of the 1996 order and applied it to all of the non-profit hospital plan corporations.²

The Community Health Reinvestment Agreement (CHR Agreement) grew out of proceedings before the Department of Insurance concerning the size of Blue Cross reserves and excess surplus. Both the Insurance Commissioner at the time, Diane Kokken, and groups representing consumers and small businesses expressed a belief that the Blues were amassing excess surpluses, at the time around \$3 billion, that were contrary to their statutory obligation to provide insurance to individuals who were otherwise unable to obtain coverage. The 2005 proceedings before the Insurance Commissioner were resolved when the Blue Cross plans entered into the CHR Agreement.

Large surpluses were common among non-profit Blue Cross/Blue Shield insurers across the country in the late 1990s and early 2000s and were condemned by policymakers and the public at large. As a result of the increase in profitability, Blues in some states sought approval to convert to for-profit operations and in several, including California, New York and Wisconsin the assets (surpluses) were transferred to charitable foundations or directly to the state for health care services. Pennsylvania's

¹ This standard was set forth by the Pennsylvania Supreme Court in Hospital Utilization Project v. Commonwealth of Pennsylvania, 487 A.2d 1315 (Pa. 1987).

² In 1996, the Department approved a consolidation and change in control of a number of subsidiaries of the predecessors of what became and is now, Highmark, Inc. In Re: Application of Medical Service Association of Pennsylvania, et. al., Docket No. MS96-04-098 at 47. In the final Order ("the Order"), then Commissioner Kaiser specifically directed Highmark, Inc. to commit "to social or charitable endeavors 1.25% of its direct written premium as reported in its most recent Annual Statement..." Id. at 47-48. The Order also listed the programs to which Highmark could contribute in fulfillment of its required charitable obligation. This standing and unchallenged Order, establishes a precedent for the Department's authority and provides a starting point for the Department's efforts to create a state-wide concrete and enforceable standard definition for the charitable obligations of the Plans.

approach, to assess the Blues and use the funds to subsidize insurance for adults, was considered an innovative alternative to for-profit conversions and a model for the country.³

When it passed Act 62 of 2008, the Legislature reinforced the Blues charitable obligation and made it clear that only well defined contributions would count toward fulfilling that obligation.

The Blues have argued that they are not charities. The record could not be any more clear. The Blue Cross plans have a charitable obligation. The Commonwealth has a precedent for defining and enforcing that obligation. The obligation has been reinforced in recent state statute.

During the period between 2004 and 2010, the Blues surpluses have grown. As of June 2010, the combined surpluses for Pennsylvania subsidiaries stood at \$5.9 billion. If you add the profits from other subsidiaries that total increases to almost \$7 billion. The surpluses are sufficient to completely cover the commonwealth's budget shortfall and retain \$3 billion.

These are large and complex companies. Independence BlueCross operated 35 affiliated companies in three states. Highmark is a bigger company with 42 subsidiaries in several states and does a great share of business through its non-profits.

It is also important to remember that insurance companies will expand their customer base significantly as a result of federal health care reform and much of the new business will be from younger, healthier and less costly individuals. New regulations on insurance companies with respect to pre-existing conditions and rating are likely to benefit the Blues, who are currently insurers of last resort.

The Blues have argued that they are good corporate citizens and make charitable contributions within their communities. The Blues own reports indicate the level of outside charitable giving.

In 2010 Highmark reported \$154 in charitable expenditures. \$9.2 million, or 6% left the company. The rest are calculation of underwriting costs for adultBasic, CHIP and other Blues products.

NEPA had a CHR obligation of \$2.365 million all of which was obligated to AdultBasic. The company also had a sizable contribution to the Commonwealth Medical college, the largest contribution of any of the Blues. IBC reported \$79 million in charitable spending of which \$4.3 went outside the company (\$3 million went to pay administrative expenses for The Caring Foundation). Capital Blue Cross had no overpayments from previous years and so no AdultBasic obligation and reported \$680,000 in outside giving.

So here we are. What steps can be taken.

³ Carol Pryor and Katherine Dunham, "*The Pennsylvania Community Health Reinvestment Agreement*", Robert Wood Johnson Foundation, State Coverage Initiative. August 2006.

First, the General Assembly should request the Insurance Department to initiate a new investigation of the Blues surpluses. Clearly, the methodology in use to monitor the surpluses is inadequate.

Second, the Secretary of Welfare should order that every adult Basic enrollee should be affirmed screened for eligibility for Medicaid. Current enrollees may be eligible for MAWD, Special Care for Women or other Medicaid products. They should receive priority and the application review should begin immediately.

Third, it is critical that implementation of federal health reform continue. The plan includes tax credits for small businesses, a Medicaid expansion, and tax credits for individuals earning up to 400% FPL to help pay for insurance. Pennsylvanians need affordable insurance, and they need protection from high cost, lousy insurance products.

Finally, the general assembly should consider some successor program. For example, a premium assessment on the Blues, and even other insurers, could allow more individuals to access a Pennsylvania version of the PA Fair Care high risk pool. Insurers pay such a premium in other states to support such a program and the current \$10 million Tobacco Settlement funding could be applied to this program.



I want to thank the House Democratic Policy Committee for inviting me to testify today. My name is Freddi Carlip and I here am on behalf of the Pennsylvania Health Access Network (PHAN) is a statewide coalition of over 50 organizations from across the Commonwealth working to improve access to affordable, quality health care through the expansion of coverage. PHAN is the lead coalition representing the consumer voice in Pennsylvania.

I wish I were here today to testify about how we should implement the new federal health care law in a way that would best serve consumers and expand access for the nearly 1.3 million uninsured in our commonwealth. But instead I am here because on Monday over 41,000 individuals lost their health insurance when adultBasic ended.

I am the face of adultBasic...

I was on adultBasic for about six years after being on the waiting list. I was very fortunate. As a divorced self-employed woman, I was struggling financially. I wouldn't have been able to afford insurance had I not been on adultBasic. I am very grateful. I'm now on Medicare (as of December 2009) and my spot on adultBasic was given to someone on the waiting list. I like that I was able to "pay it forward" and let someone else have the opportunity I had. But as of Monday over 41,000 Pennsylvanian's no longer can rely on the program and have been added to the 1.3 million who are uninsured.

I was able to get the care I needed while on adultBasic. In addition to using adultBasic for checkups, mammograms, pap smears, I needed to see my family doctor during the year as I have hypertension and my BP must be checked. I couldn't have done that without aB. I couldn't afford each visit. I also had questionable lesions on my face and back. They needed to be removed and biopsied. Thank you, adultBasic for that and knowing the lesions were benign. What if they weren't and I didn't have adultBasic?

AdultBasic gave me my sight back. I developed cataracts and they got so bad, I couldn't drive at night or take walks at night due to night-blindness. I couldn't see. I am a writer and editor. My eyes are my doorway to doing my work. Thanks to adultBasic, I had cataract surgery in both eyes and my sight is better than ever. I can do my job. I can drive at night. It's a blessing. If not for aB, how would I do my job? I could never have afforded the needed surgery.

The faces of adultBasic are hard-working low-income people who, with this insurance, can focus on putting food on the table, clothes on their children, gas in the car to get to work, and until this week they did not have to worry about not having insurance and what would happen if they got very sick.



We *need* to help these people. We need to give them one less thing to worry about. I have a friend who has no insurance now that aB has ended. She can't afford it and she is a breast-cancer survivor. I have another friend on the waiting list. She is a business owner in Lewisburg. These are the faces of adultBasic.

Last week you heard the stories of numerous adultBasic consumers. So where are they now that the program has ended?

Last week you met Natalie Ross a 31 year old nanny from Philadelphia. She shared with you her story "I have been on adultBasic since March 2006. I had no other choice, because I have migraines. Although they are minor and treatable, migraines are something that insurance companies feel that they can completely reject your application over or they will only cover you at an astronomical cost. That is not an option for lower income WORKING individuals. Without health insurance, I wouldn't be able to see my doctor regularly to get refills for the preventive medication that has eliminated my migraines completely for the past two years or get the necessary blood test that goes along with it. If my migraines were to return, I would no longer be able to work. AdultBasic has been there for me through all of my sinus infections, several serious respiratory illnesses, and a torn cornea.

But most of all, adultBasic was also been there for me when I suddenly developed a rapid heart rate and endured over six months of different cardiac tests at a specialist's to try to come up with a diagnosis. Unfortunately, it seems that the change in medications that we thought had fixed my heart rate problems a couple years ago, must not have done the trick, because I just discovered a couple weeks ago that my rapid heart rate has returned. But this time, I'm on my own...there is no time to get into a specialist or find out what is wrong before adultBasic is scheduled to end. On Monday Natlie joined the 1.3 million uninsured Pennsylvanian's in our commonwealth. She is not eligible for any other programs and currently she is not sure she can afford Special Care. While Natalie ways her options she will test her luck and hope she does not get sick and end up in the emergency room.

Linda Nahgrang, who owns Charmingly Linda's Quality Consignments in Frazer, Chester County. Her and her husband both relied on the program.

