



House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Affordable Health Care
King's College – Wilkes-Barre, PA
April 4, 2018

AGENDA

- 10:00 a.m. Welcome and Opening Remarks
- 10:10 a.m. Cor Catena
CEO
Commonwealth Health and Wilkes-Barre General Hospital
- 10:30 a.m. Panel from State Agencies:
- Leesa Allen, Executive Deputy Secretary, Pennsylvania Department of Human Services
 - Alison Beam, Chief of Staff, Pennsylvania Department of Insurance
- 11:10 a.m. Ashley Weale, RN
Emergency Room Nurse
Pennsylvania Association of Staff Nurses and Allied Professionals
- 11:30 a.m. Marc Stier
Director
Pennsylvania Budget and Policy Center
- 11:50 a.m. Closing Remarks



Statement By

CORNELIO CATENA, CEO, COMMONWEALTH HEALTH

APRIL 4, 2018

PA. LEGISLATIVE DEMOCRATIC POLICY COMMITTEE

Thank you, Rep. Pashinski and the members of the Democratic Policy Committee for offering me the opportunity to speak on behalf of Commonwealth Health, the largest health care network in Northeastern Pennsylvania.

I'd like to tell you about Commonwealth Health and how proud our affiliates are to provide care to the people who live in the four counties and surrounding communities we serve.

Commonwealth Health is an affiliation of five acute care hospitals – Wilkes-Barre General Hospital; Regional Hospital and Moses Taylor Hospital in Scranton; Berwick Hospital Center, and Tyler Memorial Hospital in Tunkhannock. Also affiliated is the area's only freestanding behavioral health hospital, First Hospital in Kingston.

In addition, the system includes the Berwick Retirement Village; Commonwealth Health EMS, a vast emergency medical services fleet that provides basic, advanced and critical care services on the ground and in the air; more than 200 physician and mid-level providers; walk-in clinics and laboratory and radiology locations throughout several counties; drug and alcohol treatment; and psychiatric care for adults, adolescents and children.

Last year, Commonwealth Health celebrated five years of service to the people of Northeastern Pennsylvania. When pulling together the statistics, even I was astounded at the numbers.

Adding up the total admissions, number of surgeries, outpatient and emergency room visits and babies the affiliates have delivered in five years touched 10 million lives...and counting.

Commonwealth Health is proud to contribute to the regional economy and support school districts, fire and police departments and other municipal and county services through the property taxes paid each year.

Collectively, Commonwealth Health employ nearly 6,000 people and from 2012 to 2017, paid more than \$1.5 billion in salaries and wages and more than \$27 million in property taxes.

More than \$270 million has been invested in the hospitals and work continues to plan improvements to all facilities.

Commonwealth Health proudly supports health-related organizations such as the American Heart Association, along with other community efforts, through major sponsorships.

So, when we talk about the rising cost of health care, it should be noted that the cost to hospitals to provide health care is constantly increasing.

From the hospital's point of view, I can tell you that the bills patients receive can often be misleading.

Hospitals are paid according to fixed or negotiated rates that are typically a fraction of the rates charged. Hospital charges rarely reflect what they are actually paid by government or private insurers – and that is much less than what is charged.

There are several reasons hospital costs are on the rise:

- Hospital ERs provide care, whether the patient is insured or not. In just five years, Commonwealth Health affiliates provided \$181 million in charity and uncompensated care.
- Federal regulations influence a large percentage of reimbursements. Medicare patients represent 60 percent of all hospital admissions yet Medicare's payments to hospitals is declining. Medicaid pays even less, and when it comes down to it, these programs pay less than what it costs to care for patients.
- Preparation 24/7 to meet the community's health care needs means having staff, equipment and supplies ready to treat patients at all times.
- In some regions, and that includes Northeastern Pennsylvania, there is a high incidence of cancer and a high percentage of elderly with chronic conditions such as heart disease and pulmonary disease. Stricter federal guidelines penalize readmissions within a 30-day period.

The hospitals of Commonwealth Health, like all hospitals throughout Pennsylvania, are always looking for ways to help manage health care costs while continuing to provide the highest quality care.

By creating Commonwealth Health, the hospitals combined purchasing and improved operations, helping to control costs.

Our network of hospitals looks forward to a continued, strong relationship with insurers and elected officials on the state and federal levels to collaborate on ways to reduce health care costs while providing the highest quality care.

**Testimony on the Accessibility and Affordability of Healthcare in
Pennsylvania**

Leesa Allen, Executive Deputy Secretary

House Democratic Policy Committee

April 4, 2018

Good morning Chairman Sturla, Representative Pashinski and members of the House Democratic Policy Committee, and staff. I am Leesa Allen, Executive Deputy Secretary for the Department of Human Services. Thank you for the opportunity to provide information on behalf of the Department of Human Services (DHS) regarding our current and future initiatives to address the accessibility and affordability of healthcare in Pennsylvania.

Currently, in Pennsylvania, the Medical Assistance (MA) program provides coverage to almost 2.9 million Pennsylvanians, which represents 22 percent of the Commonwealth's population. The MA program covers preventive services, like vaccines and well-child visits; life-saving treatments for chronic diseases such as cancer, opioid addiction, liver disease and Hepatitis C; and services that help people with disabilities and seniors remain in their homes and communities. More specifically, the MA program in Pennsylvania currently serves:

- 1.2 million children, more than 387,000 of whom are between birth and 5 years of age;
- More than 350,000 seniors 65 years of age and older;
- More than 600,000 individuals who receive outpatient mental health services;
- 230,000 individuals with a substance use disorder (SUD) diagnosis; and
- More than 50,000 individuals who receive services in nursing homes each month.

In addition, the MA program pays for \$104.8 million in direct health and health-related services to children to help them with school participation and also provides \$29.9 million to school districts for administrative costs related to the provision of these direct health and health-related services.

