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HOUSE DEMOCRATIC POLICY COMMITTEE

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Affordable Health Care

Wilkes University – Wilkes-Barre, PA

February 28, 2019

AGENDA

- 10:00 a.m. Welcome and Opening Remarks
- 10:10 a.m. Dr. Anthony Aquilina
Regional President
Geisinger Northeast Region
- 10:40 a.m. Patrick Keenan
Policy Director
Pennsylvania Health Access Network
- 11:10 a.m. Closing Remarks

Testimony on Healthcare Affordability in Pennsylvania to the House Democratic Policy Committee

*Given by Patrick Keenan, Director, Consumer Protections & Policy
February 28, 2019, Wilkes-Barre, PA*

Good morning Representative Pashinski and members of the committee. Thank you for this opportunity to discuss something that weighs heavily on the minds of all Pennsylvanians: affording the rising costs of healthcare. Our organization, the Pennsylvania Health Access Network, is a consumer-led organization working towards high quality, equitable, and truly affordable healthcare for all Pennsylvanians. Each year, we answer nearly 10,000 calls and regularly work with consumers in 61 of the commonwealth's 67 counties. It is not uncommon that people come to us frustrated, discouraged, and-- too often--- frightened about whether or not they can get the care they need.

While we track these interactions and compile our own data, we felt it was important to have an accurate, non-biased picture of the problems Pennsylvanians were facing with healthcare. Through funding from the Robert Wood Johnson Foundation, the Pennsylvania Health Access Network partnered with Altarum's Healthcare Value Hub during the last quarter of 2018 to conduct the first-ever study of healthcare affordability in Pennsylvania. This study included a representative sample of all adults in Pennsylvania across all insurance types, including the uninsured, and across all regions of Pennsylvania. We have been able to create regional reports thus far for all regions except the Northwest that compares and contrasts geographic variations in the data.

The findings of this study are not surprising and yet profound:

- Half of Pennsylvania's adults have struggled to afford healthcare in the past year. This includes: struggling to pay bills, going uninsured due to high premium costs, or being unable to get the care they needed due to costs. For a majority of Pennsylvanians, some part of our current system did not work for them in the past year, jeopardizing their health, financial stability, employability, or family life.
- 4 in 5 are worried about affording healthcare in the future. For a state with a rapidly aging population, this is not a good sign. We have some of the highest quality healthcare available to us in the country, and yet most of Pennsylvanians are uncertain as to whether the door to that healthcare will be open or closed, based on their insurance and ability to pay.

What does this mean for ordinary Pennsylvanians? Our family, friends, and neighbors? The data is compelling:

- Nearly 1 in 3 delayed getting care.
- 1 in 4 either avoided care altogether or skipped a recommended test or treatment.
- 1 in 5 did not fill a prescription.
- 1 in 6 skipped doses or cut pills in half.

Cost was by far the most frequently cited reason for not getting needed medical care, exceeding a host of other barriers, such as transportation, difficulty getting appointments, lack of childcare, or others.

For those who went uninsured, high premium costs were the number one reason for not having coverage, far exceeding reasons like “don’t need it,” or “don’t know how to get it.”

Lastly, for those who did get care, they often faced a struggle paying the resulting bill. Thirty-two percent of Pennsylvania adults struggled to pay a medical bill in the past year. Besides the psychological harm this has done to them, there have been real world consequences generated by medical debt:

- 15% of Pennsylvania adults have been contacted by a collection agency
- 12% used up all or most of their savings.
- 10% were unable to pay for basic necessities like food, heat, or housing
- 7 to 8% either racked up large amounts of credit card debt or borrowed money

The high cost of healthcare is putting people in perilous financial situations, even if they have insurance. Because of these challenges, people are likely to get sicker, or preventable conditions may go untreated.

As a note for you, Representative Pashinski, each of these statistics in the Northeast and North Central regional was either equal to, or a couple points below that statewide numbers, but still just as serious and significant.