"As a small business owner, I have the ability, as the economy improves, to add jobs. I should say 'HAD' the ability. I am actively making plans to either close, or sell my business in order to get a job with benefits. This after being in business for 12 years. This isn't a decision I make lightly. As soon as I knew I was losing my health care benefits I went to my doctor and had a mammogram, PAP test, physical, etc. I have always been a very healthy person but I don't know when I will ever be able to have these tests again. THIS time the doctor found "something." Just weeks before I lose my health care, I now find I have a growth on my thyroid. I don't have time to get any necessary treatment before my healthcare ends. And, even if I COULD start treatment,



I now have a pre-existing condition. The state's recommendation. Special Care are IBX plans costing more than 5 times what we now pay.

“My husband and I have run this business for all of these years without him receiving a paycheck. Not one. My paycheck is just enough to pay the household bills. That's it. We've worked very hard and have made tremendous sacrifices to stay in business and support the state economy. I now feel like we're being "punished" for working so hard, paying taxes, and helping keep money in our community. We could have just gotten jobs at a big box store years ago and spent these years selling stuff made in China. I feel so naive and stupid. I especially feel that we've put our health in jeopardy. Please say a prayer for us.” So where are Linda and her husband now. Linda has enrolled in Special Care but unfortunately they are not able to afford Special Care for her husband who also relied on adultBasic for care. He will also hope that he does not get sick.

For every one of these stories, there are another 100 more just like them. Rosanne Davis of Perkasio, Bucks County, a mother of two, has been on adultBasic for six years. She suffers from Crohn's disease and ulceris colitis. She had intestinal fistulas, but thanks to adultBasic coverage, they are gone as long as she can continue remicade treatment, which costs roughly \$19,000 once every 8 weeks. She told us “Losing adultBasic is a death sentence for me.” On Monday the same day adultBasic ended Rosanne went for surgery. She wanted to fit it in before her insurance expired. Luckily Rosanne found out from the health care navigator at the Philadelphia Unemployment Project that she was eligible for Medical Assistance for Worker's with Disabilities. However in a month or two Rosanne may qualify for Social Security and then her income may be too high to qualify and she will have to start the search for health insurance again.

The Governor says there is no money to continue adultBasic, even though during his campaign he supported a six-month extension to work on finding a solution. But his so-called solution is not a workable one for the 42,000 people who received their cancellation letters three weeks ago. His alternative, Special Care, will cost recipients up to four times more for very limited coverage. This is not a solution. The non-profit blues who receive tax breaks for being non-profits have seen their surpluses grow from \$3.2 billion in 2002 to to \$5.9 billion in 2010. They could fund the program for a year with just 3% of their surpluses. Legislation introduced in both the Senate and the House offer viable funding sources. But instead of looking for solutions, Governor Corbett and his colleagues added over 41,000 consumers to the commonwealth's 1.3 million uninsured. That is no solution at all.

What will happen if we fail to act? What happens if opponents repeal the Affordable Care or we fail to implement the law in Pennsylvania? It means that there is no solution for the 1.3 million uninsured and the over 41,000 that just joined them this week.



More importantly what happens to the 1.3 million uninsured who will not be able to get subsidies and access to the exchange? What does a loss of coverage mean for Linda, the Eastons, Rosanne, Natalie and the thousands of other Pennsylvanian citizens will join the ranks of the uninsured on Feb 28th? These people were counting on adultBasic to serve as a bridge to 2014 when health care reform is fully implemented.

In 2008, Families USA released a report that shows that 2 people die every day in Pennsylvania from lack of health insurance. Uninsured adults are more likely to be diagnosed with a disease in an advanced stage. For example, uninsured women are substantially more likely to be diagnosed with advanced stage breast cancer than women with private insurance. Uninsured adults are 25% more likely to die prematurely than those with private health insurance, Three out of five uninsured adults under the age of 65 reported having problems with medical bills. Who pays the cost of those bills? We all do. We all pay the cost of the uninsured, through our taxes and about 10% of our personal insurance premiums.

One more person you should hear about: Billy Kohler, from Pittsburgh. Billy is no longer with us, because unlike my mom he lost his health insurance. When he was laid off from his job as an electronics technician in 2003, he found himself facing a situation that confronts 27.4 million unemployed U.S. workers right now: he lost his job—and with it, his health insurance. He got work delivering pizza, a job that offered no benefits. Despite the meager pay, he made too much to qualify for Medical Assistance. In 2007, Bill collapsed at work and was rushed to the emergency room. Doctors said that he would need a new defibrillator battery for his heart to function properly.

Because Billy did not have insurance, he could not get the new battery he needed. The device and surgery would have cost \$10,000, far beyond his or his families' financial reach. Billy was never able to afford the care he needed, and when his defibrillator battery died, so did he—slumped over the steering wheel of his car on his way home from work. His sister Georgeanne wrote: "Without health insurance, my brother couldn't get the necessary cardiac care to keep him alive. This is the face of uninsured Americans whom we loved most dearly. Without meaningful reform, there will be many more. We just don't know their names yet."

How many more Billy Kohlers will we allow to die? How much longer will we put politics before people's lives? What kind of a society are we if we allow this to continue? I think we are better than this. In my tradition, repairing the world is of the utmost importance. AdultBasic is a step forward in doing that, one person at a time.

Our Commonwealth needs to be concerned and care about *all* of its citizens. We all matter.

Thank you.

LUTHERAN ADVOCACY MINISTRY IN PENNSYLVANIA
TESTIMONY ON ACCESS TO HEALTH CARE IN PENNSYLVANIA,
ADULT BASIC HEALTH INSURANCE AND H.B. 42,
AND THE FEDERAL AFFORDABLE CARE ACT
BEFORE THE HOUSE DEMOCRATIC POLICY COMMITTEE

March 3, 2011

Thank you for the invitation and the opportunity to submit this testimony. I am the Rev. Amy Reumann, Director of Lutheran Advocacy Ministry in Pennsylvania (LAMPa). LAMPa is a partnership ministry of the Evangelical Lutheran Church in America (ELCA) and its agencies and institutions in the Commonwealth of Pennsylvania. We work with 7 Bishops and their geographic districts, or synods, for a total of 1265 congregations around the Commonwealth. We serve alongside 18 social ministry organizations that provide a broad range of services, including long term and nursing care, foster care and adoption, emergency shelters, domestic violence programs, and more. We relate to four colleges, two theological seminaries and numerous outdoor ministries and camps. Our mission is to advocate in both public and private sectors of society on behalf of, and in partnership with, those persons who are denied justice and dignity and who lack adequate representation and voice in the arenas of public policy.

As I travel the state, I visit our congregational and community-based programs that provide health services, and hear the concerns of those who lead and serve their communities. What I have to say, while on behalf of the Lutherans, is not necessarily unique to one denomination, but taps into broader Judeo-Christian values and the theologies and principles of other faith communities, with whom we often work in partnership to address poverty and human need.

Our Lutheran concern about health care is grounded in our church's social policy statement called "Caring for Health: Our Shared Endeavor", which states,

"Health is central to our well-being, vital to relationships, and helps us live out our vocations in family, work, and community. Caring for one's own health is a matter of human necessity and good stewardship. Caring for the health of others expresses both love for our neighbors and responsibility for a just society. As a personal and social responsibility, health care is a shared endeavor".

We understand health care as more than an individual obligation, or solely the responsibility of government or up to the mechanisms of the market place, for none of these means alone can provide equitable access. It is a social good and works best when consumers, government and the health care industry work together, with shared responsibility and accountability on all sides.

The ELCA is a church committed to equitable access to basic health care for all people and advocating for just, compassionate, and effective health care policy. Our concern centers in particular upon the 'rights of the needy' (Jeremiah 5:28). Because health is central to personal well-being and functioning in society, we understand that a just society is one that supports the health of all its members.

We have advocated for many years for health reform of the American health system. Our priorities have included improving access to health care and finding adequate support for public health and preventive, acute, and long-term care services. While Lutherans are not unanimous about the best combination of public and private means for achieving this goal, the Affordable Care Act provides a way forward and a starting point by which to help many Americans, especially those left out and left behind of our current health care system. The ACA will expand coverage to millions of people and put into place important consumer protections and benefit guarantees that particularly assist those currently without coverage.

The following provisions of the ACA are consistent with our vision for a more compassionate health care future that fits our criteria of being inclusive, affordable, accessible and accountable. These points can be found with more detail at the website www.faithfulreform.org.

Inclusive Health Care: Health care is a shared responsibility that is grounded in our common humanity.

- Children under age 19 can no longer be denied coverage because of pre-existing conditions.
- Young adults up to age 26 can stay on parents' policies that go into effect after 9/23/10, unless they are offered coverage at work.

Affordable Health Care: Health care must contribute to the common good by being affordable for individuals, families and society as a whole.

- Medicare enrollees now receive wellness and prevention benefits with no cost-sharing or co-pays. They also are receiving discounts for their medications when they reach the gap (doughnut hole) in their Medicare prescription drug coverage.
- Key preventive care, such as mammograms, colonoscopies, immunizations, pre-natal and new baby care will be covered without co-pays or deductibles in new plans.

