REMARKS BEFORE THE HOUSE INSURANCE COMMITTEE
OF THE PENNSYLVANIA GENERAL ASSEMBLY
PRESENTED BY PENNSYLVANIA HEALTH LAW PROJECT
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Good morning Chairman DeLuca and members of the committee.

My name is Janice Meinert, and I am a senior paralegal in the Pittsburgh office of the Pennsylvania Health Law Project, a 20-year-old, non-profit, non-partisan law firm dedicated to increasing and improving publicly funded health care. The Health Law Project provides free legal services and advocacy to Pennsylvanians denied health insurance coverage or services from government funded health programs. We pay closest attention to Pennsylvanians whose health is threatened by poverty. Through our Helpline we assist low income, elderly or disabled Pennsylvanians become eligible for public health programs like Medical Assistance, CHIP or adultBasic. And when they are enrolled in these programs we represent them at administrative hearings when they are denied medically necessary services by health insurance companies.[1]

We appreciate this opportunity to comment on Pennsylvania's implementation of the federal health reform law. In preparing for today's testimony we discovered that very few state legislatures are conducting listening sessions like these. By getting a head start now, in 2010, you can anticipate and better oversee the many changes coming to Pennsylvania's health insurance markets.

Our testimony outlines the work ahead to ensure that state-level policies and practices demanded by health reform are informed by and meaningful to consumers. We prepared these remarks with our clients in the forefront of our minds; low and moderate income Pennsylvanians, particularly those

[1] We also represent Pennsylvanians on the verge of poverty because of poor health. This committee is well aware that medical costs and conditions have proven to be a key cause of thousands of home foreclosures. According to the Pennsylvania Housing Finance Agency (PHFA) medical issues were the second leading cause of home foreclosure under loss of a job.

with chronic and disabling conditions, who will rely on state supported health insurance through either the health insurance exchange or through Medicaid, known in Pennsylvania as Medical Assistance.

Today's in person testimony will focus on the implementation of Medicaid, known in Pennsylvania as Medical Assistance. PHLP has identified several critical components of successful state health reform implementation. In each we emphasize the importance of 1) providing all Pennsylvanians with easy enrollment and retention in state health programs, 2) maximizing federal funding, and 3) improving the health of Pennsylvania's citizens so they can enjoy life.

Before reviewing the critical components it might be prudent to open with a brief description of eligibility in our current Medicaid system and Medicaid expansion under health reform.

The current Medicaid system in Pennsylvania is an income **plus** system. In other words you can't just be low income. You have to be low income AND fit in a certain category of eligibility. For example, a pregnant woman, a disabled adult, a child in a low income family, or women with breast or cervical cancer are current examples of existing Medicaid categories. Eligibly for this important health insurance program is complicated, confusing and not consumer friendly.

Under the healthcare reform, "categorical eligibility" is eliminated. By 2014 Pennsylvania must simply expand eligibility for individuals up to age 65 whose income is less than 133% of Federal Poverty for a single person (that's $14,400 per year). Resource limits will be eliminated for most people with some exceptions. These changes to eligibility are the good news for consumers, but the challenge for Pennsylvania is implementation.

The following are the critical components of healthcare reform implementation based on our 20 years of experience in assisting consumers in navigating the system.

1) First, Simplify and Integrate Eligibility Systems

The new health reform law calls for streamlined and coordinated enrollments between Medicaid and CHIP, together, and the new state-based exchange. What that means is that we really need to rethink our

systems for enrolling and renewing people and how we are marrying those systems so there is truly a system instead of disparate components.

Pennsylvania cannot simply rely upon existing enrollment procedures. Dramatic simplification of eligibility and the application and enrollment process is the only way to achieve the promise of near-universal coverage embodied in the federal law. To put it bluntly, you cannot extend Medicaid/Medical Assistance or exchange-based health coverage to an estimated 2 million additional Pennsylvanians by relying upon the public benefit, county-based eligibility platform. That is a cumbersome and intrusive process which will crumble under the projected load of newly eligible persons needing either Medicaid or exchanged-based health coverage.

Our current system of Medicaid eligibility already rejects nearly 40% of its applicants, requiring that these deserving Pennsylvanians seek legal professionals and advocates to navigate them through complex public health insurance programs. The new system must be streamlined, simplified, and approachable in order to be successful. It must serve all Pennsylvanians.

Massachusetts's success with its health insurance connector was not only attributable to its expansion of eligibility and individual mandate. The state also simplified enrollment using an online "virtual gateway" and invited partners to help with enrollment, including community health centers, hospitals and community based organizations.

With guidance from the federal government, Pennsylvania must completely redesign its eligibility systems and processes to assure seamless transitions between Medicaid and state based health exchange as families' incomes rise and fall, families are formed, grow, or dissolve, as part time, seasonal, and migrant workers change status, and as people move from one part of the state to another—or to another state entirely. This is a massive undertaking, with the promise of incredible efficiencies and dramatic improvements in customer service and, ultimately, access to care, if done well.