Given these numbers, it’s not surprising that 4 out of 5 adults, across party lines, are dissatisfied with our current state of affairs. Even more, 9 out of 10, again, across party lines, support a broad array of solutions. It’s also important to note that Pennsylvanians spread the blame across actors: 76% say drug companies charge too much, 72% say insurance companies charge too much, and 70% say hospitals charge too much. In other words, tackling one sector alone will still not solve all of Pennsylvania’s problems.

At levels of support above 90%, respondents endorsed making it easier to switch insurers if a health plan drops your doctor, showing a fair price for specific procedures, requiring insurers to provide upfront cost estimates to consumers, and authorizing the Attorney General to take legal action on unfair prescription drug price hikes.

We also saw bipartisan support for action directed at the rising cost of prescription drugs. With overall support at 90%, 88% of Republicans, 92% of Democrats, and 89% of Independents said the government should require drug companies to provide advance notice of price increases and justify those increase.

Similarly, with overall support at 88%, 86% of Republicans, 91% of Democrats, and 86% of Independents said the government should set standard prices for drugs to make them affordable.

The report concludes with the following: “The high burden of healthcare affordability along with high levels of support for change suggest that elected leaders and other stakeholders need to make addressing this need a top priority.” We urge you to take these matters seriously.

In closing, I'd like to offer some particularly helpful actions Pennsylvania should take in this legislative session:

- **End surprise medical bills.** Pennsylvania should adopt a measure that protects consumers from unavoidable, inadvertent balance billing in both emergency and non-emergency situations. Such a measure should keep consumers out of the middle, pay providers fairly, maintain high quality networks, and not drive up premiums. The General Assembly has considered such a measure in the previous two sessions, and its time we deliver this common sense protection to Pennsylvanians. Pennsylvanians should not live in fear that they will get a large, unexpected bill from a provider they did not know was out-of-network.
- **Restrict Short-Term Limited Duration Plans.** The Trump Administration recently made it easier for consumers to purchase these plans that fail to offer real health coverage to consumers. They are not required to cover pre-existing conditions, they can cap or limit the kinds of care that you can get, they can exclude many routine or common procedures or medications, and they can impose restrictions on covered care. Consumers need clear, upfront notice of the potential harm these plans create. The Commonwealth should also impose a specified term equal to 3 months on these plans, limit renewability, and prevent "stacking" these plans. We should return these plans to their namesake: short term and limited duration. Doing so will help us maintain a healthy risk pool in the individual insurance market and lower premiums. Doing so ensure that more people can purchase insurance at a lower rate.
- **Create a targeted, temporary state-based reinsurance program.** Pennsylvania has benefitted from a marketplace that is more stable than other states, however, we could easily pursue a solution that would level out some of the large year-to-year fluctuations in premiums and foster additional competition. Models at both the federal level and in other states have proven effective. This, too, would reduce premiums.

Once we increase enrollment in our individual and small group markets, we should explore ways to increase consumer choice. Pennsylvania has a strong Medicaid managed care system that has been effective for over two decades. We should consider whether pursuing a Medicaid buy-in to create a public option would help improve choice and further drive down costs.

It is also important given the uncertainty at the federal level created by the *Texas v. Azar* case that Pennsylvania protect people with pre-existing conditions by codifying at the state-level guaranteed issue and community rating protections. We should also require all plans in the Commonwealth to cover the Essential Health Benefits. Lastly, at the state-level, we should outlaw lifetime or annual limits.

Many of these actions target the insurance market and I do not want this committee to only consider actions in that area. We at the Pennsylvania Health Access Network saw the overwhelming demand for action on prescription drugs across party lines and have begun to form the Pennsylvania Coalition for Fair Drug Pricing. It supports solutions that focus on achieving fair, affordable drug prices through state-based action and calls on lawmakers to:

- Develop clear, current, and actionable data on drug prices.
- Leverage existing market dynamics to help more employers, government entities, and hospitals negotiate with drug companies; and

- Consider creating an entity specifically tasked with developing and implementing Pennsylvania-based solutions to high, unaffordable, and rapidly rising drug costs. We hope this committee will devote some specific time to the issues surrounding drug pricing and drug manufactures in the near future.