As you are aware, the Affordable Care Act (ACA) gave states the option to expand Medicaid eligibility to individuals 19 to 64 years of age with incomes up to 138 percent of the federal poverty level, an option that Governor Wolf pursued immediately upon entering office in

2015. As a result, more than 715,000 newly eligible Pennsylvanians now have access to health care coverage through the HealthChoices program. This includes 130,000 individuals with SUD who have gained access to medically necessary drug and alcohol services. These services are critical given the current opioid crisis. In 2016, 4,642 Pennsylvanians died of a drug-related overdose, an increase of 37 percent from 2015 according to the federal Drug Enforcement Administration's Philadelphia Field Office, which equates to approximately 13 drug-related overdoses each day.

Because of Medicaid expansion and the ACA, the Commonwealth's uninsured rate fell from 10.2 percent to 5.6 percent in the five years since the ACA was enacted. Medicaid expansion has had other significant and positive impacts on Pennsylvania. For example, 71,300 individuals with an Opioid Use Disorder (OUD) diagnosis gained access to treatment.

Additionally, according to the Pennsylvania Health Care Cost Containment Council, general acute care hospitals saw a \$221 million (or a 21 percent) decrease in uncompensated care after Medicaid expansion in 2015. Prior to the implementation of Medicaid expansion, uncompensated care had increased annually since 2001.

Finally, these changes generated an infusion of more than \$1.8 billion in direct care health spending into the Commonwealth in calendar year 2015 and the addition of 15,500 jobs in Pennsylvania in year one.

Building upon the success of increasing coverage and access to treatment, DHS is focusing on four priorities in order to enhance both the accessibility and the affordability of healthcare in the Commonwealth including:

- Implementing and tracking Value Based Purchasing Targets within the managed care delivery system;

- Implementing Managed Long Term Services and Supports (known as Community HealthChoices) statewide;
- Addressing Social Determinants of Health; and
- Addressing the Opioid Crisis.

Value Based Purchasing

DHS has been focusing on the adoption of Value Based Purchasing in the Medicaid program over the past few years to drive payment reform. DHS began evaluating the progress toward alternate payment methodologies (APMs) in 2015/16. The National Governor's Association (NGA) and the Center for Health Care Strategies provided technical assistance to DHS in March 2016 to accelerate our planning and research needed to adopt APMs in the MA Program. In addition, the Center for Medicare & Medicaid Services (CMS) convened a national public-private partnership called the Healthcare Payment Learning and Action Network (LAN). In January 2016, The LAN developed a broad framework for APMs that provides a progressive roadmap for adoption of APM strategies.

DHS adopted the LAN framework and set targets for the Physical Health Managed Care Organizations (PH-MCOs) beginning with the 2017 HealthChoices agreements. Each PH-MCO is required to spend a defined percentage of the medical portion of its capitation and maternity payments through APMs. The percentages are 7.5 percent in 2017, 15 percent in 2018 and 30 percent in 2019. The PH-MCOs must enter into arrangements with providers that incorporate value-based purchasing strategies such as:

- Provider pay-for-performance programs;
- Patient Centered Medical Homes (PCMH);

- Shared savings contractual arrangements;
- Bundled or global payment arrangements; and
- Full risk or Accountable Care Organization payment arrangements.

Provider pay-for-performance is the least complex APM and full risk arrangements are the most complex. In 2017, the PH-MCOs can meet the goal through any of these strategies. In 2018 and 2019, PH-MCOs will need to place more emphasis on the more complex strategies to meet the annual goal. Compliance with the 2017 goal will be determined during the summer of 2018 but preliminary data suggests all PH-MCOs will meet the 2017 goal.

Pennsylvania is working toward expanding the use of value-based purchasing strategies more broadly in the Commonwealth. In February 2018, DHS hosted a value-based purchasing roundtable meeting that included representation from the MA program, Children's Health Insurance Program (CHIP) and commercial payers. The goal of this session was to start the conversation about multi-payer alignment with respect to the use of APMs. The NGA supported the meeting and provided speakers with national expertise in value-based purchasing through the State Health and Value Strategies program, a grantee of the Robert Wood Johnson foundation. DHS plans to expand this work by hosting a future roundtable session with providers.

To enhance efficiency in the HealthChoices program and manage growing medical costs, during the annual capitation rate development process, our actuary identifies opportunities for improved managed care efficiencies in controlling cost and utilization. This is done through review of the MCOs' claims data from the rate base year. The actuary identifies inefficiencies in both MCO costs and utilization in four major categories:

- Pharmacy;
- Inpatient;

- Outpatient - which includes: emergency department, radiology and durable medical equipment; and
- Third party liability/coordination of benefits.

Total inefficiencies resulted in adjustments from the rate base year of more than \$153 million or 2.33 percent of the base year's medical costs for the 2018 calendar year capitation rates. These efficiency adjustments allow DHS to ensure the viability of the Program through cost-effective strategies.

Community HealthChoices

DHS is committed to increasing opportunities for older Pennsylvanians and individuals with physical disabilities to live in the environment of their choice. Community HealthChoices (CHC) is a managed care program that will optimize such opportunities by coordinating delivery of both physical health benefits and long-term services and supports (LTSS). Physical health services are practitioner and acute or short-term services. LTSS, as the name suggests, are long-term; they address chronic conditions. In addition to services provided in nursing facilities for persons who need those services, LTSS support the ability of individuals to remain in the community.

By transitioning hundreds of thousands of Pennsylvanians to a managed care program that will coordinate physical and long-term care services, DHS will enhance service delivery for some of our most vulnerable friends, family members, and neighbors. CHC will serve more people in communities while giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life. CHC will cover individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid, and individuals who are 21

years of age or older and eligible for Medicaid because they need the level of care provided by a nursing facility.

CHC is being rolled out in three phases. The first phase began in the southwest portion of the state on January 1, 2018. The second phase will occur in the southeast portion of the state on January 1, 2019. The remainder of the state will be part of the third phase occurring on January 1, 2020.

For the southwest implementation, approximately 85,000 individuals were enrolled. Of that number, 52 percent enrolled in UPMC Community HealthChoices, 26 percent enrolled in Pennsylvania Health and Wellness, and 22 percent in Amerihealth Caritas.