Accessible Health Care: All persons should have access to health services that provide necessary care and contribute to wellness.

- Women now have direct access to OB/GYNs without a referral.
- Lifetime limits on insurance payouts are now eliminated; annual limits are greatly restricted and will eventually be eliminated.
- Expanded funding for community health centers will increase access to medical care in under-served areas.

Accountable Health Care: Our health care system must be accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community.

- Insurance companies can no longer drop people from coverage because of illness.
- Members of Congress and their staff members will receive their health insurance from the same exchanges.

Health care justice and the common good are best served when everyone is actually participating in a nation's system of health care. With everyone participating, we'll all have timely access to the benefits of health care coverage rather than waiting until too late, or worse, getting no care at all. With everyone insured, society-at-large partners with the health care system for the sake of the common good, fairly distributing the responsibilities, costs, risks, and benefits.

The requirement to have insurance ultimately protects all of us from the costs of medical care for patients who can pay for insurance but refuse to do so. The subsidies will be designed so as not to impose a burden greater than any one person or family can bear. It also affirms the government's rightful role in regulation and oversight on behalf of the public good. It is an effort to get everyone playing by the same rules, resulting in fair treatment for everyone in return.

The persons exempt from the requirement cover a wide range of circumstances and conditions. It includes those whose faith communities object to insurance; those without coverage for less than 3 months; American Indians; undocumented immigrants; those with hardship exemptions (for whom the lowest cost plan available exceeds 8% of individual income); and those who earn too much to qualify for Medicaid but earn too little to file income tax.

If the requirement to have insurance is repealed, insurance costs would likely rise for everyone. In the negotiations leading to reform, this requirement was coupled with the ban on the insurers' practice of banning persons from coverage because of pre-existing conditions. The costs for adding persons with pre-existing conditions will escalate if enrolling the sick is not off-set with healthy enrollees. The costs of uncompensated care will continue to increase costs system-wide. Very few people are fortunate enough not to have to access the health system at some point. The penalty for not purchasing insurance simply helps offset the medical costs for those who choose not to purchase insurance, but do not have the ability to pay for expensive care.

The adultBasic program is a model of shared responsibility for health care that serves the common good. It hits the criteria above by providing health care that is inclusive, affordable, accessible and accountable. The adultBasic program shares responsibility between government, insurers and consumers, and keeps its subscribers healthy, employed and contributing to society. It has been affordable for those who would otherwise fall through the cracks or be priced out of the market or denied coverage due to pre-existing conditions. It has been accessible, for those who reach the top of the waiting list, with many more waiting for a chance. AdultBasic has required accountability from all parties: accountability from the Blue Cross companies to make use of their surpluses and commitment to provide charity care; accountability from state government, not only to support its vulnerable citizens, but also to protect all citizens from the high cost of treating uninsured individuals, and accountability from those subscribing to make use of it, manage their health, to pay their copays and hospital expenses, and the cycle off the program when their income rises or they find other forms of insurance.

Yesterday I received an email from a physician with the following offer. "Yesterday," he wrote, "while volunteering at Volunteer Doctors Care, a free clinic in Upper Bucks Co., I learned that our clinic will treat any patient that has lost adultBasic coverage as a result of the program's termination that was effective yesterday. Free treatment will be offered for three months upon presentation of a letter or proof of termination of their adultBasic coverage. After three months

they will need to submit an application for continuing eligibility. They must be residents of Quakertown or Pennridge School districts in Upper Bucks Co.”

This is wonderful news, for those who happen to live in 2 school districts out of the 500 in the state. But we know that all our free clinics, faith-based and community health services cannot adequately cover the needs of 40,000 new patients or manage their conditions.

The end of funding for adultBasic brings the inadequacies of the current system into focus and need for the reforms noted above. We are already beginning to hear stories of persons formerly on adultBasic deciding to ration their care, making the agonizing choice whether to ignore a pain or a symptom and whether they can afford to have them treated. Many who relied in the past on adultBasic may have to choose between healthcare, food, or paying their mortgage or rent. Others fear that without preventative health care to manage chronic conditions, they will no longer be able to work and support their families. In all these cases, those formerly on adultBasic will turn to already-strapped human services, for support and programs.

It makes no economic sense to end adultBasic. At a recent event, Mr. Bob Rundle, the CEO of Lutheran Social Services for South-Central Pennsylvania, noted the economic cost of not continuing adultBasic through the end of the fiscal year. He calculated it would cost \$52 million to continue adultBasic for all 42,000 people through June, which translates into roughly \$1,250 per participant. Based on 2008 data, he said, it costs \$1,265 per emergency room visit. He said, “We’re telling people to leave a health insurance program that gives them both care as well as the comfort they need to move forward and, in return, go to our community hospitals, go to our emergency rooms and drive our costs up,” he said. “I do not think that is a good and wise use of our limited resources.”

It is neither good nor wise to take a program that works, that combats poverty by supporting human health and dignity, that helps citizens to be productive and contribute, that enhances the Commonwealth’s economy, and let it end in the way that adultBasic has been sacrificed. It is a moral tragedy for our state.

The ELCA Social Statement “Caring for Health: Our Shared Endeavor” states, *“We call on our society to give priority to people and groups who are not benefitting from access to health care services and research: people who are uninsured and underinsured, people living in poverty...and those suffering the consequences of our failure to implement adequate public health protection”.*

Finding a way to continue to fund adultBasic is an opportunity to give priority to over 40,000 persons who do not have adequate access to health care services. It is also to remember the half million who have been on the waiting list. Government has a unique role to play.

Again, the social statement says, *“As guarantors of justice and promoters of the general welfare, governments also have the unique role of ensuring equitable access to health care for all. Governments have the obligation to provide leadership and coordination in balancing competing private and social interests in moving toward the goal of equitable access to health care.”*

Thank you for your work to preserve adultBasic and for the continued attempt to provide health care that is inclusive, affordable, accountable and accessible.

**Kati Sipp, Executive Vice President, SEIU Healthcare Pennsylvania
Testimony on Pennsylvania House Bill 42 and Adult Basic
March 3, 2011**

My name is Kati Sipp and I am the Executive Vice President of SEIU Healthcare Pennsylvania, the state's largest health care workers' union, with 22,000 members who work in hospitals, nursing homes, state facilities, and home care throughout the state.

It is front-line workers like the members of SEIU Healthcare Pennsylvania who actually deliver the health care that Pennsylvanians need, and it is important that the voices of these workers be heard. So we thank this committee for the opportunity to testify on the subjects of House Bill 42 and the expiration of the Adult Basic program. But to be frank, the very fact that we have to have this debate again is disappointing, even outrageous. House Bill 42, which would prevent Pennsylvania from complying with the federal Affordable Care Act, is an act of political theater and not a serious proposal. It is a distraction from the genuine discussion that this Commonwealth needs to have about how best to implement the Act in a way that guarantees health care for everyone, without leaving sick people with unmanageable medical bills.

After two years of misleading propaganda and political stunts on this issue, and a year since the bill itself passed, we should remember why we needed the Affordable Care Act in the first place, and why we should take its full implementation seriously, rather than gutting it before it has had a chance to work.

In the past, you've heard us cite the statistic from a Harvard Medical School study that half of all bankruptcies in the United States are due to medical bills.¹ That is an almost inconceivable figure, but it is important to understand the consequences of it for real people. Just the other day, you could open the pages

¹ Dianne Finch, "Half of Bankruptcies Due to Medical Bills, Harvard Study Says," *Bloomberg*, February 2, 2005. <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aolabyFcYBVY>

of the *Lebanon Daily News*, right here in Pennsylvania, and read a story about Amie Rogers, a 30-year-old woman with lupus and two rare blood disorders, who was scheduled for a kidney transplant at Hershey Medical Center, where the registered nurses are members of our union.² Like most people in our country with inadequate health insurance or none at all, Ms. Rogers works a regular job, in her case as a waitress. Yet Ms. Rogers ran a children's game booth at the local Rotary Club's Bologna Fest as a fundraiser to try to pay the estimated \$40,000 she will owe in medical bills. She raised a little over \$1,000. The positive part of this story is that the Rotary pitched in to raise some more money for her. But there are many thousands of stories like hers that never make the papers, and no local charities will ever raise enough money to keep these nameless thousands of people from facing a lifetime of financial ruin because of an illness.

Instead, we need a rational system of health coverage in this country, and our elected policymakers need to act to make that happen.

Our continued failure to do this has disastrous consequences. Healthcare workers in emergency rooms across the Commonwealth will tell you that every day they see people come into the emergency rooms with severe health problems that could have been dealt with at a less severe stage in a primary care setting. But people with no coverage or inadequate coverage avoid going to the doctor for fear of just the financial consequences we've talked about. The result, for the rest of us, is actually increased health care costs, because people who go without primary care clog the emergency rooms with more severe problems, and since they have no way to pay for the costs of their treatment, the rest of the system eats those costs. The result, for the people actually caught up in this, is even more disastrous.