Besides healthcare affordability, few issues have such a broad and lasting impact on your constituents. We appreciate your concern. Thank you again for your time and I am happy to take your questions.

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Testimony on the Affordable Care Act

**Jessica K. Altman
Commissioner
Pennsylvania Insurance Department**

House Democratic Policy Committee

February 28, 2019



Chairman Sturla and members of the House Democratic Policy Committee, I would like to thank you for the opportunity to submit this testimony on behalf of the Pennsylvania Insurance Department to elaborate on the value of the Affordable Care Act (ACA). My testimony covers some of the key provisions of the ACA that are designed to help protect consumers, make health care more affordable and stabilize the insurance market across the country. I would like to also thank Representative Pashinski for being an ardent supporter of the ACA and for hosting the hearing in his legislative district.

We should take a moment to recognize the impact that the ACA has had on Pennsylvanians; that begins with remembering what our health care system looked like prior to the ACA's enactment. Before the ACA, sick people couldn't get health insurance due to a pre-existing condition, or if they were able to pay the expensive cost for the coverage, often their pre-existing condition would not be covered under the policy. Individuals with chronic medical issues or anyone who underwent a costly procedure, like a transplant, could face annual or lifetime limits leaving them in financially devastating circumstances. Women would often see higher coverage costs than men and perhaps not have had access to contraception or maternity care coverage. Finding coverage for other critical services like mental health and substance use disorder treatment services and prescription drugs was often difficult, if not impossible. Most importantly, more than 10 percent of Pennsylvanians went uninsured during that time.

Since the ACA's enactment and according to the most recently released Census data, Pennsylvania's uninsured rate has dropped to 5.5 percent – the lowest rate in our state's history. Over 1.1 million Pennsylvanians have access to coverage only available because of the ACA, and the current coverage is much more comprehensive than before because of protections required by the ACA. 5.4 million Pennsylvanians cannot be denied health insurance coverage due to their pre-existing conditions, 4.5 million Pennsylvanians can access coverage so that they no longer have to worry about large bills due to annual or lifetime limits on benefits, and 6.1 million Pennsylvanians benefit from access to free preventive care services. Additionally, more than 175,000 Pennsylvanians have been able to access substance use disorder treatment services through the marketplace and Medicaid expansion coverage. This is critical as our Commonwealth strives to combat the overwhelming impact of the opioid crisis.

In addition to these significant coverage gains, the ACA fundamentally changed the way that insurance works, particularly in the individual health insurance market, by establishing consumer protections that had never been required by law. Each of these protections has made coverage more reliable and accessible to



consumers and it is important to understand how each of these aspects has re-shaped our health insurance markets since the passage of the ACA.

Pre-existing conditions

A Kaiser Family Foundation analysis¹ about a year and half ago found that 52 million adults under 65 – or 27% of that population — had pre-existing health conditions that would likely make them uninsurable if they applied for health coverage under medical underwriting practices that existed in most states before insurance regulation changes made by the ACA. In Pennsylvania, the analysis also estimated that 27% of non-elderly adults have conditions that would likely result in coverage being declined if they were to seek coverage in the individual market under pre-ACA underwriting practices.

With over one in four Pennsylvanians having a potentially deniable condition, it should be of no surprise that these conditions are common and well known to many of us. Whether it be a child with asthma or diabetes, a mother who previously had breast cancer but has been in remission for a decade, or a father with high blood pressure, people with pre-existing conditions are our family members, our neighbors, our colleagues and our friends.

The ACA made it illegal to deny these individuals coverage, to exclude coverage for care related to their pre-existing conditions, or to charge more for providing coverage because of pre-existing conditions. It is unacceptable to consider returning to the pre-ACA world where these people could once again be shut out of our coverage system. As modifications to existing insurance laws at the federal level are considered, those with pre-existing conditions should continue to be protected here in Pennsylvania.

