Testimony Regarding Pennsylvania's Implementation of The Patient Protection and Affordable Care Act

Submitted by

SEIU Healthcare Pennsylvania

to the

Pennsylvania House Insurance Committee Hearing July 21, 2010

Pennsylvania | SEIU Healthcare United for Quality Care

nurse alliance of SEIU PA

1500 North Second Street, Harrisburg, PA 17102
717-238-3030 * www.seiuhealthcarepa.org

Making Health Care Reform Work for Pennsylvania

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SEIU Healthcare Pennsylvania is the largest union of health care workers in Pennsylvania, representing approximately 22,000 direct care workers in nursing facilities and in home and community-based settings, registered nurses and allied employees in hospitals, and State-employed health care professionals. We are part of the largest health care union in North America, uniting 1 million caregivers in the U.S., Canada, and Puerto Rico.

SEIU thanks members of the House Insurance Committee for hosting this hearing on the Patient Protection and Affordable Care Act, which is the most important piece of social reform we've accomplished in generations. Whether we succeed or fail in delivering quality, affordable insurance to every Pennsylvanian will be determined in large measure by what we do in the coming months and years to implement this critical new law; we appreciate this opportunity to share our experience and views.

Georgeanne Koehler's testimony is an appropriate place to start, not least because it reminds us that our health care system remains very very broken. It is worth reminding ourselves that today about 1.2 million Pennsylvanians lack insurance, as Billy did. And about half of all people who have insurance report that copayments, deductibles and coverage gaps mean they either skip necessary treatment or struggle to pay bills. In Pennsylvania, our conversation about health care included Shirley, a homecare worker, who keeps her mouth closed even when speaking because she hasn't been able to afford dental care for three years, and one of her front teeth was rotting. We met Duane, a factory worker from Erie, whose arm has a bone sticking out of the side. When he broke the arm, the doctor wanted to operate on it. But because he didn't have insurance he said,

"I ain't gonna have it operated on." The doctor said, 'Well, I can wrap it up.' Duane said, "Let's do that, then."

Our conversations about health care showed us that poor health generally brings more problems with it. The loss of teeth makes eating fresh fruits and vegetables difficult, and a diet heavy in soft, processed foods exacerbates more serious health problems, like diabetes. The pain of untreated injuries leads many people to "self-medicate" with alcohol or drugs prescribed for others. Pennsylvanians struggling to get ahead in the job market told us that the unsightliness of, say, a bone sticking out of arm, can become a major barrier. With a bone sticking out of your arm, you're not going to get a job as a salesman or a flight attendant or a cashier. You're going to be put in the back somewhere. Our conversations about health care showed us that years and years of un-insurance, underinsurance, and inadequate insurance have created a group of Pennsylvanians who look different from others and suffer in ways that others do not. The leading cause of personal bankruptcy in our state – as in most states -- is unpaid medical bills. Half of the uninsured owe money to hospitals, and a third are being pursued by collection agencies. Lung-cancer patients without insurance are less likely to receive surgery, chemotherapy, or radiation treatment. Heart-attack victims without health insurance are less likely to receive angioplasty. People with pneumonia who don't have health insurance are less likely to receive X rays or consultations. The death rate in any given year for someone without health insurance is twenty-five per cent higher than for someone with insurance.

We also learned that we are not receiving enough health care for our healthcare dollars. Pennsylvanians spend over $5,000 per capita on health care every year, almost two and half times the industrialized world's median of about $2,000; the extra spending comes to hundreds of billions of dollars a year. But Pennsylvanians have fewer doctors per capita than most Western countries. We go to the doctor less than people in other Western countries. We get admitted to the hospital less frequently than people in other Western countries. We are less satisfied with our health care than our counterparts in other countries. Our life expectancy is lower than the Western average. Childhood-immunization rates are lower than average. Infant-mortality rates are in the nineteenth

percentile of industrialized nations. Nor is our system more efficient. In Pennsylvania, we spend more than a thousand dollars per capita per year—or close to four hundred billion dollars—on health-care-related paperwork and administration, whereas Canada, for example, spends only about three hundred dollars per capita.

The Patient Protection and Affordable Care Act is our historic opportunity to address many of these problems, and we will offer some specific recommendations about what Pennsylvania should do – and do quickly. We also think it is very important to begin implementation with a clear understanding of our most important goal, and that is to create access for everyone.