² Brad Rehn, "Rotary Club comes to woman's aid," *Lebanon Daily News*, February 20, 2011. http://www.ldnews.com/ci_17437977

You have probably heard about the *American Journal of Public Health* study that estimated that over 44,000 people a year die in the United States, when they would have lived had they had adequate health insurance.³ Once again, this is a figure so staggering that it is difficult to comprehend. For one thing, it means that ten times as many people die *each year* because of inadequate health insurance as there have been United States soldiers killed in Iraq since the start of that war in 2003.⁴

There are also names and faces to this tragedy. SEIU member Georgeanne Koehler, who works at UPMC's Western Psychiatric Institute and Clinic in Pittsburgh, has been in front of bodies of elected officials like this one many times, telling the story of her brother. Bill Koehler was another member of our country's vast army of the working poor. He had heart arrhythmia and needed a defibrillator to survive. When he lost his job, he lost his health insurance, and even when he took another job as a pizza delivery driver to pay the bills, he was turned down when he tried to get health insurance again, because of his pre-existing condition. He collapsed at work in December of 2007, and his doctor informed him that he needed a new battery for his defibrillator. The cost was far more than he or his family could afford. On March 7, 2009, two years ago almost to this very day, his defibrillator battery failed when he was coming home from work, and Bill Koehler slumped over the steering wheel of his car and died.

There are over 44,000 Bill Koehler stories each year in the United States.

This is why it borders on the bizarre for the sponsors of House Bill 42 to call it the "Freedom of Choice in Health Care Act." This bill would make it impossible to enforce the individual mandate to purchase insurance in Pennsylvania; under the guise of attacking one of the Affordable Care Act's unpopular provisions, it seeks

³ Andrew P. Wilper, Steffie Woolhandler, et. al., "Health Insurance and Mortality in US Adults," *American Journal of Public Health*, December 2009. Available at <http://pnhp.org/excessdeaths/health-insurance-and-mortality-in-US-adults.pdf>

⁴ Compare to <http://icasualties.org/>

to undermine the Commonwealth's participation in the new law as a whole. But as the story of Bill Koehler and thousands of others illustrates, it is a curious kind of "freedom" to have no health insurance. If you're obliged to choose between bankruptcy and losing your house on the one hand, or risking your health and possibly your life on the other, there are a lot of ways to describe your situation. But "freedom" isn't one of them.

The Commonwealth has just extended this dubious variety of "freedom" to over 40,000 people who had health insurance through the Adult Basic program. Cutting that many people from their health insurance is the wrong way to go at this time, when we should be talking about how to tide people over until the most important provisions of the Affordable Care Act go into effect in 2014, and when we should be talking about how best to implement those provisions in our Commonwealth so as to maximize the benefits for the people of Pennsylvania. It simply does not do, at this point in time, to say that Adult Basic was "out of money." Adult Basic was too small a program to begin with, and had a huge waiting list. But it did offer affordable coverage to tens of thousands of people, and as others have said over the course of the last few weeks, extending the program for another year as it would have cost only 3% of the value of the Blues' surplus in the state. The previous administration was able to coax out the money for this program. There is no reason we could not do it again.

Meanwhile, rather than discussing gimmicky and irresponsible schemes to block implementation of the federal Affordable Care Act, we should have a serious discussion about how to take full advantage of the Act's state-level flexibility in order to create a robust health care exchange that will mean better health care for all the people of the Commonwealth.

Provided our elected officials are serious about moving forward instead of looking backward, our union has recommendations for how we should implement the Affordable Care Act in Pennsylvania. For instance:

(1) States have an opportunity under the law to review rate history and rate justifications for carriers that want to sell their plans on the exchange. In setting up the exchange in Pennsylvania, the Commonwealth should act to ensure (a) that rate increases reflect actual costs, not excessive profit margins; (b) that carriers abide by the Act's restrictions on medical loss ratios, so that they spend at least the required minimum of premiums on actual patient care (this is the 85% requirement); and (c) that carriers compete to provide the best coverage for the best price.

(2) States can create a higher, more robust "floor" for services covered under plans offered on the exchange. Pennsylvania should ensure that the highest-quality benefits are provided to individuals and families.

(3) The Commonwealth should ensure that health plans include in their networks essential community providers serving low-income populations, and also ensure access to care across all geographic areas of the state.

(4) The Commonwealth should act to minimize the risk of "adverse selection" on the exchange. Insurance plans on the exchange will not be competitive if regulations allow exchange plans to become high-risk pools while allowing insurance carriers to "cherry-pick" healthy individuals to be served outside the exchange. To avoid this, Pennsylvania should (a) charge the exchange governing board and its managers with creating an effective and ongoing process to guard against adverse selection; (b) regulate the individual and small group markets identically inside and outside of the exchange; (c) require insurers to offer the same plans inside and outside the exchange; and (d) exercise the option under the law to establish community rating for all individual and small group insurance plans offered in the state.

(5) We should also penalize insurers who do not comply with the law and the requirements of the exchange.

(6) There will be a large group of people who, because of fluctuations in income, will move back and forth between Medicaid and private coverage through the exchange. The Commonwealth should act to make these individual transitions as quick and seamless as possible.

(7) The Commonwealth should ensure comprehensive and targeted outreach to individuals, families and businesses about opportunities to participate in the exchange. The exchange should ensure that information about carriers' plans is factual and communicated in easy-to-understand terms, and that individuals have access to unbiased information about their options, so that consumers can easily compare cost and benefits to determine the best plan for them. There should never be excessive wait times or difficulty accessing service, and consumers should be able to reliably access a trained employee and receive timely responses to their questions. There should always be an alternative to online enrollment for all exchange programs in order to service consumers who lack access to the Internet. All outreach and communication should be designed to overcome traditional health barriers, including income, geography, and English literacy. Enrollment periods should be generously long.

(8) We should act to ensure that the exchange operates with maximum transparency, prohibits conflicts of interest, and clearly defines a process for public comment, performance review, and accountability.

Pennsylvania government has a lot of work to do to make the Affordable Care Act work for all Pennsylvanians. But we're all best served by looking forward instead of backward.

**COMMUNITY JUSTICE PROJECT'S
TESTIMONY ON
ACCESS TO HEALTH CARE IN PENNSYLVANIA,
ADULT BASIC HEALTH INSURANCE AND H.B. 42,
AND THE FEDERAL AFFORDABLE CARE ACT
BEFORE THE
HOUSE DEMOCRATIC POLICY COMMITTEE
MARCH 3, 2011**

Submitted by:

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Thank you, Chairman Sturla and Members of the General Assembly who are gathered today for this important hearing on access to health insurance and health care. The Community Justice Project is here to speak on behalf of our clients, who are low-income Pennsylvanians from across the Commonwealth. Many of our clients are among the 1.3 million uninsured in Pennsylvania and the additional 42,000 working class adults on adultBasic health insurance who lost their health insurance coverage, effective Tuesday, March 1.

Over 101 articles were published on Tuesday about the termination of the adultBasic program. The New York Times described it as “one of the largest disenrollments in recent memory.” For one of the adultBasic recipients (now former recipients) interviewed in the Times article, the ending of the program means:

“the end of coverage that made possible an aortic valve replacement last May. While the life-saving procedure cost about \$85,000, he said he had paid only \$915 out of pocket.”
(See, attached article)

While the 42,000 working adults on adultBasic health insurance—whether they were be in the middle of cancer treatments, kidney dialysis or expecting a child soon— were notified that their health insurance would be terminated in as of March 1, no remedies to sustain adultBasic are being put forth by the Corbett Administration, the majorities in the General Assembly, or the four Blue Cross Plans who have caused the crisis by ending their funding of adultBasic. It is important to note that funding from Blue Cross has not been just a volitional charitable offering. Instead, it has arisen under a state law mandate stemming from the Blues’ long-standing tax-exempt, charitable status in Pennsylvania, which compels them to dedicate their funds to the needs of the uninsured.

The Corbett administration has pointed out that alternative coverage may be available to those terminated from adult Basic through the “Special Care” program offered by Blue Cross/Blue Shield, but the coverage under this program would be far less comprehensive than adultBasic and the premiums four times as high.

Meanwhile, as Pennsylvania’s 1.3 million uninsured await the full implementation of the historic federal Affordable Care Act (ACA) in 2014, one of the first measures that was voted out of a House Committee this legislative session, H.B. 42, is an effort to preclude implementation of this law. The ACA will not only bring access to health insurance for millions of Americans, but will also bring to the Commonwealth and its taxpayers tens of millions of dollars in health insurance policy subsidies to policyholders under 400% of the federal poverty guidelines, and tens of millions in generous federal financial participation for Medical Assistance to a population under 135% of the poverty guidelines.

At the House Health Committee hearing several weeks ago in Harrisburg, proponents of H.B. 42 chastised the federal ACA as replete with “sticks” rather than “carrots.” To the contrary, the ACA contains almost all “carrots” due to these unprecedented subsidies to Pennsylvania citizens and state government. The large majority of Pennsylvanians who are uninsured will be subsidized through a tax credit to allow them to buy private health insurance.