2) Second, Expand Provider and Health System Capacity

On average, people without health insurance use about 60% of the health care services as people with coverage. Therefore, expanding coverage will increase demand for services. This is a good thing, but it will strain the capacity of those parts of the health care system that are already under pressure. Low physician participation has often been an issue for Medicaid. Particular challenges will arise in the areas of primary care, culturally competent and linguistically accessible care, and highly specialized care – including mental health and drug and alcohol treatment services – and in the rural areas of the state. Particular institutions will also face unusual strain—especially community clinics, health centers and public and other safety net hospitals.

The law takes steps to bolster the supply of those who will care for the poor by raising primary care reimbursement rates in Medicaid to Medicare rates in 2013-2014 and by boosting funding for community health centers and the National Health Service Corps. Pennsylvania should consider expanding the scope of practice for health professionals who are not physicians or dentists (such as nurse practioners), and emphasizing the use of team based care and improved coordination of physical health and behavioral health services.

Health coverage expansions will not create a provider supply problem, but they will highlight the problems we already have. Support for health reform will suffer if the newly insured find that their coverage is a hollow promise, or those who are currently insured perceive that their access to care has been adversely affected by those who have gained coverage.

3) Third, Attend to Benefit Design by Encouraging Comprehensive Coverage

The health reform law allows states to provide newly eligible Medicaid beneficiaries either with the regular Medicaid benefits package or with a less comprehensive package (known as "benchmark" coverage) comparable to commercial health insurance. We believe uninsured childless adults would be best served by a comprehensive benefits package identical or comparable to the package that Medicaid offers to low income parents and people who have disabilities. Consider these two reasons.

First, the federal government will pick up the vast majority of the costs of this Medicaid expansion — 100 percent for the first three years and 96 percent overall over the next ten years, so this makes it more viable for Pennsylvania.

Second, this group of newly eligible persons for Medicaid tends to have more medical conditions and to be in poorer health. It results, in part, from poor, uninsured childless adults going without coverage and failing to receive care early on due to cost, and finding themselves with more severe and costly health care needs later on as a consequence. Populations such as the homeless or chronically unemployed will require a comprehensive array of health care services to address longstanding untreated or undertreated medical conditions.

4) Fourth, Focus on the Dually Eligible

In Pennsylvania, people eligible for both Medicare and Medical Assistance account for approximately 50% of total Medicaid spending (that's $7.7 billion dollars). Yet this group of frail elders and a subset of people with disabilities experiences poorly coordinated care and high costs. Improvements in care for the duals should be a priority. The federal law creates one new challenge and some important opportunities.

On the challenge side, the changes to the Medicare Advantage program, specifically reducing the federal payments to these plans, will have implications for existing Special Needs Plans, which, despite their limitations, have been one source for coordination between Medicaid and Medicare. It is not yet clear how this will play out.

On the opportunity side, the law allows states to convert some home and community-based waiver services into state plan options, and it expands and extends the Money Follows the Person demonstration program to facilitate moving people from nursing homes back into the community. The federal law creates a new office within CMS that focuses exclusively on the duals, and the dually eligible are a target population for reforms that can be implemented by the new Center for Medicare and Medicaid Innovation. These two latter offices have not yet taken shape, but they offer unique vehicles for states to pursue models of integration between Medicaid and Medicare that have never before been available.

5) Fifth, Use Data

Data is the engine of improvement. The American health care system is notably negligent relative to other sectors of our economy and relative to the health systems of other nations as operating with limited data. Its roots are paper medical records, payment methods that are treated as trade secrets, and fragmented delivery systems- including the separation of physical health services from behavioral health services - and payers, each of which owns its own data.

There are myriad provisions in the law that call for the collection of new data. Data elements include race, ethnicity, and language, price and utilization, program enrollment, and quality metrics. New data will be collected on, among other things, consumer complaints, wellness program, the prevalence of chronic diseases, and the health care workforce. Purchasers—individuals, employers, and the exchange—can use data to drive improvement in outcomes and quality. Doctors, hospitals, and health systems can use data to achieve the same ends. The Commonwealth can aggregate data across systems to monitor population health, identify priorities for improvement, and track progress toward goals.

Effective use of data requires a commitment to collect it, a strategy to combine data that come from different sources, and selection of priority areas for analysis. Pennsylvania must have a strategy and plan to put appropriate subsets of the data in the public domain where it can become a force for improvement.

6) Sixth, Engage the Public in Policy Development and Implementation

The public remains confused about how health reform will affect them, and public attitudes toward reform remain as sharply divided as they were at the time of enactment. We know from the large number of people eligible for Medical Assistance but not enrolled that simply creating opportunities for coverage does mean people will take them up. Fundamentally, health reform can only succeed if it is more about culture and norms than it is about mandates and penalties.

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Mr. Chairman, we congratulate you on your decision to hold these hearings as a vehicle for pursuing effective implementation of health reform. There is a great deal to do, but there is enough time to get this right. Leadership will be required, but those who lead will find that the federal law contains the elements that, when supplemented with appropriate, thoughtful, and strategic state choices, will yield a better performing health system, dramatically improved access to care and financial protection for those who are most vulnerable, and a health care system that we can afford. In that vein, we applaud the Rendell Administration for publicly announcing its commitment to implementing health reform.

Thank you again for this opportunity. I will try to answer your questions, if I can.