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**Testimony before the Senate Committee on Health, Education, Labor and Pensions
Charles D. Baker, Governor of Massachusetts
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Chairman Alexander, Ranking Member Murray and members of the committee, thank you for this opportunity to provide testimony before the Senate's Health, Education, Labor and Pensions Committee hearing on Stabilizing Premiums and Helping Individuals in the Individual Insurance Market.

Thank you for your willingness to engage in a bipartisan way in order to find much-needed solutions. I am especially appreciative that you have convened a group of governors to testify as we are on the front lines and are eager to work with Congress and the federal government on health care reform.

As a former state secretary of Health and Human Services, former CEO of a health plan and current governor of a state justifiably proud of its excellent and robust health care system, I care deeply about access to and the affordability of health care. These are challenges that must be tackled in a bipartisan, collaborative way, between the states and the federal government, and with full participation from patients, employers, insurers and providers. I appreciate the opportunity to share my thoughts with you this morning.

The Massachusetts Health Care Landscape

Massachusetts believes strongly in health care coverage for its residents. For more than ten years, the Commonwealth has been engaged in designing and implementing health care reform solutions, first on a state level with our comprehensive, bipartisan state reform in 2006, and later with implementation of the Affordable Care Act. Working with the federal government, we have made considerable progress toward the goal of near universal health care coverage for our residents. 99% of our children and youth, and more than 96% of all of our residents have health care insurance, the highest percentages in the country. Today more than 257,000 individuals are covered through our state exchange, with 190,000 low to modest income residents receiving federal and state subsidies. An additional 300,000 adults have Medicaid as a result of the expansion permitted through the Affordable Care Act. The Massachusetts state-based exchange,

known as the “Connector” maintains a robust individual insurance market with 62 plans offered from 10 carriers for the current plan year.

Additionally, while health coverage is important first and foremost for its benefits to residents, health care is an economic engine for Massachusetts due to our standing as a global center of excellence in field medical research and home to some of the best treatment facilities in the world. The health care industry contributed \$19.77 billion to the state’s economy in 2014, outpacing any other industry. One out of every ten workers is employed in health care related fields.

Massachusetts’ success in expanding health care coverage is rooted in our ongoing bipartisan approach to problem solving that includes insurance, business, health care, political and advocacy communities and that began in the 1990’s. At the center of that success is our shared belief that health care coverage is a shared commitment, not the singular responsibility of government.

As you consider legislation to stabilize premiums and address the individual insurance market, I would like to emphasize four key concepts.

Bipartisan Collaboration

First, bipartisan collaboration is going to be essential to achieve affordable health care coverage and stabilize the insurance market. The current debate in Washington about health care reform has destabilized the insurance market; carriers have responded by leaving some markets altogether or proposing to markedly increase rates to adjust for the uncertainty. The majority of Americans support a bipartisan approach to stabilizing the market and engaging in meaningful health care reform that yields affordable health care coverage.

Market Stabilization

Second, Congress should take immediate affirmative steps to stabilize the insurance market as an interim step until longer term reforms are enacted. Carriers need certainty in order to finalize rates for plan year 2018 and begin preparing rates for plan year 2019, and providers and employers also need certainty about what those rates are going to be. Month to month resuscitation of cost sharing reductions is not stabilization; they should be maintained for at least two years.

I cannot stress enough how critical it is for federal cost sharing reduction payments to be resolved affirmatively in order to maintain market stability and to constrain rate increases. It is also important to note that the Congressional Budget Office recently reported that ending the cost sharing reduction payments will actually cost the federal government more than making the payments, because they will be paying out more in premium tax credit subsidies.

As Congress contemplates future reforms, serious consideration should be given to reintroducing a reinsurance program as a form of market stabilization. As you know, reinsurance simply reimburses a portion of high cost claims exceeding a given attachment point.

A key contributor to market stability is the presence of younger and healthier people in the market. When Massachusetts passed its universal health care law in 2006, it included an individual mandate, which I support. I support it for two reasons. First of all, no one really knows when they might get sick or have a tragic accident, and if they do get sick or have an accident, they will seek care, it will be provided, and in many circumstances, they will be unable to pay for it. That means everyone else who has insurance will be paying for the health care services rendered to those without coverage. Second, if people have unlimited access to purchase coverage, many will purchase health insurance only when they need it, and then drop it once their care is provided, defeating the whole point behind insurance coverage.

