Center on Budget and Policy Priorities

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TESTIMONY OF JUDITH SOLOMON
HOUSE BILL 700, THE PENNSYLVANIA HEALTH CARE REFORM ACT
HOUSE INSURANCE COMMITTEE
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Thank you for the opportunity to testify before you today on House Bill 700, the Pennsylvania Health Care Reform Act. My name is Judith Solomon. I am a Senior Fellow at the Center and work primarily on state Medicaid policy issues. I commend the Committee for providing an opportunity for substantial public input on this important bill.

Since 1981, the non-profit, non-partisan Center on Budget and Policy Priorities has worked at both the federal and state levels on fiscal policy and public programs that affect low- and moderate-income families and individuals. The Center conducts research and analysis to inform public debates over proposed budget and tax policies and to help ensure that the needs of low-income families and individuals are considered in these debates. The Center promotes fiscally responsible budgets at the state and federal levels, and is regarded as one of Washington's leading budget watchdog groups.

Over the last year, I have been following and analyzing the efforts states are making to expand health insurance coverage and reduce the number of uninsured state residents. While these plans have some similarities, they are not identical. Each plan is built on the needs and characteristics of the individual state, including the size and characteristics of its uninsured population along with the state's workforce, fiscal capacity, and insurance market. To be successful at the state level, a health care reform plan must carefully balance the needs and responsibilities of individuals, employers, insurers, health care providers, and government.

Like these other state plans, Pennsylvania's plan appears complex. It is important, however, that the plan be considered as a whole. Even though it appears to have a number of separate components, the provisions of House Bill 700 need to be considered as an integrated plan. As a whole, the plan would reduce the number of uninsured state residents through a new program called Cover All Pennsylvanians, while taking into account the state's fiscal capacity and the need to be mindful of how ERISA limits a state's choices in health care reform. The components of the plan are interdependent and making significant changes or eliminating any of the plan's key components could undermine the state's chance for a successful effort at achieving the goals of the plan to lower the costs of health care while at the same time raising quality and increasing affordability and accessibility.

In the time I have this afternoon, I cannot discuss all the components of the bill. I would like to make three main points, all relating to the need to preserve and strengthen key features of Pennsylvania's plan as set forth in the House bill:

- Why the state needs to redirect some of its disproportionate share hospital (DSH) funds in order to provide federal matching funds for the state dollars currently spent on the Adult Basic program.

- Why the insurance reforms included in the House bill are critically important.

- Why affordable and adequate coverage is essential to successful implementation of Cover All Pennsylvanians.

Federal Funding for Cover All Pennsylvanians

According to Governor Rendell's budget for Cover All Pennsylvanians, Pennsylvania is currently spending $83.5 million in state funds on the Adult Basic program. The state plans to obtain $104 million in federal Medicaid funds to match this state spending in order to provide subsidized coverage for Cover All Pennsylvanians. (The formula used in determining federal matching funds provides Pennsylvania with $1.19 for every state dollar it spends.) Federal matching funds provide the bulk of new funding for Cover All Pennsylvanians.

In order to receive federal matching funds, the state will have to obtain a Medicaid waiver. States can use waivers to obtain federal matching funds to cover adults without children who are under 65 and not disabled. These adults cannot be covered under Medicaid unless the state gets permission to cover them through a waiver. States can also use waivers to provide coverage in ways not usually allowed under Medicaid rules. For example, with some exceptions, Cover All Pennsylvanians will limit coverage to those who have been uninsured for a certain period of time. This is not usually allowed under Medicaid.

While waivers allow states to receive federal funds to provide coverage in ways not usually allowed under Medicaid, the federal government will not provide more federal matching funds than it would have in the absence of a waiver. Pennsylvania can meet this requirement of "budget neutrality" in two ways. The state could try to save money by making changes to its current Medicaid program and use the federal funds it would have received without the savings to subsidize coverage for newly eligible individuals. The other way the state could meet the budget neutrality requirement is to divert some of its disproportionate share hospital (DSH) funds and use these funds to subsidize coverage for low-income Pennsylvanians. (DSH funds are provided to states to help them support hospitals that care for large numbers of uninsured patients and Medicaid beneficiaries.)

It would be very difficult for Pennsylvania to meet the budget neutrality requirement by saving money in its existing Medicaid program without negatively affecting coverage for existing Medicaid beneficiaries. Pennsylvania already enrolls most beneficiaries in some form of managed care, which is the method many states used in past years to free up funds to cover childless adults, so this would not be an effective strategy for Pennsylvania. However, Pennsylvania reportedly has $90 million in *unspent* DSH funds. These are funds allocated to Pennsylvania that the state has not drawn down and are not currently being used to assist hospitals that provide care to the uninsured. Pennsylvania can use the state funds currently spent on Adult Basic as the state funds needed to draw down these federal matching funds.

By using mostly unspent DSH funds to meet the budget neutrality requirement, the ability of safety net hospitals to continue to provide care for residents who remain uninsured should not be impaired. Over time as more residents become insured, the state could shift more of its DSH funds to provide subsidies, because at that point the hospitals would receive increased reimbursement from insurance coverage. As more people have coverage, the demand for uncompensated care should decrease although it will never be eliminated.

The approach taken by Massachusetts shows how such a transition could be accomplished. Under a Section 1115 waiver agreement with the federal government, Massachusetts has established a Safety Net Care Pool that makes $1.34 billion in state and federal funds available each year for a combination of subsidies for insurance coverage, provider-rate increases, and payments to safety-net health care providers. The plan takes into account the need for a transition period in which payments for uncompensated care are gradually reduced as the number of people with health coverage increases. Between fiscal years 2007 and 2009, the amount budgeted for payments to providers for uncompensated care declines from $610 million to $320 million to reflect the expected decline in number of uninsured; during this same period, subsidies for coverage are slated to increase from $160 million to $725 million.