Essential Health Benefits

Prior to the ACA's enactment, insurance companies could decide which benefits they wanted to cover, other than certain mandated state benefits that were limited in scope. As a result, certain categories of benefits that are necessary aspects of care for many people were commonly excluded from coverage. Mental health services, substance use disorder treatment, prescription drugs, and maternity care topped the list of critical benefits that were difficult if not impossible to find coverage for in the individual market.

¹ <https://www.kff.org/health-reform/press-release/an-estimated-52-million-adults-have-pre-existing-conditions-that-would-make-them-uninsurable-pre-obamacare/>

To ensure coverage being sold and subsidized by the federal government was truly comprehensive, the ACA required coverage of ten “essential health benefits” (EHBs), which include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Pennsylvanians need to know that the health insurance coverage they have will allow them to access necessary health care when they need it, and that means it should cover all the benefit categories necessary to meet their health care needs. Therefore, it is critical that health insurance coverage in the Commonwealth continue to be comprehensive and cover these benefits that are, truly, essential. This is especially relevant given the devastating impact of the opioid crisis that Pennsylvania is working hard to combat. Individuals and families struggling with addiction need to know that they will be able to access and afford treatment, and we cannot afford to risk returning to a time when these services were largely shut out of our coverage system.

Ban on Lifetime and Annual Limits

Prior to the ACA, an insurance plan could put a ceiling on how much it would pay for care under the policy, by medical condition or service, or globally, on an annual or lifetime basis. These limits adversely impacted those with the most significant health care needs – for example, those with chronic, complex conditions or expensive treatment regimens. Such limits were also not uncommon. In fact, prior to the ACA, in 2009, 59% of covered workers’ employer-sponsored health plans had a lifetime limit².

Since the passage of the ACA, insurance policies cannot include these limits. This means that, in concert with capping out-of-pocket costs as discussed below, insurance policies under the ACA are constructed to limit how much a patient will ever have to pay for their care, where before the ACA these caps were part of limiting how much the insurance company would ever have to pay.

Even with the ACA and these consumer protections, affordability of health insurance and health care is probably the number one concern we hear about. We should not return to a time when our system shifted costs from insurance companies to those with the greatest need, as these caps allowed.

² <https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7936.pdf>



Dependent Coverage

Prior to the ACA, it was not guaranteed that young adults could remain on their parents' health insurance policies through their early and mid-twenties. State law did ensure coverage through age 19 and allow coverage up to age 30, but did not require coverage for adult children into their 20s. This requirement is important because this age group can have relatively low income and experience significant life transitions as they pursue education and navigate the beginning of their careers. These factors can lead to young adults choosing to forego health insurance coverage thinking they will not need care. Ensuring these young adults have coverage not only protects them in the case of unexpected health care needs, but improves our system overall by incorporating relatively healthier individuals into the risk pool.

The ACA requires health plans to offer coverage to adult dependents up to age 26, providing parents with the opportunity to ensure their children have coverage and young adults with the security of knowing that coverage is available to them. An estimated 89,000 young adults in Pennsylvania have benefited from the ACA provision that allows dependents to stay on their parents' health insurance up to age 26. Dependent coverage should always be provided for all young adults, regardless of life circumstance and not at the whim of an employer, because it allows young adults to be better protected against unforeseen medical events, and protects them from facing unexpected medical debt.

Ban on Rescissions

Prior to the ACA, it was not uncommon for insurers to rescind health insurance coverage from an enrollee. Even unintended omissions or mistakes on applications for health insurance could cost people their health insurance coverage, retroactively as well as going forward. In these cases, primarily but not exclusively in the individual market, insurers typically required people applying for coverage to fill out lengthy, complicated forms soliciting information such as medical care received during the prior year (including all doctor visits, medications prescribed, and lab results), whether or not a person had specific conditions (such as heart disease, HIV, or ear infections), and requesting authorization for the insurer to review the person's medical records. The application might also include open-ended – "is there anything else we should know" – type questions. If the applicant were accepted and later filed a medical claim under the plan, the insurer could investigate whether the claim might be related to a medical condition the person already had — but inadvertently failed to disclose — when applying, and decline to pay the claim and retroactively rescind the policy.

