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Introduction

Thank you to Chairman Enzi, Ranking Member Sanders, and the members of Subcommittee for the invitation to discuss the importance of health insurance coverage for patients of Federally Qualified Health Centers (FQHCs or Health Centers).

My name is Tess Kuenning, and I am the President and CEO of Bi-State Primary Care Association located in Montpelier, Vermont, and Bow, New Hampshire. Bi-State is a non-partisan, non-profit 501(c)(3) charitable organization that promotes access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations. On behalf of the Bi-State and the 29 Community Health Centers, which provide care for nearly 302,000 Vermonters and New Hampshirites, I thank you for the opportunity to participate in the Roundtable discussion today before the Committee regarding the effects of a recently released Department of Labor Proposed Rule regarding Association Health Plans[i] on Health Centers as they provide and expand access to comprehensive primary care services in medically underserved communities.

I have served as the President and CEO of Bi-State for nearly 23 years and just prior worked for the U.S Public Health Service and HCFA, now CMS. I am a clinician by training and have worked in tertiary ICU and primary care both in the United States and in Nepal. My background as a Clinical Nurse Specialist and experience across government agencies, as well as private health care sectors, have shown me that barrier-free access to comprehensive primary and preventive services is the difference between a robust healthy life or not.

In New Hampshire and Vermont, as well as across the nation, Health Centers are the nation's largest network of comprehensive primary and preventive health care practices. Health Centers are and continue to hold the promise to fulfill access to care for our nation's communities. Health Centers historically have, and will continue to care for all patients in their community, extending their expertise in caring for our most vulnerable: the uninsured and underinsured.

Association Health Plans

The Department of Labor recently released a Notice of Proposed Rulemaking (NPRM) related to Association Health Plans. Association Health Plans are a type of health coverage for qualifying employers. The rules defining when Association Health Plans can be used have changed over the past several years, with this latest NPRM intending to expand access to this type of health

coverage. According to President Trump's Executive Order signed in October 2017, this change related to Association Health Plans is meant to encourage competition and choice for small businesses and lower their administrative and other costs.[ii] Some states, like Vermont, also have laws that impact Association Health Plans (*see* 8 V.S.A. s. 3368 and 8 V.S.A. s. 4079(2)).

The proposal intends to adopt a new definition of "employer" for purposes of determining when employers can join together to offer or enroll in an Association Health Plan that is treated as a group health plan under ERISA. Depending on the type of Association Health Plan, which state it operates in, and the number of individuals covered, the benefits covered and the costs incurred may be different than those currently required by federal law for the small group and individual market. By design, the NPRM allows for more flexibility around benefits covered by Association Health Plans. The benefits impacted include: limitations on pre-existing conditions, essential benefits, and out-of-pocket maximums. Under current law, these benefits are standardized for the small business and individual health insurance markets.

Concerns have been raised by organizations like the National Association of Insurance Commissioners, National Governors' Association, American Academy of Actuaries, and the NCSL National Conference of State Legislators regarding health coverage options, like Association Health Plans, that could fragment existing health insurance markets.[iii] Fragmentation is considered to be bad for health insurance markets. The fragmentation would occur when employers and individuals leave the general small group and/or individual health insurance market and join an Association Health Plan. Those leaving would join an Association Health Plan because the cost is lower (the cost is lower because those in the Association Health Plan would either be healthier than those in the general insurance market and/or the coverage would be different- without maternity or mental health for example). If healthy individuals leave the general insurance market, that leaves those who are less healthy- and more expensive. Over time, the balance between health and unhealthy can shift so much that the general insurance market goes into a 'death spiral' where the coverage becomes increasingly more expensive and potentially unattainable.

Other concerns harken back to past Association Health Plans that left a legacy of insolvency and fraud with millions of unpaid claims. These issues along with federal preemption of state regulation of AHPs are noted among the reasons why some state governments, labor, provider groups and even consumers have expressed apprehension.[iv]

In Vermont, Association Health Plans are regulated by the Department of Financial Regulation[v] and this regulation can serve to mitigate potential market fragmentation and ensure Vermont consumers are protected. This regulation could also potentially be used to ensure that the coverage offered is similar to that offered in the general health insurance market and there are no exclusions for services like mental health or maternity. In Vermont, these Association Health Plans would be considered a type of Multiple Employer Welfare Arrangement (MEWA) and thus subject to state insurance laws and regulation including solvency and reserve contributions to ensure payment of

plan benefits. However, Vermont's authority is limited to policies that have a minimum of 100 persons at the time of incorporation if formed outside the State, and a minimum of 25 persons at the time of incorporation if formed in the State. Association Health Plans that are created in another state, or are below the thresholds specified by Vermont law, may not be able to be regulated by Vermont and Vermonters could purchase plans that have different consumer protections that those offered within the state. Vermonters in the general health insurance market could end up with more expensive plans as those individuals would need Vermont's consumer protections.