The implementation plan for CHC was based on a significant amount of research on other state experiences in their roll-out of managed LTSS programs, as well as the 20 years of managed care experience from the HealthChoices program. This research and the lessons learned from the HealthChoices program supported CHC program design, the need for broad stakeholder and participant engagement, and the identification of participant protections. These participant protections include:

- A robust complaints and grievances process;
- A 180-day continuity of care period for LTSS beneficiaries receiving their services in the community; and
- The grandfathering of LTSS nursing facility residents to continue to receive their services in their nursing facility indefinitely following the CHC launch.

DHS has made communication with enrollees a priority, and we saw proof that we were effective as enrollees were selecting their plans. Over 40 percent actively chose a plan rather than waiting to be auto-assigned, which significantly exceeded national averages of around 20

percent for these types of programs. In addition, approximately 9 percent of individuals were assigned into the CHC-MCO that aligned with their Medicare coverage.

During all phases, participants will receive pre-transition notices and information that will provide details of this change. Participants will also receive guidance on how to work with the Independent Enrollment Broker to select a CHC-MCO that most closely aligns with their current services and their current service providers. Community sessions will continue to be scheduled throughout these launches to give participants the opportunity to have their questions answered in person. Throughout these launches and by way of close monitoring of the CHC-MCOs, DHS will work to ensure that there are no interruptions in participant services or provider payment.

Social Determinants of Health

As we move the MA program forward in improving overall health outcomes, it is important we recognize that, more often than not, barriers prevent the population we serve from achieving better health and overall quality of life. We are looking to do more to help individuals by identifying and assisting with removing barriers that are preventing them from achieving their own individualized goals.

DHS is working collaboratively along with our PH-MCOs to build upon the initiatives already in place to help remove barriers that prevent our members from participating in employment, training and education activities. To begin these efforts, DHS hosted a roundtable with its MCOs in early February to share our existing programs, activities and initiatives that support our members in this effort, and also initiated the conversation on how we can partner to expand identification, outreach and participation by the populations we serve.

The MCOs already have processes to assess and identify many of these social barriers. They are using this information to help build programs and community partnerships aimed at addressing some of these needs. Their initiatives include but are not limited to GED and skill based training programs, food delivery and nutritional education through partnerships with MANNA (a nonprofit organization that delivers nutritious meals and provides nutrition counseling), homeless shelter based medical and professional services, and investments in housing. DHS is committed to supporting and increasing these efforts through its HealthChoices agreements.

Addressing the Opioid Crisis

As you know, Governor Wolf has issued a disaster declaration to address the opioid crisis. The MA program has been a leader in the implementation of evidence-based utilization management practices for opioid prescription within both the fee for service and managed care delivery systems, and DHS is working with DOH and the Insurance Department to encourage the application of these policies consistently across payers.

Pennsylvania averages 13 opioid-related deaths per day, so maintaining a sense of urgency and placing a strong emphasis on continued concerted efforts to combat the opioid crisis remains a top priority. We have shown progress in fighting the epidemic by:

- Increasing access to treatment through Medicaid expansion;
- Increasing access to medication-assisted treatment; and removing prior authorization from some buprenorphine agents;
- Updating prior authorization policies to support appropriate utilization of opioids to protect patient health and safety;

- Expanding opioid education and training for health professionals;
- Establishing a Naloxone standing order; and
- Opening a 24-hour help line that connects people to treatment.

In 2016, the Centers of Excellence (COEs) were established by Governor Wolf when he named the opioid epidemic a top administration priority. The COEs generated immediate, strong interest among the public and providers alike. To date, there are 45 COEs across 27 counties that began with a staggered implementation approach in October 2016, and ended with the final COE going live in May 2017. The COEs are intended to transform the SUD service delivery system to focus on team-based treatment, that focuses on the whole person to address both mental and physical health concerns, as well as to assist in navigating care so individuals stay engaged in their treatment.

COEs have proven to be a critical part of our efforts to enhance treatment for people suffering with OUD and other SUDs, with many successes during the first year of implementation including:

- 14,654 individuals having interacted with a COE;
- 10,903 individuals having received a level-of-care assessment, which helps to determine the type, level, and length of treatment;
- 71 percent of individuals seen by a COE having been engaged in treatment, an increase from 48 percent before these centers were established, and;
- 62 percent of individuals having been engaged in treatment for at least 30 days, an increase from the prior 33 percent.

The administration's efforts have resulted in the development of integrated systems that are allowing addiction and other physical and mental health issues to be treated simultaneously

while closing treatment system gaps using community-based care management teams, so fewer people seeking recovery relapse.

DHS is expanding access to medications that help people recover from addiction and is developing relationships with other treatment providers, the criminal justice system, primary care practices, emergency departments, and other potential referral sources where people with OUD might present.

Pennsylvania has made significant gains over the past several years in improving health outcomes for its most vulnerable citizens. Jobs have been created as a result of Medicaid expansion, the uninsured rate has been reduced to an all-time low, uncompensated care rates for hospitals have significantly decreased, and most importantly, more than 715,000 individuals have obtained health care coverage. Moving forward, implementation of the four priorities discussed today will contribute to the continued enhancement of accessibility and affordability of healthcare in the Commonwealth. I welcome your comments on the information presented and look forward to continuing to partner with the committee and General Assembly. Thank you for the opportunity to provide testimony.

Statement before the House Democratic Policy Committee

Affordable Health Care

April 4, 2018

Alison Beam, Chief of Staff of the Pennsylvania Insurance Department



Good morning Chairman Sturla, Representative Pashinski and Members of the House Democratic Policy Committee. I am Alison Beam, Chief of Staff at the Pennsylvania Insurance Department. Thank you for the opportunity to be here today to speak about the ways that Governor Wolf's Administration has made health care more affordable in the Commonwealth and how the Administration is working to accomplish this aim in the future. Health care affordability is an issue that is extremely critical for residents of the Commonwealth of Pennsylvania, and I applaud the Committee's efforts to shed light on such an important topic.