We will now speak to some critical aspects of the adultBasic program, H.B. 42, and the ACA.

I. Save adultBasic Insurance for 41,000 Working Class Pennsylvanians

Since 1992, adultBasic health insurance has saved lives and sustained the health of tens of thousands of working class Pennsylvania adults with incomes under 200% of the federal poverty guidelines. More than 85% of adultBasic enrollees have incomes below \$30,000 a year. It provides such an urgently needed health insurance benefit; as of January 2011, 490,000 people were on its waiting list. Simply stated, it should be re-instated.

A. H.B. 500 and S.B. 420 Will Save adultBasic

We must thank Representative Anthony DeLuca and the 70 co-sponsors of his H.B. 500, which would continue adultBasic using available surplus monies within the Insurance Department coming from the Mcare Fund. Ongoing funding would come from a surcharge that the Legislature enacted some years ago to address what was called a medical malpractice crisis—and which no longer appears to be a crisis.

We also must thank Senator Michael Stack and the co-sponsors of S.B. 420, which would, alternatively, save adultBasic by drawing from the Legislature's own operating budget surplus of \$189 million. As a *Philadelphia Daily News* Editorial recently stated,¹ the generous health insurance package that legislators are given at taxpayer expense creates a moral imperative for the Legislature to find a remedy to continue health insurance for those on adultBasic health insurance.

B. Blue Cross Plans Have Reneged on Charitable Obligations to Fund adultBasic

We must emphasize that the adultBasic funding crisis has been caused directly by the Blue Cross Plans' refusal to continue the charitable funding that they provided under the Community Health Reinvestment Plan (CHRP) Agreement with the Commonwealth from 2005 through December 31, 2010.

During this same period that the Blues were collectively making \$900 million in charitable payments (60% of which funded adultBasic), the combined and consolidated surpluses of their parent holding and subsidiary companies virtually doubled to more than \$7 billion,

¹ See Editorial, *Lawmakers' health coverage will make you ill*, Phila. Daily News, Feb. 11, 2011, available at http://www.philly.com/philly/opinion/20110211_DN_Editorial__Lawmakers_health_coverage_will_make_you_ill.html (copy attached).

according to the Pennsylvania Budget and Policy Center in Harrisburg. Thus the Blues have faced no financial problems as a result of funding adultBasic. In fact, Highmark Blue Shield—which is now causing the termination of about 20,000 adultBasic enrollees—has found \$45 million for a line of credit to pursue a pending merger with Blue Cross Blue Shield of Delaware. A very small percentage (under 3%) of the Blues' surplus could fully fund adultBasic for a year.

The Blues' funding of adultBasic has not been a simple offering that can be extinguished suddenly. Their financial commitment was *and remains* firmly grounded in state law that grants the Blues tax exempt status while qualifying them as "institutions of purely public charity," which requires them to "benefit a class of persons who are legitimate subjects of charity." In doing so, the Blues "must render a substantial portion of services freely or at a greatly reduced, subsidized price, and relieve the government of some of its burden."²

The precipitous cessation of Blue Cross funding is now resulting in the termination of 41,000 adultBasic enrollees. Neither the Insurance Department nor the Attorney General have taken any remedial actions to enforce the charitable obligations of the Blue Cross Plans toward the uninsured.

The Blues' charitable obligations pre-dated the CHRP Agreement, as the Insurance Department directed in 1996 that Highmark make annual charitable payments for "social or charitable health care endeavors" that would constitute 1.25% of its written premiums.³ This annual, ongoing obligation was not time-limited. Although the CHRP Agreement replaced that obligation from its execution in 2005 through its expiration on December 31, 2010, the obligation must continue to be enforced against Highmark for the period after December 31, 2010.

Consumer health groups and advocates have written to Acting Insurance Commissioner Consedine asking him to take immediate steps to enforce the charitable obligations on the Blue Cross Plans to keep adultBasic alive. (A copy of that letter is attached.) With the doubling of the Blue Cross Plans' accumulated surplus to over \$7 billion, we also believe that the Insurance Department should open a new, a full-scale investigation into the propriety of and need for the Blues to have this surplus, especially as they run away from their obligations to the uninsured.

² *Hosp. Utilization Project v. Commonwealth of Pennsylvania*, 487 A.2d 1306, 1312, 1315 (Pa. 1987). For a more detailed legal analysis of the Blues' mandated charitable obligations to the uninsured, please see the attached memorandum, *Pennsylvania Law Establishing Charitable Obligations Upon the Blue Cross Plans*, by Community Legal Services and the Pennsylvania Health Law Project. *See also* J. Stein, *Letter to the Editor: How can Blue Cross toss its customers overboard?*, Phila. Inquirer, Feb. 6, 2011, (copy attached).

³ *See Decision and Order Re: Application of Medical Service Association of Pennsylvania, et. al.*, Docket No. MS96-04-098 at 47-48 (Nov. 27, 1996).

C. Pennsylvania's Termination of 41,000 adultBasic Recipients is Unlawful, Violating Due Process of Law and the Americans with Disabilities Act

Finally, we believe that the planned termination of the 41,000 adultBasic enrollees is illegal and must be stopped because many individuals on adultBasic are also eligible for Pennsylvania's Medical Assistance (MA) program, which is run by the Department of Public Welfare (DPW). When people applied for adultBasic insurance, state policy explicitly held that their applications were *also applications for MA*.⁴

MA is comprised of more than 50 different categories of health insurance eligibility. Categories include programs for women with breast or cervical cancer, for pregnant women, for women in need of gynecological and family planning services, for the working disabled, and for certain adults between the ages of 59 and 65. With varying income eligibility levels and medically qualifying conditions, we believe that a majority of persons on adultBasic might well be eligible for MA, if only the state were to offer a helping hand and consider MA eligibility as it terminates adultBasic eligibility, in conformance with state policy. It is important to note that many MA eligibility decisions could be considered in light of medical and other data that the Insurance Department and its agents have already compiled

For these reasons, we maintain that every person on adultBasic must be screened for MA eligibility and enrolled if eligible into an MA program before anyone's adultBasic coverage terminates. The Insurance Department and DPW have overlooked their legal obligations to consider enrollees for MA eligibility. Furthermore, they have not taken steps to allow adultBasic beneficiaries with disabilities to access the MA program, as required by the Americans with Disabilities Act. Attached is the letter that Community Legal Services of Philadelphia sent last week to Mr. Consedine and Acting Welfare Secretary Gary Alexander, setting forth claims that Due Process of Law and the Americans with Disabilities Act have been violated, and asking them to delay any adultBasic terminations.

II. Oppose H.B. 42 to Ensure Appropriate Implementation of the Federal Affordable Care Act

The federal Affordable Care Act (ACA) is undoubtedly one of the most important federal laws to benefit Pennsylvania in many years, as it will bring federal health insurance policy subsidies to persons under 400% of the federal poverty guidelines, which are almost all of the uninsured of Pennsylvania. And its generous Medical Assistance federal financial participation subsidy will allow Pennsylvania to cover at least all persons under 135% of the federal poverty guidelines.

Yet H.B. 42's intent is to subvert these federal health reforms by creating mass confusion among elected officials. Its provision to bar Pennsylvania from penalizing persons who do not purchase health insurance as required by the ACA is largely a symbolic act, as the ACA authorizes penalties from the Internal Revenue Service as its enforcement mechanism. It is

⁴ *See* AdultBasic Policy and Procedure Manual § 9.5 (Mar. 2009).

patently unconstitutional for a Legislature to direct a Governor or state officials not to follow federal law.

Stakeholders across the health care community are solidly behind ACA implementation, including the American Medical Association, American Cancer Society, and the AARP. A Pennsylvania Advisory Committee on ACA implementation, including everyone from hospitals and doctors to insurers and businesses to consumers, has unanimously recommended that the state move forward with ACA implementation.

As explained earlier, the ACA is filled with “carrots”—that is, large subsidies to persons required to purchase health insurance, and equally major subsidies to state governments for Medical Assistance expansion. It also establishes provisions to curb rising medical costs.

H.B. 42 speaks of “freedom to contract.” However, the only “freedom” limited by the ACA is the freedom to manipulate the health insurance system by waiting until one gets sick or injured to buy health insurance or enter an Emergency Room, driving up health care costs for everyone. Pennsylvania does not permit drivers to wait until they have an accident to purchase auto insurance, and an analogous requirement for “personal responsibility” in health insurance should be supported similarly.

In conclusion, H.B. 42’s victims would be the 1.3 million Pennsylvanians who are uninsured, including the half-million persons who are on the adultBasic waiting list across Pennsylvania. Throwing monkey wrenches into ACA implementation will prevent the uninsured from accessing affordable health insurance in 2014.

III. Use Federal Funds *Now* to Preserve Health Insurance Coverage for Thousands of Pennsylvanians While Reducing the State Budget

The ACA encourages states to phase in the federal expansion of the Medicaid program before 2014, at which time the ACA will offer states 100% federal funding for newly covered MA individuals through 2017.