We should be clear that creating access to care is something of a revolutionary idea in the world of private health insurance – though it builds squarely on the achievements of our public insurance programs. For decades, our country's private health care insurers have deliberately focused on reducing access and in fracturing the risk pool. Most of us here have directly experienced the increasingly costly and complex barriers to care – for most people, going to the doctor means navigating and financing co-pays and co-premiums, co-insurance costs, network lists, deductibles, and utilization reviews. The idea of insurance for everyone also goes against the tide of private industry practice: employers and billboards increasingly talk to us about individual HSAs, cafeteria plans, and actuarially "engineered plans" aimed at particular populations with particular needs. In short, the insurance industry has been in the business of undermining the very role of insurance.

To reverse these trends, legislators and regulators must support and strengthen those provisions of the Act that ask private insurers to create competitive no cost plans for basic preventative care. It will take some work, as these provisions run squarely against ingrained industry thinking about the necessity for consumers to have a "skin in the game" to ensure efficient consumption of care. We should be ready to do this work: as anyone who has skipped care because of high out of pocket costs knows, a skin in the game doesn't just reduce *wasteful* consumption – that unnecessary trip to the ER for a

case of the sniffles. It also reduces *necessary* consumption. That's why people with high-copays who suffer hypertension don't do nearly as good a job of controlling their blood pressure as those in other groups, resulting in a ten-per-cent increase in the likelihood of death of these high copay consumers. In fact, many of the things we do only because we *have* insurance—like getting our moles checked, or getting our teeth cleaned regularly, or getting a mammogram or engaging in other routine preventive care—are anything but wasteful and inefficient. These are behaviors that could end up saving the health-care system a good deal of money.

Creating access for everyone also entails supporting and strengthening those provisions of the Act that bring people together in mixed age/health status/income risk pools and that limit "cherry picking." Here too we will have to reverse private industry's increasing fondness for actuarial models of health insurance, which have had profoundly harmful effects on our insurance network. As we have learned, when people pay for their health insurance based on their current health and projected utilization, the sick inevitably end up paying more than the healthy. And when people choose an insurance plan that fits their individual needs, those with significant medical problems will choose expensive health plans that cover lots of things, while those with few health problems will choose cheaper, bare-bones plans. The more expensive the comprehensive plans become, and the less expensive the bare-bones plans become, the more the very sick will cluster together at one end of the insurance spectrum, and the more the well will cluster together at the low-cost end.

We know the results: paradoxically, the insured start to look a lot more like the uninsured, as those in comprehensive plans assume more and more of cost of their care, and as those in bare bone plans have less and less care covered. Actuarial insurance is the reason that companies unlucky enough to employ older, high-cost employees—like United Airlines—have run into such financial difficulty. It's the reason that automakers move their operations to Canada. It's the reason that small businesses that have one or two employees with serious illnesses suddenly face unmanageably high health-insurance premiums. It's the reason that people with medical conditions can't get anyone to insure

them at all and the reason young people don't bother to buy low cost catastrophic plans that don't cover anything until, as a niece put it to me, "we're already dead."

Instead of increasing barriers to access and further fragmenting risk pools, The Affordable Care Act approaches reform by moving our health insurance system a step or two in the direction of the nation's successful, popular, and effective social insurance systems – like Social Security and Workers Compensation. The idea behind these programs is very simple: we know that some of us will face events that could ruin our lives – like the inability to work, or unemployment, or a disabling accident. We also know that none of us can handle these events on our own. Our best defense is to have everyone chip in to as large a pool as possible and then pay the claims of the unfortunate.

Social insurance in health care doesn't mean public ownership of medicine or that every procedure is covered. But it does mean that if you are sixty and have heart disease and diabetes, you don't pay substantially more for coverage than a perfectly healthy twenty-five-year-old. It does mean that the twenty-five-year-old pays the same in premiums even though he doesn't go to the doctor at all in the previous year, because he wants to make sure that someone else will subsidize his health care if he ever comes down with heart disease or diabetes. Medicare is a health insurance program already rooted in the social insurance model, and, when Americans with Medicare report themselves to be happier with virtually every aspect of their insurance coverage than people with private insurance (as they do, repeatedly and overwhelmingly), they are referring to the social aspect of their insurance. They aren't getting better care. But they are getting something equally valuable: the security of being insulated against the financial shock of serious illness.