The ACA banned such rescissions, only allowing insurers to rescind coverage in cases of fraud or intentional misrepresentation by the consumer. If the rescission protections of the ACA were to be repealed, once again, insurers could pursue rescissions of coverage by comparing what a person said, or failed to say, on his or her application to what medical care they had received in the past and possibly terminate their health insurance coverage retrospectively. Individuals should have confidence in the reliability of their health insurance coverage and not face the unnerving process of a post-claims review of their medical history, fearful of losing their coverage even for unintended omissions or mistakes on applications for health insurance.

External Review

Prior to the ACA, there were some protections in state law to ensure appeal rights to consumers following coverage denials, claims denials, or other types of adverse determinations made by their insurance company. However, those protections were incomplete, most notably because they did not apply to all types of health insurance plans.

The ACA ensured that all policyholders have access to a clear and consistent process, including an expedited process in the case of a medical emergency, that allows for both internal appeals to the insurance company and a guaranteed right to an independent and binding external review performed by an entity not affiliated with their insurance company. Appeal rights are a critical part of ensuring insurance consumers have a remedy if they believe their insurance company is denying access to care that they need.

Maximum Out-of-Pocket

Prior to the ACA, individuals were not able to prudently budget for their health care costs, in addition to paying a monthly premium, individuals faced expenses associated with deductibles, co-payments and co-insurance to an unlimited extent. Out-of-pocket costs were particularly harmful for individuals who required considerable health care services, as each interaction with a health care professional generally required additional out-of-pocket payments on top of the monthly premium. Further, unanticipated, costly medical episodes could result in substantial debt for individuals that found themselves shouldering unlimited medical bills.

The ACA created a maximum out-of-pocket limit, which caps the costs a person will incur annually, in addition to their monthly premium, to receive health care services. These limits are based on the accumulation of all types of cost-sharing, including deductibles, co-pays and co-insurance, associated with



care received at in-network providers, ensuring that individuals with significant health care needs are protected from excessive costs. The maximum out-of-pocket is an important protection because it allows consumers to better prepare for unforeseen medical events and protects individuals who have secured health insurance coverage from facing unexpected medical debt.

Medical Loss Ratio

Prior to the ACA, the amount of an individual's premium that was actually spent on medical care was mostly a mystery – there was not an easy way for an individual to hold an insurer accountable to make sure their premium was used for medical care rather than profit. Because of the lack of transparency, certain profitable lines of business unfairly cross-subsidized less profitable lines at times, and consumers were powerless to challenge the use of their premium dollar.

The ACA instituted a minimum medical loss ratio (MLR) requirement for insurers to encourage accountability and transparency with regard to how an individual's premium is spent. MLR is a measurement of the portion of collected premium that is spent on administration, marketing and profits, measured against the portion spent on medical care. The ACA requires insurers to publicly report the portion of premium dollars spent on health care and quality improvement and other activities in each state in which they operate, and it sets a floor for how much of an individual's premium must be spent on actual medical care. Further, the ACA requires that if any insurer fails to meet the applicable MLR standard, they must refund to consumers any portion of the premium payment that should have been spent on medical care through rebates to consumers. In total, \$4 billion in medical loss ratio rebates have been issued across the individual, small group, and large group markets, across the country from 2012 to 2018 (based on insurer financial results from the 2011-2017 plan years). An MLR requirement is an important tool to ensure accountability and transparency in how premiums are spent.

