Marshfield Clinic HEALTH SYSTEM

SecurityHealth Plan

Testimony on the Stabilization of the Individual Market

before

The United States Senate Committee on Health, Education, Labor and Pensions

By

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On behalf of the physicians and staff and patients of Marshfield Clinic Health System (MCHS) I am honored to make the following statement. Throughout my comments I will be discussing our Health System's experience with the Affordable Care Act (ACA) individual market, both on and off the Federal marketplace, and our unique perspective as a rural health system caring for this population.

The ideas that we offer in the following testimony are what we believe will have the greatest impact on stabilizing the market in the short and long term. The ideas presented are not partisan. Instead, they seek a higher ground for our discussion focused on how we can best help the patients and members we serve maintain health coverage to ensure the best possible health care outcomes.

I. A history of caring for rural Wisconsin

The mission of MCHS is to enrich our patients' lives by creating healthy communities through accessible, affordable and compassionate health care.

MCHS is made up of several organizations, including: a multi-specialty physician-based practice with several hospitals in various stages of development and construction, and an insurance subsidiary providing coverage throughout Wisconsin in commercial, Medicare and Medicaid markets. We have 663 physicians and 400 non-physician providers across 80 medical specialties and more than 9,000 staff. MCHS has over 1.4 million patient encounters annually and sees patients from every Wisconsin county, every state in the United States and nearly 30 foreign nations.

There are many examples of how MCHS has been innovative in serving the care needs of our rural service area. Below are some recent examples that demonstrate our commitment to defining the future of health care services for our patients:

- **Precision Medicine Program:** Three Wisconsin-based medical and scientific organizations – Marshfield Clinic Research Institute, University of Wisconsin School of Medicine and Public Health and Medical College of Wisconsin – have collectively been awarded more than $5 million to help implement in Wisconsin the National Institutes of Health's (NIH's) *All of Us* Research Program that aims to benefit communities across the country.

  The *All of Us* Research Program is an ambitious nationwide effort to advance research into precision medicine, an approach for disease treatment and prevention that takes into account individual variability in biological makeup, environment and lifestyle for each person. The Wisconsin awardees will use their collective resources to enroll interested individuals and gather health information to help researchers understand how these factors can help determine how to best prevent or treat disease.

- **Comfort and Recovery Suites:** MCHS expanded its ambulatory surgery centers in Marshfield, Eau Claire and Wausau, Wisconsin to include comfort and recovery suites for post-surgical procedures performed in their ambulatory surgical centers. The comfort and recovery suites offer the same high-quality, post-operative care received in a hospital but at a considerably lower cost. This approach has saved the MCHS insurance subsidiary, Security Health Plan, more than $1 million in just under two years and patient satisfaction is extremely high with an average rating between 4.5 and 5 on a 5-point scale.

- **Dental Care Program:** The Marshfield Clinic Dental Initiative has improved the overall health care for the population we serve by providing clinical and economic value to patients and communities. The program is comprised of ten dental centers with 41 dentists and 39 hygienists. This staff provides dental services to almost 90,000 patients from all 72 counties in Wisconsin. The dental centers serve all patients, whether Medicaid, Medicare, commercially insured or uninsured, with a sliding scale fee so that everyone can have access to dental care. As an indicator of the importance of this dental care, we have documented evidence that when we open a dental center in an underserved community the incidence of ER visits due to dental problems drops dramatically.

- **Behavioral Health Integrated Care Model:** MCHS experiences difficulty in recruiting clinical psychiatrists, despite overwhelming demand for these services. In order to serve the unmet needs of patients and increase access to care, Marshfield Clinic developed the Behavioral Health Integrated Care Model. This care delivery model improves the value of care delivered by encouraging appropriate patients to be managed by a primary care physician and integrated care coordinator, rather than using more costly services.

  MCHS is currently collecting outcomes data to demonstrate changes in depression and anxiety symptoms for patients enrolled in the integrated care model. While the outcomes have not yet been validated, the evidence suggests that we will see:
  - A reduction in patient claims for behavioral health treatment
  - A reduction in ER visits
  - A decrease in visits to primary care

  The health system is working with Security Health Plan to determine the overall change in cost of care for patients after 18 months in the program.