Pennsylvania currently provides state-funded MA coverage to certain individuals like disabled adults who have applied for SSI or SSDI benefits from the Social Security Administration, caretakers for disabled household members, and persons undergoing drug and alcohol treatment (for up to nine months in a lifetime). To be eligible, these individuals must be at very low income levels, about 23% of the federal poverty guidelines (this is referred to as “GA-related MA” as the income eligibility is pegged at the General Assistance eligibility level).

Community Legal Services has explained in a policy paper (attached)⁵ how Pennsylvania can follow a number of other states to convert the GA-related MA program into a federal

⁵ Cmty. Legal Servs. & Pa. Health Law Project, *Seizing Opportunities in Tough Economic Times: Using Federal Funds to Preserve Health Insurance Coverage for Thousands of Pennsylvanians While Reducing the State Budget*, Jan. 2011.

Medicaid program, and draw down 55% of the costs of the GA-related MA program, or \$112 million of the \$203 million program. Converting the program might result in a small, additional enrollment of people at the 23% of poverty income levels who otherwise might not qualify for GA-related MA. We believe that receiving 55% federal financial participation for current recipients would more than cover these new costs.

We urge the Corbett Administration, with the support of the Legislature, to immediately convert GA-related MA into a federal Medicaid program under the ACA. This conversion would be a rare “win-win” opportunity to preserve health insurance coverage for tens of thousands, while saving state funds.

We thank you for this opportunity to contribute our commentary and analyses to this very important hearing.

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March 1, 2011

Feeling Budget Pinch, States Cut Insurance

By **KEVIN SACK**

EASTON, Pa. — Ken Kewley woke up Tuesday without health insurance for the first time in nearly nine years.

So did most of the 41,467 other Pennsylvanians who had been covered by adultBasic, a state-subsidized insurance program for the working poor that Gov. Tom Corbett shut down on Monday in one of the largest disenrollments in recent memory.

Mr. Corbett, a Republican elected in November, has said the program he inherited is not sustainable with Pennsylvania facing a \$4 billion budget shortfall. He blames his predecessor, Edward G. Rendell, a Democrat, for not keeping the plan solvent. His administration notified beneficiaries in late January that their coverage would expire Feb. 28.

For Mr. Kewley, 57, an abstract artist in this gritty town in the Lehigh Valley, it meant the end of the coverage that made possible an aortic valve replacement last May. While the life-saving procedure cost about \$85,000, he said he had paid only \$915 out of pocket.

The state has pointed Mr. Kewley toward other options, but the coverage would be less comprehensive and the premiums far higher than the \$36 he had been paying each month. Now any minor symptom, like a mild pinch in his chest, prompts a devil's calculation about whether he can afford to have it checked.

When he noticed such discomfort on Tuesday morning, he broke into a cold sweat, felt his stomach tightening and experienced "a sense of impending doom," he said. For the moment, Mr. Kewley is trying to convince himself it is just a pulled muscle.

"It's a worry, and it's draining," he said, seated in the home studio where he applies bold acrylics to landscapes of the sloping hillsides nearby. "It's always present in my mind so it's hard to come up here and do my work."

Pennsylvania is one of several destitute states seeking to help balance budgets by removing adults from government health insurance programs.

Gov. Christine Gregoire of Washington, a Democrat, recently removed 17,500 adults covered under Basic Health, a state-financed plan for the working poor. In Arizona, Gov. Jan Brewer, a Republican, proposes to remove up to 250,000 childless adults who have been insured by her state's Medicaid program under a decade-long agreement with the federal government.

Medicaid, which is financed jointly by state and federal governments, primarily covers low-income children, parents and the disabled. Most states do not now offer coverage to childless adults, but starting in 2014, the new federal health care law will require them to expand Medicaid to insure adults earning up to 133 percent of the poverty level.

Former Gov. Tom Ridge, a Republican, started Pennsylvania's adultBasic program in 2001 to cover those who earned too much to qualify for Medicaid but too little to afford private insurance.

Originally supported with national tobacco litigation proceeds, the policies were made available to adults who earned up to twice the federal poverty level (which would be \$21,780 this year).

When the tobacco money started to dwindle, Mr. Rendell negotiated a deal with the state's four nonprofit Blue Cross/Blue Shield insurers, which had been accumulating large surpluses. The Blues agreed to contribute to the plan to show they were fulfilling the charitable obligation that accompanies their tax-exempt status. The agreement expired on Dec. 31.

Over six years, the Blues provided \$542.7 million to the plan, and \$356.5 million more to other state health programs. They agreed last year to add \$51 million to help maintain coverage through the fiscal year, which ends in June. It was not nearly enough.

The program's revenue streams have never met more than a fraction of its demand, which has soared in the economic downturn. When the program closed, 505,000 people were on its waiting list, nearly seven times as many as in early 2007.

In an interview, Kevin Harley, a spokesman for Governor Corbett, called the program's closing "unfortunate," and then quickly blamed Mr. Rendell. He said the former governor had pledged to find \$56 million to sustain the plan as part of last year's deal with the Blues, but never did.

Donna Cooper, who was Mr. Rendell's secretary of policy and planning, and the senior official in those negotiations, called Mr. Harley's assertion "just wild."

"That is patently untrue," said Ms. Cooper, now a senior fellow at the Center for American Progress. "That commitment was never made."

Mr. Corbett met with the Blue Cross plans, but did not persuade them to make additional contributions. "My understanding is that the Blues were not willing to continue," Mr. Harley said. "They fulfilled all their obligations under the law."

The Obama administration rejected the state's request to allow refugees from adultBasic to qualify immediately for the high-risk insurance pool authorized under the federal health law. Kathleen Sebelius, the secretary of health and human services, responded that she could not waive the law's requirement that applicants be uninsured for six months.

In Harrisburg, the state capital, Democratic legislators proposed to keep the program alive by seeking \$25 million each from the Blues and the state, and by nearly doubling premiums. The Republicans, who control both houses of the General Assembly, have expressed no support.

"At the end of the day, the Blues are not willing to do it," said Senator Jay Costa Jr., the minority leader, "and the administration is not willing to put the strong arm on them to get them to participate in the way that Governor Rendell did."

The Blue Cross/Blue Shield plans continue to run substantial surpluses, rising to a cumulative \$5.6 billion in 2009 from \$3.5 billion in 2002, according to the Pennsylvania Budget and Policy Center, a research group that advocates for low-income families.

But the insurers say their obligation to pay for a state program has ended. "Our support to adultBasic was always a temporary financing mechanism," said Aaron Billger, a spokesman for Highmark Blue Cross Blue Shield, the largest of the state's plans. "We have long told the state that it was unsustainable."

As the program's shutdown loomed, many enrollees scurried to schedule doctors' appointments and procedures. Mr. Kewley had his blood checked, and asked for new prescriptions. Roseanne Davis, a mother of two from Perkasio, scheduled a hysterectomy for Monday, her final day with coverage.

Doctors had discovered a benign ovarian cyst in January, but told her it did not have to be removed immediately. "I said, let's get this done before I roll off insurance," Ms. Davis said. "Down to the last day."

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February 16, 2011

VIA FAX (717-772-1969, 772-2062)

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**RE: Termination of the adultBasic Insurance Program
And Enrolling Those Eligible for Medical Assistance**

Dear Mssrs. Consedine and Alexander:

We represent many of the 41,000 low-income Pennsylvanians who are scheduled to lose their adultBasic health insurance at the end of this month. These beneficiaries—generally working adults earning less than 200% of the federal poverty income guidelines—have received letters from the Pennsylvania Insurance Department notifying them of their termination from this state health insurance program. The termination letter sent by Deputy Commissioner Peter J. Adams informed recipients that “you may qualify for Medical Assistance (MA),” the safety-net, health insurance program administered by the Department of Public Welfare (DPW). However, the letter provided no additional information as to how to establish eligibility for MA or offered any type of individualized pre-termination assessment and assistance for those affected to be enrolled in MA without any loss in health insurance coverage. We believe these omissions are unlawful and must be corrected. By this letter we are requesting a meeting with you at your very earliest convenience.

The Medical Assistance program offers coverage in approximately fifty different categories based on, among other things, an individual’s income, assets, family size, age, pregnancy, and disability. The Commonwealth, its contracted adultBasic insurers, and its medical providers currently have information on adultBasic recipients that would determine, or help to determine, which adultBasic recipients continue to be eligible for Medical Assistance. We would estimate that it is likely that more than 50% of adultBasic beneficiaries are eligible for MA.

Under Department of Insurance policy, an application for adultBasic constitutes an application for Medical Assistance. This practice is referred to as “any form is a good form.” “Information submitted on an adultBasic application will be used to apply for Medicaid and information provided on a Medicaid application will be used to apply for adultBasic.”¹ AdultBasic Policy and Procedures Manual (Mar. 2009) § 9.5.

Thus all adultBasic beneficiaries subject to termination must be viewed as having already applied for Medical Assistance. This has created a reasonable expectation among adultBasic beneficiaries that if the adultBasic benefit might expire they would still have a viable MA application filed that would be decided upon by the state before any loss in health insurance coverage.