While health care affordability is an unwieldy topic, I would like to take the time you've offered me today to first speak about the dramatic improvements that the Affordable Care Act (ACA) has made in Pennsylvania, and then speak about some of the challenges we're facing to keep that market stable. Finally, I will provide an overview of the various initiatives that we're working on in the Commonwealth to address health care affordability.

The Affordable Care Act Has Increased Access to Health Care

When discussing the affordability of health care, we must first recognize the positive impact that the ACA has had on Pennsylvanians. As a brief reminder, prior to the ACA, individuals seeking access to health care faced barriers such as pre-existing condition exclusions, which either denied individuals access to commercial health insurance outright, made insurance prohibitively expensive or allowed an individual to obtain insurance but not for services related to the pre-existing condition. Likewise, individuals with chronic medical issues or anyone who underwent a costly procedure like a transplant could face financially devastating annual and lifetime limits. Women could see higher monthly premiums than men and perhaps not have access to contraception or maternity care. Finally, coverage for other critical services like mental health and substance use disorder treatment services were difficult to obtain. These challenges contributed to more than 10 percent of Pennsylvanians and 16 percent of Americans nationwide going uninsured.

Since the ACA's passage, Pennsylvania's uninsured rate has fallen from 10.2 percent in 2010 to 5.6 percent in 2016 – the lowest it's ever been. More than 1.1 million Pennsylvanians have accessed coverage through the ACA, and that coverage is much more comprehensive than what was previously available. Of the 12.7 million Pennsylvanians, more than 40 percent of us – 5.4 million individuals – have pre-existing conditions and cannot be denied health insurance coverage due to the ACA. In addition to this, more than 175,000 Pennsylvanians have also been able to access substance use disorder treatment services through their individual market or Medicaid expansion coverage. These services are critical as our Commonwealth and other states around the country strive to combat the overwhelming impact of the opioid epidemic.

The Individual Market Still Faces Challenges

While the ACA has made great strides to achieving health care access, the ACA's individual market still faces challenges to remain stable. Many of the challenges include actions that the federal government has taken, such as not funding Cost-Sharing Reduction (CSR) payments, the encouragement of Short-Term Limited Duration (STLD) insurance and Association Health Plans (AHPs), and curtailing efforts to grow the risk pool during the open enrollment season. I'll explain each of these challenges in turn, and how the Insurance Department has approached each challenge with the aim of mitigating harmful consequences for Pennsylvanians.

De-funding of Cost Sharing Reduction payments

The federal Administration's decision to discontinue CSR payments to insurers and Congress' inaction to appropriate these funds increased Pennsylvania's individual market health insurance rates last year from an expected 7.6 percent increase to an average 30.6 percent. As a reminder, CSR payments provide additional benefits for people with lower incomes to assist with their out-of-pocket costs. To mitigate the impact of the lack of funding of these payments, the Wolf Administration prudently planned to allow insurers to account for the non-funding of these payments. We also worked closely with insurers in an attempt to cut through the massive consumer confusion and guide each consumer to the most suitable plan for their needs. As a result, many consumers were able to purchase a plan for 2018 that provided them better value.

Encouragement of Short-Term Limited Duration Insurance

The federal Administration recently released a proposed rule which would allow STLD insurance to be positioned as an alternative to individual market coverage by allowing the policy to have a similar duration to individual market coverage. STLD insurance is referred to by some as "skinny plans," which is a reference to the trimmed down benefit package and coverage limits in these plans when compared to ACA coverage.

While the Insurance Department has underlying concerns that the encouragement of STLD insurance will further destabilize the individual market, the Department is also concerned about the misunderstanding and confusion these plans create for consumers. Frequently these plans are marketed as "ACA-compliant," and consumers purchase them believing they are buying coverage that includes all of the benefits required by the ACA, that they can purchase the plan using the ACA's subsidies, that their pre-existing conditions are covered, and that they can renew the coverage without being re-underwritten. After they purchase the plan, consumers discover that they have been misled, and the coverage is not as promised. Within the last two years, we have suspended the licenses of seven agents who misrepresented limited benefit plans as complying with the ACA, and we have open and ongoing investigations and continue to address this issue.

Proposal to expand Association Health Plans

The federal government threw yet another challenge to the individual market when it recently proposed a rule that would encourage AHPs. AHPs are viewed by some as an alternative to participating in the individual and the small group market, which creates instability in the marketplace by siphoning individuals out of the individual market risk pool. The proposed rule broadened the population that can avail themselves of AHPs by allowing more individuals and small employers to join together as groups to purchase AHPs. In a comment letter on the proposed rule, the Insurance Department voiced concerns that the expansion of AHPs will cause potential consumer harm immediately and on an ongoing basis, as the ripple effect of the proposed changes will affect market stability, insurers, and the provider community. The proposed rule, if finalized as drafted, would result in greater barriers to high-quality coverage and decreased affordability for many consumers.

Shortened Open Enrollment Season

The federal government shortened the time period for people to enroll in health insurance for 2018, while also cutting outreach funding. These efforts jeopardize market stability, as the health of any insurance market depends on the strength of its risk pool, and reduced enrollment strains the risk pool and contributes to rising costs for those in it. In an effort to avoid such consequences and serve as a resource for consumers during the abbreviated enrollment season, the Department worked alongside insurers, legislators, health care providers, consumer advocates, and other stakeholders to reach our common goal of increasing covered Pennsylvanians and informing them of important changes to the open enrollment period. Because of these collaborative efforts, almost 400,000 Pennsylvanians selected health plans for 2018, only a slight decrease from 2017. We will continue to carry out outreach and enrollment efforts, as encouraging enrollment helps everyone – people have access to coverage, insurers have a more robust risk pool, and providers are more likely to receive compensation for care provided.