Insurance coverage is about shared risk. We all have coverage so that together, we can pay for the care provided to the small number of people who need very expensive care. And for those who do get sick, costs can be very high. It is not unusual to have 1% of the population incur 30% of the total cost of care provided to that group. In many cases, 5% of the population incurs 50% of the cost of care received by that group.

If people do not have to carry coverage when they are healthy, and can access it only when they get sick, break a leg, need to have a procedure, or something else, then the rest of us are unfairly tagged with paying for the cost of their care.

Continuous coverage, encouraged one way or another using incentives and consequences, is a critical element in ensuring that everyone is treated fairly. A mandate is one way to encourage continuous coverage. It can also be done using financial penalties for people who do not have continuous coverage, or by establishing limited open enrollment periods. Different states can choose different approaches – or some combination – but if we want to make it easy for people to purchase insurance if they do not have access to it through work, and they don't qualify for public coverage, we need to nudge them into purchasing coverage, and keeping it.

Federal/State Partnerships

Third, Congress should establish broader parameters for insurance market reforms that include greater latitude for states to meet the unique needs of their residents. States are incubators and innovators of health care reform solutions and initiatives in both their Medicaid programs and commercial markets.

States should be allowed to broaden 1332 waivers for greater flexibility. These waivers are still very new tools for states to utilize as they have only been available since January 1, 2017. Massachusetts is committed to providing access to quality, affordable health insurance for our residents; rather than walking away from that commitment, we believe that increased flexibility would allow us to meet that commitment in more effective ways. In fact, this week, Massachusetts will be submitting a section 1332 waiver seeking additional flexibilities that promote market stability with a premium stabilization fund in the event that Congress does not appropriate funding of cost sharing reductions. Additionally, I will be submitting a letter to Secretary Price that seeks transitional relief regarding reviving the state's employer shared responsibility program and continuing to use specific state based rating factors. Finally, later this

year, we will be submitting an additional waiver seeking permission to administer the federal small business health care tax credit at a state level in order to promote commercial group coverage among small businesses with lower wage workers.

I offer the following three examples where changes to 1332 waivers would be of significant benefit to states as we continue to reform our health care system. These examples concern essential health benefit compliance, benefit design and budget neutrality. Massachusetts is a strong benefit state; we support essential health benefits (EHB). However, even in our state, it was a challenge to adapt to the federal framework. Technical improvements to the process should be allowed that support sufficient benefits that comport with best practices and market mechanisms. A prime example of one of these challenges which we still grapple with is the inclusion of pediatric dental coverage into the EHB standard. The need for dental coverage for children and youth is not in question, but addressing that need shouldn't require a rigid link between dental and health benefits within the same plan. EHB required that plans sold in the individual and small group market included pediatric dental benefits, which has not historically been included in most medical plans. There can be more than one efficient and effective way that states can ensure children covered by individual or small group plans are assured access to pediatric dental care. Even today, despite good faith efforts, most of our medical carriers still struggle to efficiently integrate dental benefits into their health plans, facing significant technical and operational barriers. All of these changes result in the carrier passing the cost down to the consumer. All the while, our dental insurance carriers had been providing dental coverage for children, adults and families with proven success and with the efficiencies that come with specialization and scale. It is critical that health plans provide coverage for the care that keeps people healthy, but federal mandates should leverage common sense market practices and provide states with flexibility to match local requirements to local needs. Federal frameworks can balance local experimentation without sacrificing essential benefit categories

Greater flexibility is also needed around benefit design. Value-Based Insurance Design (V-BID) approaches to benefit design seek to align patients' out-of-pocket costs, such as copayments and deductibles, with the value of services. Certain technical parameters of EHB make important kinds of benefit design innovation difficult. For example, in many areas, bronze and silver plan deductibles are extremely close to the maximum out of pocket (MOOP) limits. States may want to experiment with designing plans in which there are lower MOOP levels for high-value care (like chronic illness care) in exchange for a slightly higher MOOP overall, perhaps exceeding the existing EHB MOOP limit for relatively lower-value services. This would help make sure people who opt to buy high deductible plans don't put off care that will keep them healthy and also help make sure they don't develop an even more costly medical condition.