For more than 100 years, MCHS has been living our mission of enriching lives in Wisconsin through accessible, affordable and compassionate health care. As we embark on our second century, we look forward to building on our past successes and continuing to innovate, maximize efficiencies and reduce patient costs while providing even higher quality care and a great patient experience.

II. Challenges of serving rural Wisconsin

MCHS serves approximately one million residents across our rural service area. Residents in our area have an average annual income of approximately $42,000 for a family of four, which is below the state average of more than $66,000. In addition to lower than average incomes, we also have an older population than the state average. In ten of the 31 counties that we serve there are fewer than two workers per Medicare beneficiary and in the balance of our service area there are three.

While these statistics do not tell the whole story, what they show is that in our communities, a large portion of the population is covered by public health programs. The subsidization of health coverage for low income Wisconsinites under the ACA has helped bring tens of thousands into traditional commercial coverage through the Health Insurance Marketplace. This has been vital to the health of our patients.

Wisconsin took a unique approach to the implementation of the ACA that has resulted in the uninsured rate in the state dropping by nearly 40 percent. Wisconsin expanded Medicaid to every resident under 100 percent of the Federal Poverty Level in 2014, which ensured there was no gap in available coverage, unlike other states that did not accept Medicaid expansion. Those who did not have employer health benefits were covered by the ACA individual market and the subsidies available. This approach helped to minimize the cross subsidization health care providers often have to implement to offset losses they experience in providing care to Medicaid recipients. The reduced cross subsidization resulted in keeping employer health insurance increases more moderate. Overall, Marshfield Clinic Health System's experience in the way Wisconsin structured its insurance market has been positive and has resulted in more residents achieving coverage.

In many of the areas we serve there are very few large employers, so the population has been dependent on the individual and small group insurance market to achieve health coverage. This market was subject to large variations in the cost of health insurance before the ACA. Many of the insurance products available prior to the implementation of the ACA's annual limitations on cost sharing and elimination of annual and lifetime maximums were substandard and did not adequately cover expensive services such as medications, certain hospitalizations and pre-existing conditions.

The ACA made several important changes which stabilized the market in a way that has been beneficial to the patients that we serve. We might also add that this area is very well served by multiple, high-quality insurance carriers that compete on the Health Insurance Marketplace so there is competition between and among the carriers that holds premium cost increases below national averages, accruing to the benefit of consumers.

MCHS's insurance subsidiary, Security Health Plan, participates in the exchange marketplace and has enrolled 28,000 residents in ACA plans. Between 95 and 98 percent of those who enroll in our Health Plan's insurance through the Health Insurance Marketplace receive subsidies to cover the cost of their health insurance.

In the communities we serve, 57 percent of enrollees in Security Health Plan's products are older than age 50.

- 7 percent are Under 21
- 9 percent are 21-29
- 13 percent are 30-39
- 14 percent are 40-49
- 27 percent are 50-59
- 30 percent are 60+

This population of enrollees is dramatically different than the population Security Health Plan covered prior to the ACA. This has resulted in an increased use of services to care for the chronic conditions of the population, resulting in higher costs to the health care system and higher premium increases.

During this same time our population of patients covered by Medicaid decreased from 66,197 to 55,910 – a reduction of 14.3 percent. We believe that a large percentage of these patients migrated into the exchange market. In order for these individuals to maintain coverage it will be important that there be a mechanism that allows them to afford health care on an out-of-pocket basis.

Additionally, prior to the enactment of the ACA we provided high volumes of uncompensated services. MCHS receives and treats all patients regardless of their ability to pay, and it was our experience that in 2012, before the implementation of the ACA, we were treating 13,277 residents who were uninsured and whose ability to pay for the care they received was limited. In 2016, our most recent tally of individuals without any insurance or ability to pay had dropped to 6,948, nearly a 50 percent reduction in the number of uninsured patients we serve.

As a community-based organization, our objective has been to find a way to get the population covered and promote an awareness of prevention of disease in the community.