The Wolf Administration is Diligently Working to Address Rising Health Care Costs

While the challenges I have outlined may seem insurmountable, the Wolf Administration continues to demonstrate unwavering leadership by committing to reroute the escalating path of health care costs. The Administration understands the opportunity and the responsibility that comes with being in such a uniquely situated state, with a competitive health insurance market, a world-renowned provider community, an aging population and a diverse geography. True to the principles of state democracy, the Commonwealth is serving as a laboratory for initiatives to address the challenge of health care cost containment head on.

Addressing Underlying Costs of Health Care

Stabilizing the individual market is an important first step to addressing cost concerns, but we still need to get to the root of what really drives insurance costs: the cost of health care. To put it simply, insurance is expensive because the health care it pays for is expensive. Unfortunately, it gets more and more expensive every year, which means premiums will continue to rise every year.

We need to have a serious conversation about how we can moderate the unsustainable growth in health care costs, especially in areas experiencing astronomical growth in cost like we currently see with pharmaceutical costs. There is no silver bullet to reduce the cost of health care and the conversation is not easy, but it is essential as we look to the future and the long-term viability of our health care system. We continue to look for solutions to these problems at the state level, as well as engaging in the national conversation through the National Association of Insurance Commissioners (NAIC). Recognizing the great depth of knowledge that Commissioner Altman has on this issue, the NAIC recently selected her to serve as a leader on the Health Insurance and Managed Care Committee of the NAIC, which is charged with examining health care cost drivers and state initiatives to address the issue.

Achieving Affordability Through State Innovation

We need to build upon the foundation of the ACA by making targeted and common sense changes that will make the ACA work better for the people it is not working perfectly for today. We still have a serious affordability problem in the individual market, especially for the 1-2 percent of Pennsylvanians who rely on the individual market for coverage but are not eligible for financial assistance, as well as individuals facing rising deductibles. We are exploring flexibility contemplated in the ACA to create a program to control outlier health care costs, which has the potential to meaningfully reduce health care costs statewide – especially the unsubsidized population.

Under Section 1332 of the ACA, states have the opportunity to obtain permission to waive certain portions of the ACA in order to implement creative solutions to stabilize the individual health insurance market. However, states face the challenge of securing adequate funding. While funding for such a program would largely come from federal pass-through funds under the Section 1332 Waiver, a portion of the funding would also have to come from state contributions. We recognize the constraints of state budgets so we recently urged members of the Pennsylvania Congressional Delegation to support a package of bipartisan health insurance stabilization bills, which included grants for state funding to carry out these initiatives. Unfortunately, the market stabilization bills were not included in the most recent federal spending bill, so the Department is continuing to monitor additional funding opportunities at the federal level.

Addressing Surprise Out-of-Network Balance Bills

The Insurance Department continues to work with the legislature to establish a path to resolution for consumers when they receive an unexpected balance bill. These bills unexpectedly drive up consumers' out-of-pocket health care costs, creating greater cost strain on the health care system as a whole. The Department thanks Senate Banking and Insurance Chairman Senator White and Senators Costa and Schwank for sponsoring SB 678 and Representative Pickett for sponsoring HB 1553. Both bills address the circumstances that arise when a consumer unknowingly receives services from an out-of-network physician, and is subsequently billed directly for the difference between the insurer's reimbursement and the cost of the services. These unexpected and sometimes financially significant bills are troubling and can be unaffordable for consumers, who may have done everything right when choosing to receive care in-network. The Department's primary goal for this proposed solution is to protect consumers from receiving these unexpected bills, while minimizing burden on the stakeholders involved in these complicated situations.

Leading Initiatives Within Governor Wolf's Health Innovation Plan

The Insurance Department, in partnership with the Department of Health and the Department of Human Services, is leading efforts to address health care affordability and quality contemplated in the Governor's Health Innovation Plan (HIP). The HIP is a comprehensive, multi-stakeholder statewide initiative to improve the health of all Pennsylvanians by redesigning the way we pay for, deliver, and coordinate health and health care services. The Insurance Department is leading the price and quality transparency innovation work, which includes initiatives aimed at making care more shoppable and increasing consumer health literacy. The work groups are exploring how transparency innovations impact consumers' health care experiences and decisions.

Moving the Needle on Health Care Costs

Governor Wolf's Administration is facing the health care cost challenge head on. Specifically, the Insurance Department is diligently working to stabilize the insurance market by strategically and thoughtfully anticipating and reacting to challenges presented by federal regulatory dynamics. But more than just being reactive, the Department is proactively identifying solutions to implement in Pennsylvania that can achieve meaningful affordability for consumers. Despite the immediate, burning challenges of the health insurance landscape today, we have not lost sight that we must continue to seek long-term strategies that moderate the growth of health care costs to ensure our system is sustainable and will meet the needs of those that need it now as well as those that will need to rely on it in the future.

Thank you for allowing me to speak with you today. I would be happy to take any questions that you might have.

1. Good morning, my name is Ashley Weale, and I am an ER Trauma Nurse and the Vice President of the Wyoming Valley Nurses Association, a local affiliate of PASNAP, the Pennsylvania Association of Staff Nurses and Allied Professionals. I would like to thank Representative Pashinski and the rest of the panel for the opportunity to speak on the topic of the rising cost of healthcare, it's a topic that is very important to me.

While personally I am a nurse, my mother is also a nurse, my mother in law is a nurse, my husband is a nurse, and my sister is a nurse; so it is safe to say health care is very important to me. I became a nurse for a variety of reasons, the least of all is a paycheck. All I ever wanted to do with my life was to help people, that was the only thing I have ever been certain of. So please let me be clear when I say that I do love my job, I love my profession. But, as a nurse at the bedside, I see firsthand how issues in our healthcare system drive up costs without increasing the quality of care or improving outcomes for the patients we treat.

2. Independent academic studies consistently and conclusively show that nurse staffing is a leading predictor of quality of care. Appropriate nurse staffing helps to prevent medical errors, reduces infection rates, and is associated with lower risk for ulcers, sepsis, embolisms, and accidental falls. In simpler terms, patients get out of the hospital faster, with better outcomes and fewer readmissions, when hospitals use an appropriate number of nurses.