Finally, the current 1332 regulations require that proposals are examined on their own terms with regard to federal deficit neutrality impact. This can greatly limit creative proposals by not allowing commercial innovations to draw from savings enabled on the Medicaid program and vice versa. Opportunities for change could range from coupling savings from 1115 and 1332 waivers that are filed together or to determine savings over the course of several years. These types of common sense adjustments along with consumer protection guardrails could widen opportunities for meaningful innovation and allow for far more comprehensive waivers that

integrate the ACA, Medicaid and CHIP programs into a coherent health care insurance program at the state level.

In addition to increased flexibility and waiver authority, Massachusetts supports the development of “fast-track” waiver authority to expedite federal processing and approvals.

Health Care Cost Drivers

Fourth, Congress should take action to address health care costs. Having achieved near universal coverage in Massachusetts, we are now focused on health care affordability for individuals, families and employers. As we tackle reforms to the health care system, we should bear in mind not just the implications for federal and state budgets, but also on the people and businesses struggling to keep up with the ever-increasing costs of health care coverage and services.

One critical health care cost driver that Congress should address is rising pharmaceutical costs. In 2013, Massachusetts established a health care cost growth benchmark; originally set at 3.6%, it was recently lowered to 3.1%. Although the growth in hospital and physician spending has been near or below the benchmark, drug spending is a major driver of health costs, far exceeding the state’s benchmark, growing at 8% last year.

Unfortunately, states have limited ability to control pharmaceutical costs. Among other actions, Congress should consider safely expediting the FDA approval process, increasing competition by ensuring generic drug availability, and creating greater opportunities for public payers to negotiate prices.

Medicaid and Other Reforms

While this hearing is focused on insurance market reforms, the prospect of reforms to the Medicaid program also looms large.

There are a number of reforms to Medicaid and the Affordable Care Act that would be welcomed by many states, including Massachusetts. I look forward to continuing to engage with Congress on those ideas. But I cannot support under any circumstances any Medicaid reform resulting in a substantial loss of federal revenue to Massachusetts and loss of health coverage for thousands of currently insured individuals. Additionally, I am opposed to federal sanctions regarding family planning and efforts to diminish support for behavioral health and the opioid epidemic.

Closing

As you consider these and other reforms, I ask that Congress introduce any legislative changes on a gradual timeline, ideally with state flexibility to opt out or grandfather existing programs in order to prevent market shocks and to improve market stability. We are making progress in our individual states, innovating with new ideas and we should avoid disrupting ongoing systems that work.

Additionally, I urge that whatever reforms are enacted, there be a bipartisan commitment to return to the table in the coming years to review and revise those reforms. Complex legislation

requires fine-tuning and adjustments, no matter how perfect or well-intentioned the legislation is. In Massachusetts, we have returned to health care reform several times since 2006 as we have learned from our implementation of the law and as conditions have changed, and our Commonwealth is better for it.

Finally, as Congress takes steps to stabilize the insurance market and turn its attention to longer term reforms in Medicaid and health insurance markets, we should ensure that states have the necessary federal fiscal support to maintain important health care services. This includes stability of funding for cost sharing reductions, the reauthorization of the Children's Health Insurance Program (CHIP), as well as the annual discretionary appropriations and Health Centers Fund and a delay in the implementation of the proposed Disproportionate Share Hospital rule. Massachusetts currently has approximately 160,000 children on CHIP and failure to reauthorize CHIP will cause uncertainty for the families that rely on this program for health care services. Likewise, community health centers are an integral part of our health care delivery system, providing access to lower cost care in underserved locations. For many states, including Massachusetts, this core funding provides a safety net for many of our lowest income children, adults and families which should be protected.

Thank you again for the opportunity to provide testimony on this important issue. I look forward to working with you and other members of Congress as you consider legislation.