III. Our philosophy

Throughout the repeal and replace debate, MCHS has maintained that it is imperative the individual market remain a stable, viable option for people to get and maintain health care coverage. In Wisconsin, the uninsured rate has been reduced by nearly 40 percent, in part because there are many more thousands of people who have newly attained coverage through the ACA individual market.

In 2014 and 2015, Security Health Plan was the largest carrier of ACA products in Wisconsin. Today, we remain in the top three. This is primarily because, as we noted earlier, we serve a largely rural and lower income portion of Wisconsin. The subsidies offered to lower income enrollees are a critical lynchpin in our patients' and members' ability to secure health insurance coverage.

Unlike stand-alone health insurers and their contracted providers, integrated delivery systems like Marshfield Clinic Health System and Security Health Plan have the unique ability to serve this market in a way that is economically practical as well as perfectly aligned with our mission to enrich lives through accessible, affordable and compassionate health care.

We believe the current instability in the ACA individual market will cause more of our community members to forego coverage and Marshfield Clinic Health System's mission of caring for our communities no matter a patient's insurance status puts us as a rural health system at greater risk if this occurs. Our community members who are uninsured will show up in our ERs, urgent cares and

provider offices as uncompensated care in the short term. In the long term, uninsured residents will end up in our Health Plans Medicare products, or Medicaid products, or even more inspirationally, in their group commercial products after seeking gainful employment. If these patients don't have continuity of care, they will have higher costs in the future because their care needs haven't been adequately met.

Most recently, our Health System renewed its commitment to this market by filling the second to last remaining county in the United States in the ACA individual market. This was a decision that allowed us to live our mission and step up to serve the community at a time when other health insurers are stepping back. We remain committed to the ACA individual market and patients and members that rely on it to ensure they can maintain their best health.

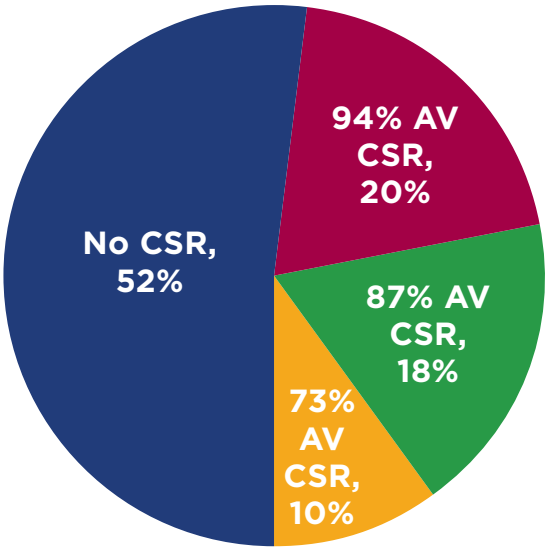
IV. Stabilizing the market

It's through the lens of our organizational philosophy that we offer a perspective unlike most other health systems or stand alone health insurance carriers on fixes that would stabilize the ACA individual market over the long term.

Some of the regulatory reliefs offered earlier this year by Secretary Tom Price at Health and Human Services did assist in giving health insurers tools to better manage their ACA individual population, but those reforms didn't go far enough to fully stabilize the market. We believe that the ideas outlined below give us the greatest chance to build on the base of the ACA and ensure continued coverage for the vulnerable population served by our Health System.

a. Cost sharing reduction payments

Security Health Plan's ACA individual population is heavily reliant on the cost sharing reduction (CSR) payments paid monthly to help our members lower their out-of-pocket costs when they use health care services. As you can see in the chart below, nearly half of the total enrollment in Security Health Plan's ACA products is eligible and enrolled in this important program. And nearly 40 percent of our total population is enrolled in the lowest income bracket of between 100 percent to 200 percent of the Federal Poverty Level who receive the highest amount of CSR subsidy.



Footnote
AV= Actuarial value
CSR= Cost sharing reduction plan

Enrollees between 100 percent to 250 percent of the Federal Poverty Level (FPL) are eligible for CSR plans based on the following:
- 100-150 percent FPL: 94% AV variant
- 150-200 percent FPL: 87% AV variant
- 200-250 percent FPL: 73% AV variant

Like many states, Wisconsin's Office of the Commissioner of Insurance created certainty where there was none by instructing carriers to assume that CSR payments will not continue in 2018. Non-payment of the subsidy has a profound impact to the rates insurers, including Security Health Plan, will charge. The assumption of non-payment of the CSR subsidy has pushed Security's rate increase to double over what it would have been if CSR payments would continue as promised.