According to the ANA, "a common reaction to cost containment pressures is to reduce professional nurse labor hours and their associated costs. This strategy, however, is shortsighted as appropriate nurse staffing levels are essential to optimizing quality of care and patient outcomes in this era of value-based healthcare."

This strategy---cutting nurse staffing in a mis-guided attempt to cut overall costs has a negative impact on safety for both the patient and the nurse and ultimately leads to an increase in the cost of care.

Having sufficient nursing staff ensures an appropriate level of attention to patient admissions, discharges, and daily nursing activities which are critical factors in controlling costs and optimizing revenue.

Hospitals in which nurse burnout was reduced by 30% had a total of 6,239 fewer infections for an annual cost saving of more than \$69 million, according to the ANA.

▪ Ultimately, this results in cost savings throughout the healthcare system.

3. And yet, even though we know the benefits and potential long-term cost-savings of safe staffing, too many hospitals continue to cut corners in this area, chronically understaffing and squeezing nurses, resulting in lower quality of care for patients — inevitably leading to many of the negative outcomes mentioned above, including longer stays, more severe complications, and many more readmissions.

- In 2017, to better understand the scope and severity of the staffing crisis, my union PASNAP sent surveys to 30,000 Registered Nurses in the Commonwealth. More than half said their facility is “always” or “often” understaffed. 88% said they have less time for patients than in the past. Three quarters said they’ve seen patient outcomes getting worse. Sadly, an overwhelming majority also said that their healthcare facility does not value input from nurses, who spend the most time at the bedside and are often the best patient advocates in the system.
 - One rationale for this lack of investment in nursing is that hospitals do not bill for nursing care. They can bill patients for rooms, for equipment, for medication, and for tests, but they don’t bill for the time that my coworkers and I spend at the bedside. CMS has tried and failed on numerous occasions to account for nursing skill and care in the acute care setting, but they always fall back to the umbrella “room and board rate” or “general nursing.” While nurses don’t want to be reduced to billable hours, as a matter of fact, we want the opposite, for healthcare to focus on patient care rather than insurance payments, copays and deductibles. But this may explain why front-line caregivers — despite the central role we play in ensuring effectiveness of treatment — are so often on the chopping block, and why administrators who have never spent a day at the bedside will pour money into infrastructure additions even as staffing deteriorates to the point of crisis inside the walls of the hospital.
4. The hospital I work for, Wilkes-Barre General, is owned by Community Health Systems, which is a for-profit, publicly traded company. In 2018 alone, we have lost sixteen nurses, only four of whom have been replaced. This problem stretches back several years and has resulted in chronic understaffing. For a current 30-day period, we have 907 shift vacancies in our Emergency Room alone — 907 unfilled shift openings in one department in one hospital. Imagine how that impacts patients and quality of care. When there are that many openings, the hospital has been relying on the staff to work through breaks, to stay 16-hour shifts, and forcing each nurse to take extra patients. Now imagine you are my 5th or 6th extra patient, on my 15th hour when I haven’t eaten since the drive into work that morning. I desperately want to provide safe and quality care to every single one of my patients, but I walk in to work feeling like I am set up to fail, in a job where failure could mean the difference between life or limb or even death. I wish I could say that occurrence is rare, but unfortunately it has become routine. So, it has become commonplace for me to work 16-hour days, and then beat myself up for the next few hours over the mediocre care I had to give, only to wake up and do it all again. Hospital corporations are making a profit off of the altruism of healthcare professionals because much like doctors, nurses are bound by an ethical standard of ‘first do no harm.’
- At the same time, rather than simply hiring additional nurses and making a meaningful investment in patient care and providing more professional jobs in our community, the hospital has squandered money on stopgap solutions, paying heavy premiums for overtime and temporary agency nurses. From 2017 through present, the hospital has paid for 223,820 overtime and agency hours. Those unnecessary costs are a drain on the system.

- Beyond that, as staffing has deteriorated and frontline caregivers have been stretched to their breaking points, CHS, our for-profit owner, has showered top executives with exorbitant pay packages, totaling more than \$95 million over the last three years. The CEO alone has pocketed \$42.6 million. And this is the CEO of a health system that is supposed to be focused on patient care. While I continue to use CHS as an example, the name of the corporation can be substituted with just about any for profit health care company—from hospitals to insurers and pharmaceutical companies.
 - A very personal example comes to mind when I think of profiting off of a person's illness. Several years back my father had a stroke, he was cognitively impaired from the stroke but had no physical symptoms, no facial droop no slurred speech. However, he had difficulty finding the right words, confused people and dates and times, and was confused to place. While he was alone in his room a billing representative from the facility where he was, came in and asked him how he planned on paying for his stay, should his insurance deny him coverage and his deductible was not met. He was then asked for collateral or credit card information. Thankfully, my father had a roommate at the time, who was able to relay the information to my mother when she came back into the room, otherwise we never would have known this occurred. My father had signed forms, confirming his home address and verifying his billing information, because he had no physical symptoms. Whenever I think about this instance, it turns my stomach to know this happens every day, to people who wouldn't know to question it.
5. Health care in the United States makes up nearly one fifth of our economy. As a nation, we spend \$3.2 trillion per year on healthcare — nearly twice as much as the next country in line — yet our health outcomes are mediocre, 37th in the world, behind countries like Morocco and Costa Rica. In a system as large and complex as ours, it would be disingenuous for me to blame ballooning costs on any one issue.
- As a whole we tend to emphasize treatment rather than prevention and wellness. Our insurance system, with high deductibles and out-of-pocket costs, causes patients to delay their care until symptoms become unbearable, which lands them in Emergency Rooms like mine rather than the office of their Primary Care Physician. I see examples of this every single day at work. The impoverished and the elderly are facing the choice between food and their medicines. I am not saying this as a general statement to tug at heart strings, I am stating this as a matter of fact, this is a legitimate problem facing the aging population every day. The cost of prescription drugs has gone up, with no end in sight. Could you imagine waking up and having to choose between your medicine and food? That seems like something that only happens in third world countries, but it happens here, all over this country every second of every day. So, they forego medicine, because hunger can be immediately relieved, they almost always choose food. Then they wait until they are so sick they require acute care hospitalization. Then we spend hundreds of thousands of dollars making them well. When all they needed was a few months' worth of pills and a doctor's appointment. When patients cannot afford to see primary care doctors in the

outpatient setting, they aren't getting the medical education or proper follow up they need to be an invested member of their own health care. When in the acute care setting, the nurses and doctors are so over tasked that we do not have the time to provide patients with all of the care and education they require, so they end up coming back, often within 30 days or less. When people don't have health insurance, they cannot go see a primary doctor so they turn to the ED for diagnosis and treatment of both non-emergent and chronic conditions. All of these are factors that drive up health care costs for everyone.