Health Centers - General Background

By way of background, Health Centers are community owned, not-for-profit organizations that receive federal funding under the Public Health Service Act to provide primary medical, dental, behavioral and mental health services — including Medication Assisted Treatment (MAT) to treat substance use disorders — and pharmacy services to all patients, regardless of their ability to pay. Health Centers also provide a variety of enabling and support services. To date, there are over 1,400 Health Centers located at more than 10,000 locations nationwide[vi], both urban and rural, serving as patient-centered health homes for more than 27 million patients.[vii] Every Health Center has relationships with their community partners such as hospitals, mental health centers, and home health agencies, to assure patients have the full continuum of care.

Health Centers are funded through a myriad of resources. Primarily, just under 20% of Health Center revenues are from federal grants; 65% are from patient related revenues, which includes Medicaid, Medicare, and private or commercial insurance; and just over 15% is from other revenues, which may include competitive state and local grants, contributions from county and municipalities as well as foundations and philanthropy. [viii]

In their communities, Health Centers are more than a safety net, as they have a demonstrated track record of improving the health and well-being of their patients using a locally-tailored health care home model designed to coordinate care and manage chronic disease. They employee skilled providers who chose to work at Health Centers given the multidisciplinary team approach to comprehensive all-inclusive whole person care. Numerous published studies over many decades have demonstrated that Health Centers are a proven cost saver. Studies have also shown that Health Centers improve the health status in communities, reduce emergency room use, and eliminate barriers to health care.

The distinctive model of care delivered by Health Centers allows them to save the entire health system, including the government and taxpayers, approximately $24 billion annually by keeping patients out of costlier health care settings, such as emergency departments.[ix] As a result of their timely and appropriate care, Health Centers save $1,263 per person per year, lowering costs across the delivery system – from ambulatory care settings to the emergency department to hospital stays.[x]

Nationally, approximately 49 percent of health center patients are covered by Medicaid and another 23% are uninsured.[xi] In return, Health Centers bring significant value to the Medicaid program, serving 1 in 6 Medicaid patients[xii,xiii] for only 1% of Medicaid spending.[xiv] Additionally, studies have shown that Health Centers save 24% per Medicaid patient compared to other providers.[xv]

In addition to reducing health care costs, Health Centers serve as small businesses and economic drivers in their communities. Health Centers employ over 207,000[xvi] individuals and generate $45.6 billion in total economic activity in urban and rural communities.[xvii]

For today's discussion on Association Health Plans, what is most important to the Health Centers is that their patients have access to the best coverage available to them. Whether that be through Association Health Plans, the Marketplace, Medicare or Medicaid, or some other form of insurance, we believe that coverage is an important element in providing good health care. Studies have long shown that people with health insurance have greater ease in accessing health care services and fewer delays in receiving care when needed.

Coverage does not just mean holding an insurance card, but rather the ability to access preventive services and care coordination, in addition to primary care needs. This also includes access to specialty care – including that beyond the walls of the Health Center. Too often we see Health Center patients that have an insurance card, but their options for care are limited, meaning that he or she must travel miles and miles to find a covered provider, or includes a prohibitively high deductible, making the coverage essentially useless to its holder. This under-insurance puts a strain not just on the patient, but on the Health Center too, who is required to provide the care, regardless of the patient's ability to pay. It is important that any proposal to create a new form of coverage offer affordable and robust coverage, allowing patients to access the care that they need, primary and preventive as well as acute, in their communities and without barriers to care.

From a financial perspective, when our patients have good coverage, that in turn eases the financial burden on our federal grant dollars that go toward covering the costs of delivering care effectively to our medically underserved patients and communities. Comprehensive coverage allows patients to access the care they need and frees up those much-needed grant dollars for those with no insurance at all.

This is even more important because of an outstanding issue that is in Congress' hands. On September 30, 2017, Health Centers went over the "funding cliff," because Congress had not yet renewed the Community Health Center Fund. Without action, Health Centers face a 70 percent reduction in funding, which would be detrimental to all Health Centers across the country. As we are here today discussing new insurance alternatives for our patients, I would be remiss if I did not mention the importance of renewing that funding. Our patients need both access to meaningful insurance coverage and restoration of full Community Health Center funding. In Vermont, a 70% loss in federal funding equates to a $14M loss, and in New Hampshire, the loss would be nearly $16M. No health care system can withstand this reduction in funding and not have a corresponding

reduction in critical health care services. The Health Centers have indicated they would reduce their services on average by 40% severely effecting access and care to our communities.