By using its unspent DSH funds for subsidies at the outset and devoting additional DSH funds for this purpose as more Pennsylvanians become insured, the state can secure federal matching funds at the rate of $1.19 for every state dollar it spends. The state can use these new federal funds to help pay for the subsidies for uninsured, low-income state residents. In this way, the state can meet the budget neutrality requirement of a federal Medicaid waiver without harming current Medicaid beneficiaries.

The Importance of Insurance Reforms

Section 7204 of the bill sets out a series of small group and individual health insurance market reforms that apply to all health plans in the state, not just those contracting with the state to provide coverage through Cover All Pennsylvanians. The bill establishes new modified community rating rules and requires that small group plans maintain a medical loss ratio of no less than 85 percent. Under the modified community rating rules in the bill, insurers offering small group and individual health insurance plans could no longer vary rates based on health status. Insurers could vary rates based only on age, geographic region, and family composition and even then, variation is limited under the bill. The bill also prohibits the plans from excluding treatment of pre-existing conditions.

The current status of Adult Basic illustrates why it is important to apply these reforms to the entire small group and individual market not just to the plans that will participate in Cover All Pennsylvanians. Coverage under Adult Basic currently costs $305 a month for basic coverage *without* prescription drug coverage or behavioral health benefits. Coverage at this price is offered to those on the waiting list when enrollment in the subsidized program is closed because of a lack of sufficient funds. At this price, the plan is likely to attract mostly individuals with health problems who cannot obtain cheaper coverage in the individual market. As more of these individuals enroll, the price of coverage continues to climb. In effect, Adult Basic functions at least in part as a high risk pool for those who cannot obtain other coverage.

By requiring insurers to enroll all individuals who apply ("guaranteed issue"), by establishing new modified community rating rules and by prohibiting pre-existing condition exclusions throughout

the state's small group and individual markets, the state assures that risks are spread among the plans contracting to provide benefits under Cover All Pennsylvanians and plans outside the program. In other words, the cost of insuring the sickest Pennsylvanians would be shared across all the small group and individual plans. Massachusetts already had modified community rating and guaranteed issue in its individual and small group markets. Governor Schwarzenegger's proposal for health care reform in California includes both guaranteed issue and modified community rating.

Without these reforms, younger individuals without health problems could still go outside the Cover All Pennsylvanians program and purchase cheaper coverage on their own. Only those who could not obtain coverage more cheaply would enroll in Cover All Pennsylvanians. This would mean that Cover All Pennsylvanians would soon become prohibitively expensive, as it would be enrolling the highest risk, most expensive individuals. By reforming the entire small group and individual market, House Bill 700 avoids this effect. Thus, it is critical that this feature of the bill be maintained in order along with all the other components aimed at holding down the costs of coverage.

The Importance of Affordable and Adequate Coverage

House Bill 700 would provide subsidies to individuals with income below 300 percent of the poverty line, a higher limit than Adult Basic which stops at 200 percent of the poverty line. Extending subsidies to at least this higher level is necessary and this feature of the plan should also be maintained.

Health insurance is expensive. A recent analysis found that unsubsidized coverage offered to individuals employed by small businesses with fewer than ten employees would, on average, cost a single person with income at 300 percent of the poverty line 13.8 percent of his or her income, while family coverage would cost an average of 17.2 percent of income for a family at that income status.[1] (The cost of comparable coverage generally would be even higher in the individual market, especially for those with health problems.) Thus it is important that Pennsylvania maintain its plan to provide subsidies to those with incomes up to 300 percent of the poverty line.

Unlike Massachusetts, Pennsylvania is not planning to impose a requirement on individuals to have health coverage. While the individual mandate in Massachusetts is somewhat controversial, it does ensure that individuals at lower risk of health problems as well as those at higher risk all enroll in health plans. Without an individual mandate, it is especially important that coverage be affordable both for those eligible for subsidies and those who are not. House Bill 700 requires the participation of all students in higher education in health care plans, which will bring in a younger and healthier population. The plan also includes discounts for small employers to provide incentives to them to purchase health coverage on behalf of their employees as well as several other initiatives designed to contain costs. These are all important provisions to ensure the broadest possible participation and hold down costs.

While every effort must be made to keep the cost of coverage as low as possible, the benefit package must be adequate to meet the needs of those with chronic conditions and other health

[1] Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs*, web exclusive, November 30, 2006.

problems and to provide preventive care and other routine services to all participants. Once enrolled in the plan, participants should not be faced with high deductibles or other forms of cost-sharing that make it hard for them to get care.

High-deductible health plans (HDHPs) coupled with health savings accounts (HSAs) would not be a helpful alternative for low-income people enrolling in Cover All Pennsylvanians. A 2005 survey by the Employee Benefit Research Institute and the Commonwealth Fund found that individuals with HDHPs attached to HSAs or similar accounts were more than two-and-a-half times as likely to pay more than 5 percent of their income in out-of-pocket medical costs as people enrolled in comprehensive insurance.[2] Moreover, low-income people get a much lower tax break for contributions to an HSA account, and their lower incomes make it less likely that they will be able to even contribute to an account.

House Bill 700 leaves much of the detail regarding benefits to be decided later. You might want to consider more specifics on benefits such as the inclusion of benefits currently mandated under state law, or at the very least specify a more participatory and public process for deciding on the specifics of the benefit package.

In closing, I would like to thank you again for the opportunity to testify and to commend you for taking on the challenge of meeting the need of uninsured Pennsylvanians for health coverage. I would be happy to answer any questions you have now or in the future.

[2] Paul Fronstin and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute and the Commonwealth Fund, December 2005.