6. But, as a nurse, I also see every day how the people who make the important policy decisions, create incentives, and allocate resources are far removed from the real work of patient care. Many have never worn scrubs or spent a day at the bedside. Too often, they treat us, the nurses and professionals on the front lines, as obstacles rather than partners: as a line item on the budget — “labor costs” to be held at minimum — instead of what we truly are --- healthcare experts trying to advocate for patients and provide the best possible outcomes for our patients and the hospital.

Thank you for your time.

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**Testimony on Healthcare Affordability before the
Pennsylvania House Democratic Policy Committee**

April 4, 2018

Wilkes Barre, PA

Good morning, and thank you to the members of the committee for holding this hearing on healthcare affordability, an issue that impacts nearly all Pennsylvanians. I am Patrick Keenan, the director of consumer protections and policy for the Pennsylvania Health Access Network. We are the Commonwealth's only statewide consumer-driven organization working to expand and protect access to high-quality, equitable, affordable healthcare for all Pennsylvanians. Our advocacy work is built on our direct connections with communities – both rural and urban – throughout Pennsylvania.

As a healthcare navigator, our staff enrolls people in Medicaid, CHIP, and Marketplace coverage. Over the past five years, PHAN has enrolled over 8,500 in healthcare coverage and fielded tens of thousands more questions about health coverage that come in through our toll-free health insurance helpline. Beyond this, PHAN works to ensure that those we have enrolled understand their benefits, know how to access them, and ultimately are empowered to get the care they need. Throughout the process of building consumers' skills, confidence, and knowledge related to healthcare, we develop and mobilize members of impacted communities to become leaders that advocate for changes to the healthcare system. By working with a broad range of healthcare consumers throughout the state, PHAN is able to identify common concerns, barriers, and needs that inform our policy agenda.

The Affordable Care Act has delivered on its biggest promise: expanding access to high quality insurance coverage for the millions on individuals who previously struggled with coverage due to pre-existing conditions, unfair rules, or who were simply priced out of the market. Nearly 400,000 Pennsylvania are covered by an ACA-compliant plan and more than 700,000 are covered by its expansion of Medicaid. Our uninsured rate is at a record-setting low of 5.6 percent. This has brought the peace of mind that over 1.1 million Pennsylvanians needed, and ended the worry that they were one medical bill away from financial ruin. Over half the Commonwealth's population benefit from the protections that the law put in place to ensure that everyone, not just those on the individual market, have high quality coverage and no longer have to worry about things like bans on pre-existing conditions, lifetime limits on benefits, and gender discrimination.

We are not done, though, improving healthcare coverage and delivering even better plans at lower prices for Pennsylvania's consumers. With the tenuous situation in Washington, and repeated attacks by the administration and Congress on the individual insurance market, it is time that Pennsylvania lawmakers worked toward solutions to close the remaining gaps. Our policy platform for the upcoming year has three facets that are particularly germane to this

work: addressing affordability, delivering coverage that means something, and telling the real story of Medicaid.

AFFORDABILITY

With high-deductible and short-term plans on the rise and rapid increases in prescription drug pricing, we must take steps to address the affordability of health plans and reduce the costs of needed treatments and care, even for folks who are covered. There are immediate steps lawmakers can take to address this issue:

- Increased transparency in prescription drug pricing, and, ultimately, accountability for drug companies, a move we hope will ultimately lead to lower prices.
- Increased visibility of healthcare spending that will provide lawmakers the tools necessary to determine how to further enhance affordability.
- State-based reforms that would stabilize the insurance market, like a state-based individual mandate, state-based reinsurance program, or stronger oversight in the rate setting process.

Prescription drug costs are a significant driver of overall healthcare spending, as well as a substantial driver of increased insurance premiums. America's Health Insurance Plans claim that spending on prescription drugs accounts for 22.1 cents of every premium dollar, larger than other categories of direct care: physician services, outpatient services, and inpatient services. At least six states — California, Louisiana, Maryland, Nevada, Oregon, and Vermont — have prescription drug pricing transparency laws, which generally require pharmaceutical companies, drug manufacturers, or both to disclose the wholesale acquisition price of prescription drugs to the state's regulatory authority. The "wholesale acquisition price" is the manufacturer's list price, excluding any discounts, rebates, or price reductions. Maryland recently became the first state in the country to pass legislation banning prescription drug price gouging by manufacturers of generic and off-patent drugs. Connecticut, Maine, Louisiana, North Dakota, and Georgia prohibit the so-called "gag rule" by which pharmacists are often barred from telling patients about cheaper ways to pay for their prescription drugs, like paying out-of-pocket, rather than through insurance co-pays, or identifying a generic version of the medication. Too often, Pennsylvanians experience sticker shock at the pharmacy. Lawmakers should take important steps to ensure that rather than worrying about how to pay for medications, the pharmacist and patient can talk more confidently about how medications can improve medical conditions and not break the bank.

The Pennsylvania Health Care Cost Containment Council (PHC4), is an independent state agency formed under Pennsylvania statute (Act 89 of 1986, as amended by Act 3 of 2009) charged with addressing rapidly growing healthcare costs. The Council's mandate is to stimulate competition in the healthcare market by:

- Giving comparative information about the most efficient and effective healthcare providers to individual consumers and group purchasers of health services; and

- Giving information to healthcare providers that they can use to identify opportunities to contain costs and improve the quality of care they deliver.