Nationwide, Medicaid and CHIP make up the majority of most Health Center patients. While Health Centers see everyone in their community, they are experts in caring for low and moderate income families. In Vermont, many Medicaid beneficiaries have annual income contributing to their families' well-being.[xviii]

Vermont's Community Health Centers

Like their counterparts nationwide, Vermont's Community Health Centers provide comprehensive primary care and prevention to Medicaid, Medicare, commercially insured, and uninsured patients. Vermont Medicaid covers 183,000 Vermonters and the Health Centers serve nearly one-third of them.[xix] The majority of Vermonters on Medicaid are children, the elderly, pregnant women, and working adults. By serving these patients, and over 106,000 Medicare and commercially insured Vermonters, Vermont's Health Centers assure access to care a reality. Insurance coverage makes access real. By providing access to comprehensive, high-quality primary care, Vermont's Health Centers ensure Vermonters get necessary services.

In 2000, Vermont had only 2 Community Health Centers with 7 sites serving just over 18,000 patients. Currently, Vermont has 12 federally funded Community Health Centers with 64 clinical sites in every county caring for the whole family from prenatal care to pediatrics, to adult and elder health care, providing a medical or health home to more than 172,000 Vermonters. Vermont Health Centers have a significant market share serving 1 in 4 Medicaid, 1 in 2 uninsured, 1 in 3 Medicare enrollees and 1 in 5 commercially insured Vermonters. Over the past ten years in New Hampshire, Health Centers have grown to16 organizations across the state serving approximately 113,000 patients in underserved areas.

Community Health Centers are also directed by patient-majority boards. This unique model ensures care is locally-controlled, responsive to each individual community's needs and, at the same time, reduces barriers to accessing health care through various services. Health Centers provide or arrange for transportation to ease the geographic barriers. Throughout Vermont, Health Centers work to bring fresh food, pharmacies, and classes for the elderly to their communities. They are more than just a doctor's office, Health Centers are a driving force to support the economic development and communities in more rural parts of Vermont. As well, Health Centers provide care targeted to reduce various cultural barriers by providing culturally competent care including translation services.

At the Community Health Center of Burlington, which is the community provider of choice for adult refugee health care, they serve a diverse population of patients that communicate in nearly 30 different languages. Interpreter-assisted visits accounts for 18% of our patient visits. CHCB's New American Health Program was founded to offer a solution to improve the health status of new arrivals, build relationships to establish a long-term Health Care Home, provide social

services assistance, and offer education leading to better health and wellbeing. The Health Center provider teams have specific experience with multi-cultural health and cultural competency; all services are offered with interpreter services; essential informational materials have been translated to their language; a Limited English Proficiency Specialist provides in person education along with in house produced videos (made possible by a state grant) both help provide health literacy and how to navigate a western health practice. Participants are also connected to dental care, mental health counseling and psychiatry as needed.

It is noteworthy that CHCB cares for over 5,000 Vermonters who identify as LGBTQ. This is testimony to their compassion, nonjudgmental and matter-of-fact attitudes and excellent quality care that we have developed into the provider of choice for these Vermonters. The Health Center specifically offer a Transgender Health Clinic, and, new this year, an LGBTQ Health Clinic. CHCB also purposefully hires to reflect their community. CHCB staff consists of French speaking Africans, Nepali, Bosnian, gay, lesbian and transgender individuals.

In New Hampshire, attention to cultural competency is a high priority as well. At the Manchester Community Health Center, of their 17,000 patients, over 7,600 patients (45%) spoke a language other than English as their primary language. There are 62 languages spoken and of the 223 staff, approximately 50% are either bilingual, bicultural, immigrants or refugees.

Health Centers work collaboratively within their local communities to support the needs of their patients. Working with hospitals, community mental health agencies, nursing homes, and others, Health Centers and their committed staff combat opiate addiction, diabetes, and other chronic conditions day in and day out. Vermont's Community Health Centers also serve as economic engines and community anchors alongside other business leaders in their communities. Vermont Community Health Centers employed 1294 FTE and generated nearly $178 million in total economic benefits; while New Hampshire Community Health Centers employed 896 FTE and generated over $114 million in total economic benefits in their communities.[xx],[xxi]

Impact of Association Health Plans on Community Health Centers and Bi-State

There are two main ways that Association Health Plans can impact Community Health Centers/Bi-State Primary Care Association: 1. Health Centers/Bi-State as employers; and 2. Health Centers as health care providers. This section will address each in turn:

1. As employers, Health Centers experience rising health care costs like every other business. Depending on their size, Vermont's Community Health Centers provide either fully insured coverage or self-insured coverage. Regardless of the type of coverage, the cost has increased significantly over the past several years. Health Centers, like other employers could opt to select an Association Health Plan if one were available for them.