The Insurance Department termination letter ignores this fact. To the contrary, it assumes that those who might be MA eligible would have to make their own inquiries and make a new application for MA after their adultBasic termination, a process that could lead to a great delay in receiving MA, even assuming that the application were properly processed. To make matters worse, many MA applications are currently delayed or improperly denied due to extraordinary staff demands on DPW’s local County Assistance Offices.

Among those on adultBasic who should be immediately transferred to MA include:

- Women who have become pregnant (for whom the adultBasic program is paying for prenatal or delivery care);
- Adults who have a disability, including those on Social Security Disability Insurance awaiting Medicare enrollment, and those who are working and are therefore eligible for Medical Assistance for Workers with Disabilities (often easily identified by their receipt of disability benefits and reported earnings);
- Those who have turned age 59 and are therefore eligible for state-funded Medically Needy Only coverage;
- Women who have been diagnosed as having breast or cervical cancer and are therefore eligible for a special federal MA program;

¹Federal guidance from the Center for Medicare & Medicaid Services (CMS) requires state Medicaid agencies to affirmatively evaluate a Medicaid recipient’s eligibility for other Medicaid categories prior to terminating her from one category. “If the ex parte review does not suggest eligibility under another category, the State must provide the individual a reasonable opportunity to provide information to establish continued eligibility. As part of this process, the State will need to explain the potential bases for Medicaid eligibility (such as disability or pregnancy).” Dear State Medicaid Director Letter, Health Care Financing Administration (now CMS) (Apr. 7, 2000), available at <https://www.cms.gov/smdl/downloads/smd040700.pdf>. Because termination of all public health insurance programs have similar repercussions—that is, it frequently ends an individual’s access to critical medical care—we believe that CMS’s directive should extend to the adultBasic program as well, to ensure that individuals who qualify for Medical Assistance receive it.

- Women between 18 and 44 who would qualify for the Select Plan for Women, a federal program that covers family planning and gynecological services and which includes the same income eligibility rules as adultBasic; and
- Those who received free or reduced price care through adultBasic, including the value of the coverage itself, who can use the value of those benefits to meet a spend down requirement of Medical Assistance.

Recipients who have used adultBasic to treat potentially disabling conditions need to be given an opportunity to establish their disability by being provided a DPW Employability Assessment Form (PA-1663) that would enable DPW to determine eligibility for MA in one of the disability categories.

With regard to all those adultBasic beneficiaries found eligible and enrolled into MA, you should be apprised that there is a greatly enhanced federal matching of funds available through June 30, 2011 of 68.95% for all such individuals, versus, currently, no federal funding being provided to the adultBasic population.²

Individualized assessment as to whether a current adultBasic beneficiary is eligible for Medical Assistance is also required by the Due Process Clause of the state and U.S. Constitution and the Americans with Disabilities Act.

In 1994, the General Assembly enacted Act 49 to significantly reduce the number of categories under which an individual could receive cash assistance under the General Assistance (GA) program, which largely depended upon a determination of disability. In response to litigation, the Department of Public Welfare, after the issuance of a class-wide Temporary Restraining Order, entered into a stipulation that required the DPW to screen each GA recipient facing termination to determine whether he or she continued to be eligible for GA under a different category. Lind v. Snider (No. 94-CV-4840, Stipulation of Settlement approved by Judge Shapiro, E.D. Pa., Sept. 21, 1994). This orderly, individualized screening used a variety of data accessible from DPW's own records and the records of its contracted medical providers. As a result of this screening, individuals facing termination who continued to meet the eligibility criteria for GA under a different category did not experience a loss of ongoing benefits.

We believe that the underlying principle in the Lind settlement is fully applicable here to prevent any loss of health insurance coverage for the many people on adultBasic who would qualify for ongoing health insurance coverage under the Medical Assistance program. For your convenience, we have enclosed Judge Norma Shapiro's Orders and the Stipulation from Lind.

In addition, we believe that the Americans with Disabilities Act (ADA), 42 U.S.C.A. § 12.132 (West 2011), is applicable in the termination via a mass mailing of a class of persons, many of whom are living with a disability. The Department of Insurance's reliance on a written notice that is confusing or incomprehensible to large numbers of adultBasic recipients, especially those with limited cognitive and comprehension abilities due to their disabilities or who have visual

² From July 1 to Sept. 30, 2011 the federal match becomes 55.64%. See <http://aspe.hhs.gov/health/fmap11.pdf>

impairments, will thwart the ability of disabled adultBasic recipients from separately applying for, and establishing eligibility for, Medical Assistance.

Similarly, those adultBasic beneficiaries with cognitive and physical disabilities will have great problems navigating the complex MA application procedures of DPW at the local County Assistance Offices. A Pennsylvania court has made clear that a state agency has affirmative duties to assist a disabled person to access the eligibility application process of the agency. *See Manley v. Office of Vocational Rehab.*, 654 A.2d 25 (Pa. Commw. Ct. 1994). The Department of Insurance and DPW must “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability.” 28 C.F.R. § 35.130(b)(7) (2011).

The U.S. Dept. of Justice Title II Technical Assistance Manual, that establishes national ADA policy in this area, specifically applies the “reasonable modifications” to the application processes for local and state government benefits. This includes, “an obligation to make reasonable modifications to its application process to ensure that otherwise eligible individuals are not denied needed benefits....providing applicants who have mental disabilities with individualized assistance to complete the process.” *See* Manual § II-3.6100. The state has violated the reasonable accommodation requirement by failing to establish processes to help disabled people apply for and get enrolled into MA, including telling people that they have a right to get individualized and where they can get such help.

We therefore ask that the Insurance Department take steps immediately to delay any terminations of those on adultBasic until the Insurance Department in conjunction with DPW and their agents and contractors have determined who is eligible for MA and then ensure a continuity of health insurance coverage under MA. Terminations must also be delayed under ADA grounds until the Insurance Department and DPW and their agents and contractors can demonstrate that they have provided adequate notice under the ADA and a process for providing reasonable accommodations to individuals with disabilities who need assistance applying for MA.

We would look forward to working constructively with DPW and the Insurance Department, in a role similar to the one that we played in the Lind litigation, to help the agencies identify the data sources and shape the procedures that would be utilized to undertake these screenings. But we believe firmly that to ensure this fair treatment of these individuals, the planned terminations must be temporarily halted, and notices immediately sent to all adultBasic beneficiaries that their health insurance will continue until these screenings are completed.

We look forward to your most prompt reply to this request given the time exigencies of this matter, and the prompt scheduling of a meeting either in person or by telephone conference call.

Sincerely yours,

Jonathan M. Stein
General Counsel

Enclosures.

February 16, 2011
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CC: Stephen Aichele, General Counsel, Governor's Office
Todd Shamash, Deputy Chief of Staff, Governor's Office
Amy Daubert, Chief Counsel, Insurance Department
Allen Warshaw, Chief Counsel, Department of Public Welfare
Peter J. Adams, Deputy Commissioner, Insurance Department



Seizing Opportunities in Tough Economic Times: Using Federal Funds to Preserve Health Insurance Coverage for Thousands of Pennsylvanians while Reducing the State Budget

In the coming weeks and months, Governor Corbett and the Pennsylvania legislature will face tough decisions about the Commonwealth's budget. Fortunately, recent changes to federal law allow lawmakers to do the seemingly impossible: preserve health insurance coverage for tens of thousands of Pennsylvanians while saving money for the Commonwealth.

This paper outlines the path that Pennsylvania lawmakers may take to draw down federal funding to preserve health insurance coverage. Section One highlights the applicable federal law. Section Two provides an overview of the Pennsylvania Medicaid program that is eligible for an infusion of additional federal funds. Section Three discusses how lawmakers could apply the federal law to adjust the Pennsylvania Medicaid program to ensure cost savings.

I. Early Medicaid Expansion under the Affordable Care Act

The Affordable Care Act will require states to offer Medicaid coverage to individuals with incomes less than 133% of the federal poverty level (FPL) (for single people, about \$1,200 per month), beginning on January 1, 2014. The Act also allows states to "phase in" Medicaid coverage to this population gradually.¹ In other words, states may choose to offer Medicaid coverage to individuals at any income level at or below 133% of the FPL before 2014. In exchange, states will receive reimbursement from the federal government at their regular Medicaid matching rates.

The option to offer Medicaid coverage under the Affordable Care Act is very flexible, but it does have some requirements. For example, states must cover all individuals at or below the selected income level. This is a departure from most Medicaid programs, which require Medicaid recipients to fit into certain eligibility categories (e.g., pregnant women, adults with disabilities, or adults with dependent children).

Effective January 1, 2014, the Affordable Care Act sets out a new way to calculate income eligibility for Medicaid, by calculating an individual's modified adjusted gross income (MAGI). If states choose to offer Medicaid coverage earlier, however, they may use any reasonable income methodology that is simple to administer and in the best interest of consumers.² States may not consider an individual's assets in evaluating eligibility.