Because our filed rates for 2018 assume CSRs will not be paid, the population of enrollees that will be primarily impacted are those above 400 percent of the Federal Poverty Level who don't receive either advanced premium tax credits or cost sharing reduction subsidies. These enrollees are subject to the full force of these substantial, and completely unnecessary, rate increases.

Finally, we take exception to the implication that these CSR payments are a "bailout to insurance companies." The CSR payments are simply a pass-through payment to providers, with no financial benefit to health insurers. Health insurers are simply the mechanism by which these payments are made to providers on behalf of members who receive these subsidies. Continuing funding for the program is fulfilling the promise the federal government has made to these enrollees.

Recommendation: Fully fund CSR payments to health insurance carriers for 2018 and beyond and allow states that have already reached their filing deadline to reopen carrier's bids to allow for an adjustment to rates.

b. Extension of the reinsurance program

Offsetting high-cost claims through reinsurance is a well-established mechanism to protect against unanticipated losses and resulting premium increases; it has worked effectively for programs including Medicare's prescription drug program.

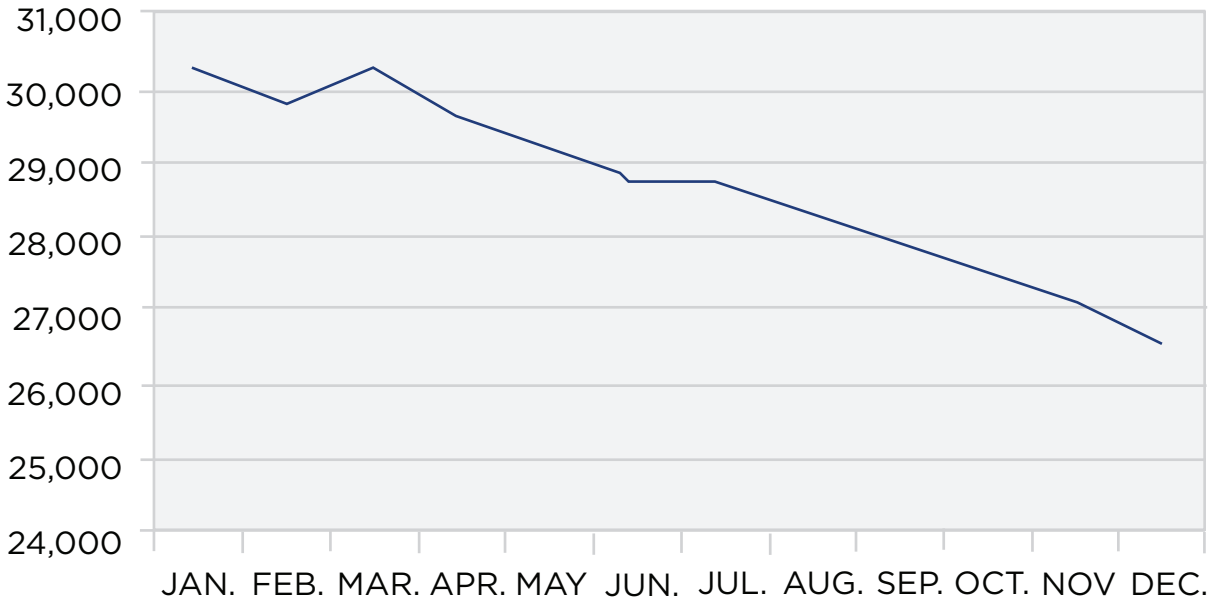
The transitional reinsurance program established by the ACA achieved its intended outcomes of holding down premiums in 2014, 2015 and 2016. Our Health Plan's experience shows that premiums would have been nearly 20 percent higher in 2014 and 12 percent higher in 2015, respectively, had this program not been in effect.