   Vermont Health Centers' experience:

Our Health Centers in Vermont over the last years have had significant increases to premiums and deductibles with increases to both the employee and employer.

One Health Center self-insured with 145 employees covering nearly 200 lives in their insurance plan are paying for a single deductible $6,350 and family $12,700. Their premiums this year are 20% higher and they have learned from their insurer that premiums will go up at least this amount yearly. They have multiple plans for employees to choose from given the high costs. They note they can't absorb and new increases in the medical premium costs. They have attempted to join other risk pools without any success.

Another Health Center with 150 employees have a commercial product for their employees paired with a health reimbursement account. They note their greatest barrier to offering health insurance is controlling costs to the organization while trying to keep costs affordable to their employees. While they have tried to keep the employee premiums low, the deductibles have increased.

One of our largest Health Centers with 350 employees, is a "quasi self-insured", using a commercial insurer with $45,000 deductible per covered life. Employees have a $1,750 individual deductible and $3,500 stacked family deductible (Employee pays first $1,750 and the Health Center pays the next $42,250 of the total for a total of $45,000 for the individual deductible, after which the insurance pays the remainder of the claim). The Health Center has also has purchased and put in place individual and aggregate stop losses to control their financial exposure for individual and aggregate catastrophic events. Under this high deductible plan with purchased stop loss maximums the Health Center operates essentially like a self-insured, with less cost and catastrophic financial exposure. As well, the employee has to pay around 20% of the actual cost of the benefit through pre-tax payroll deductions and the Health Center provides employees the option of HSA's to pay for deductible and out of pocket costs. The Health Center reported the high and increasing cost of health care, especially over the last 4 years as grown in the neighborhood of 50% increase (going from $25,000 to $45,000), and this is the largest impediment to providing health insurance. The Health Center does this because it feels it is important to offer a robust health benefit program with includes health, dental, vision, long term care, with options to purchase additional supplemental insurance for accidents and hospitalizations.

<u>Bi-State experience:</u>

Bi-State as a small business employer for 25 employees working in Vermont and New Hampshire. We have selected a plan that allows for a strong in-state network and a comprehensive package. Over the past three years, our premiums have been held to a 11-16% increase only because Bi-State chose to increase its deductibles from $2,000 to $5,000, added most notably co-insurance which is the cost above the deductible that

employees must pay until the out of pocket maximum. There have also been an overhaul in the structure and pricing of prescription plans. The in-network out of pocket maximums are $7,350 for individuals and $14,700 for a family of two.

The summary of all these experiences have in common that Health Centers and our organization care deeply about assuring our employees have robust health insurance coverage.

2. As health care providers, Health Centers provide the necessary primary care services that reduce acute health care costs on a daily basis. Those services go far beyond annual check-ups. Managing patients and their conditions requires an array of tools including prescription drugs, dental services, access to mental health and addictions treatment services, and many others. Over 20% of Vermonters have a mental health condition, which can exacerbate their diabetes, hypertension, and other chronic conditions. For example, if an individual is in treatment of an opiate addiction, but their health plan does not cover the medication used in medication assisted therapy, Suboxone, that patient's chance of overcoming the addiction is dramatically reduced. Given that Association Health Plans can offer different benefits, the concern about specific benefit offering is very real to primary care providers who have appreciated consistency in benefits covered in Vermont under current insurance market rules.

Conclusion

Without their local Community Health Center, many communities and patients would often be without any access to primary care services. Community Health Centers have proven time and time again that access to a health center translated to improved health outcomes for our most vulnerable Americans and reduced health care expenditures for this nation. Community Health Centers need assurances that their patients will continue to have insurance coverage that is comprehensive and allows them to get necessary treatment.

Mr. Chairman, we stand ready to meet the demand among those in need of primary care. However, Community Health Centers can only meet these primary care demands if we can provide access to care.

We look forward to working with you and the other members of this Subcommittee to accomplish our shared goal of improving access to primary care while reducing overall health care costs across the country.

I thank you for this opportunity to share the importance of comprehensive and reliable coverage options for health center patients.

Thank you, Mr. Chairman.

[i] The proposed rule was released on January 5, 2018 and is available for comment until March 6, 2018. Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans, 83 Fed. Reg. 614 (January 5, 2018) (to be codified at 29 CFR 2910).
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