Practically speaking, what should Pennsylvania's legislators and regulators do?

1) In the first place, they should embrace reform and **take a leadership role** in making reform work. Through The Act we can directly insure nearly half of all low income uninsured in our state, and offer subsidized access to struggling small businesses and individual subsidies. We can streamline and rationalize our

delivery systems, and get quality care to underserved areas. But it will take history-sized dedication to lead insurers, providers, employers, consumers and caregivers through the challenges ahead.

2) Pennsylvanians want **regulators to have the authority they need** to implement reform. States have a critical role in ensuring compliance and oversight of new risk adjustment, reinsurance, risk corridor and prevention-without-copay provisions. Inside the exchanges, states will also need to monitor and be prepared to adjust for adverse selection among exchange plans, particularly if sick and healthy enrollees gravitate to different plan tiers. Our Insurance Commissioner needs broad authority to conduct rate review across our entire insurance network, not just in certain segments of the industry.

3) Pennsylvania's **exchange must move as far as possible in the direction of "all in" social insurance**. To this end, the exchange should be organized as a public entity governed by a publicly accountable board of stakeholders. Insurance companies have proven themselves incapable of providing access to all so their experience counts for little here. Exchanges need to be strong players in the insurance market, and can only do so if they are large enough to minimize adverse selection, attract high quality plans, generate administrative efficiencies, and use market clout to negotiate lower premiums. Pennsylvania should consider combining our individual and small employer exchanges into one "risk pool," and allow the definition of small employer to get bigger. We should consider phasing existing individuals and small group plans into the exchange to create the largest possible risk pools and to even out costs. It is also crucial that legislators and regulators apply market reforms equitably in and outside the exchanges, so that plans do not have a disincentive to participate in the exchanges or to offer attractive and attractively-priced plans only outside of the exchange.

4) We must **keep a close eye on insurance companies** as reforms are phased in, to ensure that they implement reforms on schedule and to be sure insurance

companies aren't taking advantage before reforms kick in. We should bring legislative authority, new federal grant monies, and public pressure to bear on insurance companies – like seven of the nine largest companies in PA – who are intensifying health profiling and demanding exorbitant rate increases.

5) We should **build a strong and seamless "glidepath" between Medicaid and the exchange.** Medicaid, already the workhorse of our subsidized system, will become a bigger component of Pennsylvania's health insurance network. Details like aligning the enrollment and renewal processes for Medicaid and the exchange with one another and with the tax credit cycle will ensure that families aren't bounced back and forth between programs and bureaucracies – wasting time and resources on administration that could be spent on care. Getting the details right will also ensure the development of effective online shopping and application processes.

6) Let's build on the good work our Insurance Department is already doing to **gather and share real information with consumers in user friendly formats.** A recent award to the Insurance Department to build a solid technological infrastructure for plan comparison is an important step in this direction.

7) Finally, Pennsylvania should **jump on every opportunity to act early to bring needed reform and enhanced federal funding to Pennsylvania.** There are a number of incentives and opportunities to extend access in advance of legal requirements or into optional programs. We should seize all of these opportunities, among them:

   - ✓ Apply for the early retirees' reinsurance program for state workers, as a way to reduce the costs of medical coverage for Commonwealth employees. The program provides an 80 percent subsidy for retiree claims of between $15,000 and $90,000 but funds are limited to $5 billion, and most large employers are expected to apply.

- ✓ Implement Medicaid reforms ahead of schedule. In 2014, adults with income below 133 percent of the FPL will be eligible for Medicaid. States have the option to move early to provide this Medicaid coverage to adults. For this population, states will receive the regular Medicaid matching rate until January 1, 2014, and thereafter will qualify for even more generous federal support.

- ✓ Take advantage of opportunities to increase home and community based services through the Community First Choice Option and the State Balancing Incentive Program. Both of these programs offer opportunities for substantial new federal funding for long term care and begin in 2011.

- ✓ Explore the wide range of workforce development, payment and delivery system reform pilot and demonstration projects available to states—many offer significant new federal resources either through enhanced federal match levels, grants or new opportunities for waiver funding.