If states choose to offer Medicaid coverage under the Affordable Care Act, they will receive reimbursement at their regular federal medical assistance percentages (FMAP).³ States that choose to phase in coverage under the Act prior to 2014 will still receive full (100%) federal

funding for the covered individuals from January 1, 2014 to December 31, 2016. Stated simply, beginning in 2014, individuals will generate the same FMAP regardless of whether their states phased in coverage for them prior to that date.

II. State-Funded Medical Assistance in Pennsylvania

Until January 1, 2014, the federal Medicaid statute requires or allows states to make federal Medicaid coverage available to certain categories of low-income individuals, including children, pregnant women, adults with minor children, SSI recipients, and adults aged 65 or older. The federal government reimburses states for a percentage of the costs of providing the care.

Some states, including Pennsylvania, extend coverage to small segments of their populations with additional state funding. For example, Pennsylvania provides state-funded Medical Assistance coverage to very low-income individuals who have particular need for health insurance, but who do not fit into one of the federal Medicaid categories. Individuals who are eligible for state-funded coverage include disabled adults who have applied for benefits from the Social Security Administration, caretakers for disabled household members, survivors of domestic violence (for up to nine months in a lifetime), and persons undergoing drug and alcohol treatment (for up to nine months in a lifetime).

To qualify for this type of state-funded Medical Assistance coverage, applicants must have very low incomes. The income limits vary slightly by county, but are approximately \$200 per month for a single person, or 23% of the FPL.⁴ These Medical Assistance recipients also may be eligible to receive a small amount of cash assistance, or General Assistance (GA), so recipients are said to be enrolled in “GA-related MA.”

Approximately 100,000 Pennsylvanians rely on GA-related MA for their health care coverage. Since the recession began in December 2007, Pennsylvania has experienced sizable growth in many of its federal Medicaid programs (albeit at a much slower rate of growth than the national average – that is, 8.4% in Pennsylvania versus 13.6% nationwide).⁵ However, enrollment in GA-related MA programs has remained relatively steady, probably because the income limit is so low.

Because GA-related MA is a state-run program, Pennsylvania is not eligible to receive FMAP reimbursement. Pennsylvania does receive other federal funding that subsidizes the program, however. For example, federal Medicaid disproportionate share payments (sometimes called DSH or “dish” payments) help to offset the costs of providing care to large numbers of Medicaid or Medical Assistance recipients and the uninsured. Recent data from the Department of Public Welfare indicates that, with this additional federal funding, the GA-related MA program costs \$203 million in state funds per year.

During previous budget crises, lawmakers have considered cuts to GA-related MA as a source of budget savings. In 2005, for example, the Rendell Administration proposed sweeping service cuts to the program to address a sizable budget shortfall. After months of debate,

however, the Legislature chose to make less significant service cuts. Legislators were persuaded to keep GA-related MA largely intact by health care providers, including the Hospital and Healthsystem Association of Pennsylvania, who feared that service cuts would push low-income recipients with significant health needs into emergency rooms for treatment, boosting costs for providers and consumers and threatening the viability of many hospitals.

III. Early Medicaid Expansion in Pennsylvania

Most states, like Pennsylvania, are grappling with budget shortfalls as a result of the recession. The states that have elected to phase in federal Medicaid coverage gradually under the Affordable Care Act are states that, like Pennsylvania, offer state-funded Medical Assistance coverage and therefore would benefit from drawing down new federal funds. These states have chosen to convert their state-run programs into federal programs, thereby receiving FMAP reimbursement and saving money. Most recently, in early January 2011, Minnesota joined Connecticut and Washington, D.C. in converting a state-funded program into a federal program under the Act.

Pennsylvania could follow suit by converting GA-related MA into a federal Medicaid program. The conversion could be accomplished if the Department of Public Welfare filed a Medicaid State Plan amendment with the federal Centers for Medicare and Medicaid Services. The conversion would entitle Pennsylvania to receive federal reimbursement for approximately 55% of the costs of the GA-related MA program, or \$112 million of the \$203 million program.

In exchange, Pennsylvania would have to expand eligibility to all persons living at or below the GA-related MA income level, which is approximately \$200 per month for a single person (23% of the FPL). In other words, recipients of GA-related MA would not be required to fit into the existing categories of eligibility. This expansion might lead to new enrollees, offsetting some savings. In all likelihood, however, the number of new enrollees would be minimal: the stability of GA-related Medicaid enrollment numbers at a time when other public benefits programs are experiencing great demand indicates that the program serves a fixed population of extremely poor, high-need individuals.

We urge the Corbett Administration, with support from the Pennsylvania Legislature, to convert GA-related MA into a federal Medicaid program under the Affordable Care Act. GA-related MA is a vital program, not just for individuals who urgently need medical coverage, but for the health care providers who serve them, including physicians, hospitals, health clinics, and drug and alcohol treatment centers. At the same time, we recognize the serious budget problems that Pennsylvania faces. The conversion of GA-related MA provides lawmakers with a rare “win-win” opportunity to preserve health insurance coverage for tens of thousands of Pennsylvania residents while saving money, and we urge lawmakers to seize that opportunity.

For more information, please contact Kristen Dama of Community Legal Services at (215) 981-3782 or kdama@clsphila.org, or Laval Miller-Wilson of the Pennsylvania Health Law Project at (215) 625-3990 x 106 or lmiller-wilson@phlp.org.

¹ Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, § 2001(a)(4), 124 Stat. 119, 274 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

² For federal guidance on income eligibility rules and other aspects of early Medicaid expansion under the Affordable Care Act, see Centers for Medicare & Medicaid Services, Dear State Medicaid Director Letter (April 9, 2010), *available at* <https://www.cms.gov/smdl/downloads/SMD10005.pdf>.

³ For the federal 2010-2011 fiscal year, Pennsylvania's FMAP is 55.64%. *See* Notice, 74 Fed. Reg. 62315, 62317 (Nov. 27, 2009).

⁴ The Pennsylvania counties with the highest income limits for GA-related MA are Bucks, Chester, Lancaster, Montgomery, and Pike Counties. Households of one receive \$215 per month, or 23.8% of the FPL. Households of two receive \$330 per month, or 27.1% of the FPL. Cash Assistance Handbook ch. 168, app. C, *available at* http://services.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ca/168/168_C.htm#P13_95.

⁵ Kaiser Family Foundation, Medicaid Enrollment Growth during the Economic Recession, Dec. 2007 to Dec. 2009, <http://www.statehealthfacts.org/comparemapreport.jsp?rep=73&cat=4> (last visited Jan. 20, 2011).

Testimony of The Rev. Jake Waybright
Chair, United Methodist Advocacy in Pennsylvania
March 3, 2011
House Democratic Policy Committee

Thank you for the opportunity to appear before you today.

My name is Jake Waybright.

I am chair of United Methodist Advocacy in Pennsylvania and pastor of Middlesex United Methodist Church near Carlisle.

United Methodist Advocacy is the social justice arm of the 2,400 United Methodist congregations in Pennsylvania. There is a United Methodist Church in virtually every community across the Commonwealth. We have nearly 500,000 members.

We strongly believe Pennsylvania has an obligation to the 42,000 persons who lost their adultBasic insurance coverage this week, and the half-million more who were on the waiting list.

We believe this is a moral obligation. To not do everything possible to find a way to continue insurance for those 42,000 persons, and to help those on the waiting list borders on immoral.

The United Methodist Church believes access to health care is a human right. No one in our country should be forced to go without health care because of his or her economic circumstances or pre-existing health conditions.

That is especially important to the persons who depended on adultBasic. They were already in problematic circumstances because of health conditions and other issues. The waiting list is a clear demonstration of the need for affordable health insurance for those who are on the margins.

We know Pennsylvania – like every other state – is in a difficult financial situation. Governor Corbett did not create this problem. It was one of the challenges that came along when he recited the oath of office in January.

Our message to Gov. Corbett: Please try to find a solution to this problem. Lives are at risk. Please bring the Blues to the table and find a way to make this work.

As non-profit organizations, the Blues have an obligation to serve the needs of the greater public. They have a sacred public trust to give back. They have a history of producing significant surpluses. It is just unfortunate that they have not been more willing to tackle this problem.

Pennsylvanians are caring and creative people. Since the days of William Penn we have been good at solving problems and meeting challenges.

One of the lessons of this past year's election is that people are tired of politics as usual. They are seeking solutions to problems. They want the arguing to end and cooperation to become the byword.

That is why this problem should not be about politics. It should not be about philosophy. It should not be about Republicans or Democrats.

It should be about Pennsylvanians taking care of one another. It should be a matter of finding a solution to help people in need

To us, it is also a matter of faith.

In Ezekiel 34, verse four, God points out the failures of the leadership of Israel to care for the weak: "You have not strengthened the weak, you have not healed the sick, you have not bound up the injured." It was a failure God considered very seriously.

From our earliest days United Methodists have believed that providing health care to others is an important duty of Christians. Our founder, John Wesley, found ways to offer medical services at no cost to the poor in London.

If Wesley could do that then – when times were much more difficult – then surely we can find a way to help those who depend on adultBasic for their health care.

Thank you for the opportunity to offer our perspective to the committee.