A continuation of the reinsurance program would stabilize the market and reduce premiums for everyone enrolled (both on and off the federal marketplace).

Recommendation: Create a reinsurance program similar to the program that expired in 2017 to stabilize premiums in the ACA individual market for the long term.

c. Continuous coverage provision

One of the struggles that health insurance carriers have faced in this market is the stability of population who are insured. The three-month grace period provision for those covered by the advanced premium tax credit aligns with the individual mandate provision that someone can have up to three months of being uninsured and still avoid the tax penalty. This has created a perverse incentive for enrollees to stay insured for just enough time to avoid the penalty. The chart on the next page shows our experience in 2016, which is strikingly similar to the experience in each of the previous years.



In order to create aligned incentives between the enrollee and the health insurer, the solution would be to create a continuous enrollment provision or late enrollment penalty similar to Medicare's Part B and Part D. If enrollees failed to maintain coverage for at least the previous 12 continuous months, the health insurance carrier could institute a late enrollment penalty. The key to making this effective is creating a level playing field for the penalty across all health insurers to ensure that additional unintended consequences were not created.

This provision isn't just for the benefit of health insurers and their risk tolerance, but as an integrated delivery system, we know that when patients have an ongoing relationship with their care provider that is facilitated through continuous health insurance coverage, patient outcomes are improved.

Recommendation: Establish a late enrollment penalty and/or a continuous enrollment penalty to incentivize 12 month enrollment in the ACA individual market.

d. Risk adjustment program enhancements

The current risk adjustment program is intended to transfer funding from health insurers that have lower risk enrollees to health insurers that have higher risk enrollees. Each year, the program has a net neutral impact to the Federal budget because transfers between carriers net to zero.

In actual experience, the risk adjustment program seems to be transferring funds from rural markets into urban markets and from new insurance carriers to established insurance carriers. These transfers, although supported by the complex risk adjustment formula, are not operating in the original intent of the program.

As an enhancement to this program, we would suggest that risk adjustment not be budget neutral, but instead be structured similarly to Medicare Advantage risk adjustment. In Medicare Advantage, the Centers for Medicare and Medicaid Services pays an increasing amount of capitation to health insurers based on the number of health conditions a particular enrollee has. This program more equally compensates health insurance carriers for the risk of the enrollees in its population.

Understanding that the ACA individual market and the Medicare market are inherently different in the amount of risk assumed by the Federal government, we would suggest a scaled back program that offers some additional funding based on the chronic conditions of each enrollee instead of the insurance market as a whole within a state.

A program like this, coupled with the temporary reinsurance program noted previously, would hold premium increases in check. By keeping health insurance premium increases at a lower annual increase than is currently projected, the Federal government could net savings for this program through lower future payments of the advanced premium tax credits.

Recommendation: Enhance the risk adjustment program to pay carriers a capitation for members whose risk scores exceed a certain predefined value. Savings from this program would be captured from lower-than-current future rate increases that would reduce Federal expenditures for the advanced premium tax credits.

e. Federal funding for enrollee outreach

Health insurance and the subsidies available to help area residents afford coverage are complex and confusing topics. Because of this, Marshfield Clinic Health System has invested in having more than 25 certified application counselors on site at our busiest centers. This service is a critical resource for the community in helping patients, especially the uninsured, understand the coverage options available to them.

Because our program is funded by the System's Family Health Center through a grant from the Health Resources and Services Administration, it is not in jeopardy from the recently announced cutbacks to outreach activities. However, through our own experience, we have found how important these programs are to lowering the uninsured rate in our communities.

Even with our strong commitment to promoting coverage availability, we cannot serve this need alone and we rely on the other community organizations that receive this funding to fill the gaps.

Recommendation: Reinstate funding for navigator and assistor programs and prioritize dollars to rural areas for community outreach of insurance options.

V. Conclusion

There is no doubt that the Affordable Care Act has flaws. There are aspects of the law that will need to be continually altered to meet the future health care needs of the American people. The goal in my testimony is to offer solutions that will immediately help to stabilize the market and ensure that our patients and members continue to have access to the care they need.

Thank you to the Committee for offering us the opportunity to provide our point of view on this important topic.