Health care reform is a big complex job made up of smaller complex jobs and, as the experts are always saying, "questions for the states." But at the end of the day, health care reform is really about one very simple question – one we should remember as we struggle through the many financial, technological, political and ideological challenges ahead. The question is this: in a world where some of us will face significant health problems, and where none of us has the means to address those problems alone, are we better off trusting to our luck, or are we better off trusting to one another? We believe Americans have always made the greatest strides when we act on the idea that the more equally and widely the burdens of misfortune are shared, the better off the population as a whole is likely to be. Having experimented for decades with the disastrous notion that we do better by making the insured look and act more like the uninsured, it's time to extend real insurance to all.

Making Health Care Reform Work for Pennsylvania

Testimony of Georgeanne Koehler

Provided for the Pennsylvania House Insurance Committee

Submitted by SEIU Healthcare Pennsylvania

July 21, 2010

I am here today to tell you the story of Billy, the story of a man who fell through the cracks of our broken health care system never to return to us. Billy was a quiet hero to so many in his life's journey. He was a man with a gentle soul and a loving heart but that heart didn't always beat so good.

Billy was 39 years old when he suffered his first cardiac arrest. He was lucky because he was in the ER at the time and the staff was able to bring him back. He was diagnosed with having a sudden death type of arrhythmia. Because of that diagnosis he was a candidate for and received an AICD (automatic internal cardiac defibrillator. He had health insurance through his job at that time so taking care of his heart and his defibrillator wasn't a big deal. Through the years he went through his small pension of $25,000 to pay for the services his insurance didn't pay for. He was alright with that.

In 2003 the company Billy worked for closed. He lost his job and with it his health insurance. He and we tried to find him a private policy but no matter what company we called the answer was the answer was the same. DENIED due to his pre existing heart condition. Billy hoped to find another job that offered health insurance, but that kind of a job was no where to be found so he took a job as a pizza delivery driver.

In December of 2007 while closing up the shop, Billy collapsed. He was taken to a local hospital by ambulance. The ER admitted him to a 23 hour monitored bed. The cardiologist came, read Billy's defibrillator, left and came back a few hours later. He said

"Mr. Koehler you are a very lucky man. Your defibrillator battery is so low I'm surprised it fired this time. It needs replaced." He went on to say the replacement would be done as an outpatient and that Billy needed to set up an appointment to be seen in three months. Billy told the doctor he didn't have insurance, and the doctor told him that if he didn't have insurance by then he would have to pay up front and that Billy would need thousands of dollars. Billy said "I don't know what to do because I don't have thousands of dollars." The doctor asked Billy if he out the oil in his car so that it can run smoother and last longer. Billy said of course. Then the doctor pointed his finger at Billy and said "You get your priorities straightened out and you'll come up with that money." The doctor walked out of the room and Billy was discharged the next morning without a heart test and without a defibrillator.

Billy applied for Medicaid. He was thrilled when he received his card, but the next day he received a letter the next day telling him the card was a mistake and that he could not use it. It was then he and I knew that, short of a miracle, he would never again get medical care for his heart, that it was all over for him and that the next time that he went into V Fib it would be the last time.

On March 7, 2009, Billy left work at 5:10pm. He drove two blocks, came to a stop sign, put his car in park and slumped onto his steering wheel. The good people in Lawrenceville came to his rescue. They got him out of his car and began CPR. They wanted to give him another day of life, something his cardiologist could've done, should've done and took an oath to do but didn't.

After the funeral I thought about who is responsible for what happened to Billy. I looked at his history and his medical records and what jumped out, clear as day, was DENIED. I decided to take the advice of Billy's doctor and prioritize. I made it my business to reform those insurance companies because Billy's nightmare began with their denial.

I believe Billy was denied insurance because private insurance companies value profits over lives. To them Billy was just a loss in their profit and loss statement. Insurance

executives always say it's more complicated than that, but Billy is dead, those executives are rich, and their companies are very profitable. I'm not too far from the mark.

For too many years we allowed the private health insurance industry to ruin our county's health. We have a chance to fix that and we have to. The choice is very clear. And because the choice is very clear, if we fail to reform we do more than lose our nation's health. We will also destroy our nation's moral compass, because we will be saying loud and clear that we put profits ahead of the needs of our citizens and that we lack the will and courage to change. I believe that we will be lost and we may never find our way back.

I will fight to keep that from happening to my America. What about you? I am asking you to work together and get this done. The bells have already tolled for Billy but not for the others who need your help. I know together you can finally quiet those bells. I will pray that God blesses you with his good Grace. That Grace will lead you to do what is right.