Preventive Services

Prior to the ACA, insurers could charge cost-sharing (deductibles, co-payments and co-insurance) for preventive services, creating a disincentive for individuals to seek preventive care. Preventive care, such as immunizations and cancer screenings, is a necessary component of trying to control health care costs, as preventive services allow for access to and interactions with health care providers to stay healthy, rather than focusing on reacting to urgently treating health conditions at a catastrophic stage. Research has shown that evidence-based preventive services can save lives and improve health by identifying illnesses

earlier, managing them more effectively, and treating them before they develop into more complicated, debilitating conditions.

The ACA requires that health insurers cover, at a minimum, coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women. The coverage and cost provisions of the ACA preventive services allow individuals to continue to seek preventive care, avoiding the need to first treat conditions when presented at a more serious level, and unnecessary complications; and consequently helps to bend the health care cost curve downward. The federal HHS Assistant Secretary for Planning and Evaluation estimated that approximately 137 million people (55.6 million women, 53.5 million men, and 28.5 million children) nationwide received no-cost coverage for preventive services in the first year following the ACA's passage. Enabling access to routine preventive care allows individuals to live a life of higher quality by potentially avoiding catastrophic and expensive complications.

Governor Wolf's Leadership on Health Care Access

The Wolf Administration has worked tirelessly to improve health care access in the Commonwealth. The actions taken by the Administration began immediately upon entering office, and continue through today. To highlight a few, Governor Wolf has:

- Expanded Medicaid to provide comprehensive health care to more than a million Pennsylvanians previously without access to Medicaid.
- Increased choices for Pennsylvanians purchasing insurance in the individual market in 2019, as people in 31 of Pennsylvania's 67 counties have more health insurers offering coverage this year than last, the number of counties with just one health insurer offering coverage in the individual market decreased from 20 to eight, and Pennsylvania's individual market added a new insurer.
- Decreased premiums on average for individuals purchasing coverage through the individual market, generating a weighted, state-wide average decrease of 2.3 percent for individual market rates.
- Championed a comprehensive ACA open enrollment campaign that yielded overall steady enrollment numbers despite a reduction in funding from the Trump Administration.
- Educated and continues to caution consumers about the products that do not provide comprehensive coverage, such as short-term limited duration insurance.



The 2019 rate filings paint a positive picture for Pennsylvanians: The health insurers that currently sell in Pennsylvania's individual market will all stay in the market and their rate change requests indicate a stable market for 2019 plan year, with an average statewide rate increases of 0.7 percent.

Conclusion

We appreciate the opportunity to testify regarding the important, life-changing protections of the ACA. As the health care debate tends to risk the viability of many of the important provisions we have highlighted, we hope to engage and emphasize the importance of the ACA, which is distinct from the message of the detractors who have placed the certainty of the ACA's important protections at risk. The federal government has relentlessly attempted to throw the individual market off of the path toward stability and affordability, including by:

- Changing association health plan and short-term limited duration plan rules and messaging them as an alternative to major medical plans, while not highlighting the short-comings of these options.
- Shortening the open enrollment period, giving individuals less time to shop for and make informed decisions about their health insurance needs.
- Repealing the individual mandate, a key provision that requires most individuals to purchase health insurance coverage or pay a penalty, which helps to stabilize the market by broadening the pool of those covered.
- Reducing funding for the navigator program, a program that helps consumers and small businesses understand their new coverage options and find affordable coverage that meets their health care needs.
- Attempting numerous times to repeal and replace the ACA with proposals that do not seem to preserve protections for individuals with pre-existing conditions.

The combined effect of the above-mentioned decisions as well as pending lawsuits that seek to declare the ACA unconstitutional could lead to an environment that is similar to what existed before the ACA, where individuals find themselves unable to secure health insurance coverage, while our country's health care costs continue to grow at a rate that surpasses most economic measures of reasonability. We stand by to assist the legislature in educating others about the ACA's important provisions and serve as a trusted resource to those working to ensure these protections continue into the future.



Again, thank you for allowing me to submit this testimony to the committee. If you have any questions, please contact the Department's Legislative Director, Abdoul Barry, at (717) 783-2005.