The Pennsylvania statute specifically assigns the Council three primary responsibilities:

- To collect, analyze and make available to the public data about the cost and quality of healthcare in Pennsylvania;
- To study, upon request, the issue of access to care for those Pennsylvanians who are uninsured;
- To review and make recommendations about proposed or existing mandated health insurance benefits upon request of the legislative or executive branches of the Commonwealth.

In support of these responsibilities, the Council collects more than 4.5 million inpatient hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers in Pennsylvania. This data, which includes hospital charge as well as other financial data, is collected quarterly and verified by PHC4 staff. The Council also collects data from managed care plans on a voluntary basis. The Council shares this data with the public through free public reports. The Council has also produced hundreds of customized reports and data sets through its *Special Requests* division for a wide variety of users, including hospitals, policymakers, researchers, physicians, insurers, and other group purchasers.

In light of high healthcare spending trends, oversight agencies need broad authority to monitor spending across all healthcare sectors and financing streams. For example, oversight agencies should be tasked with identifying underlying cost drivers, such as unnecessary services, lifestyle factors and rising prices.

Monitoring spending is greatly enhanced when oversight entities have access to an all-payer claims database (APCD), also referred to as multi-payer claims database. An APCD is a large database that systematically collects medical claims, pharmacy claims, dental claims, provider files, and eligibility from private and public payers. These datasets are an important tool for understanding key cost drivers, measuring progress over time and can be used to increase price and spending transparency for consumers, purchasers and providers. With this data capability, a state could track key spending drivers like overuse of low-value care, under use of high-value care, unwarranted price variation, some quality metrics and providers' response to new initiatives, and some aspects of consumer affordability.

It is also important to mention that an APCD can be used not just by policymakers and lawmakers, but by everyday consumers to understand healthcare in their local communities. While significant effort needs to be made to ensure ease of use and accessibility for consumers, this tool could ultimately put consumers squarely in control of their healthcare choices and healthcare dollars.

COVERAGE THAT MEANS SOMETHING

You may have health coverage, but if the treatment you need isn't covered or you can't find a doctor in your area, it means very little. Action is needed to improve the quality of coverage in Pennsylvania.

The Trump Administration has taken steps to make short-term limited duration health plans and association health plans— both prohibited by the Affordable Care Act — widely available. Short-term plans are currently allowed for precisely that, a short gap. The Affordable Care Act allows these limited short-term plans to cover someone for up to three months, but requires that individuals have full coverage for the majority of the year. The Administration, however, wants to lengthen the amount of time that people can be covered by these plans, possibly extending them beyond a year.

Their use is problematic because they are not required to cover pre-existing conditions, can charge individuals more based on their health history, are not required to cover essential health benefits (e.g. prescription medications and maternity care), do not cap out-of-pocket expenses, may have benefits limits after which the coverage stops paying, and do not qualify for Federal financial assistance. And, perhaps even more concerning, an exodus from the marketplace to these plans by younger, healthier individuals will drive up premiums even further for those who remain in the marketplace.

Without any protections, the impact of short-term plans on Pennsylvania is significant, according to a new report by the Urban Institute. Importantly, the effect is cumulative when combined with the repeal of the Affordable Care Act's individual mandate last fall as part of the tax package as both policies encourage younger-healthier individuals to leave the marketplace.

According to this report, 209,000 are expected to lose coverage in Pennsylvania as a result of the repeal of the individual mandate. Because of the resulting increase in premiums, expanding short-term plans would add an additional 87,000 — or 18.2% of those who currently have marketplace coverage — to the uninsured. The 165,000 expected to be covered under short-term plans will be technically insured, but their coverage will be inadequate. Combining the effects of this exodus from the marketplace, we will see roughly a 19.2 percent increase in individual marketplace plan premiums in 2019.

The proposed rules to expand short-term plans allow states to specifically regulate how these plans operate in each state. According to a Princeton study, states have several options. They could require short-term plans to comply with all or some of the Affordable Care Act's consumer protections and market regulations. States could also limit the duration of those plans or impose stronger consumer protections. Pennsylvania currently has none of these requirements or protections, but state lawmakers can take action to limit these plans' length, limit the number of renewals, or require plans to cover pre-existing conditions.

Pennsylvania can also take action to protect consumers from Surprise Medical Bills, which occur when consumers seek care from an in-network provider, but later receive a bill from an out-of-network provider who participated in their care, often unbeknownst to them. Surprise bills often come from “invisible providers,” who consumers never see and never even know were treating them. Consumers are largely unable to protect themselves from surprise medical bills by checking provider directories in advance. Especially in emergency situations, consumers should never have to worry about a surprise medical bill. They should simply be required to pay their in-network cost sharing requirement. PHAN supports provisions like those in House Bill 1553, including banning balance billing in emergency situations, advance notices when surprise billing is likely, and limiting consumers’ responsibility to in-network cost-sharing when faced with such a bill.

TELLING THE REAL STORY OF MEDICAID

Contrary to the narrative that we sometimes hear, Medicaid is an efficient, effective program that covers millions of Pennsylvanians, mostly children, seniors, and people with disabilities. PHAN is working directly with state agencies to make Medicaid even more efficient than it already is, through creative solutions that create incentives for hospitals and doctors to provide better, evidence-based care at a lower cost.

PHAN is also working to oppose Medicaid work requirements, currently under consideration in the PA House. Medicaid work requirements would 1) harm Pennsylvania families and individuals by making it more difficult for them to qualify for and keep the coverage they need to stay healthy and 2) require extensive new bureaucracies in order to administer these requirements, wasting state and federal Medicaid dollars on unnecessary administrative burdens and new red tape.

Lawmakers need to remember the costly mistakes made the last time Pennsylvania attempted to impose work requirements through the Healthy PA plan: people faced long, unnecessary delays and lost access to care, while the state struggled with a huge administrative backlog that affected everyone covered by Medicaid, not just those subject to new requirements.

Research shows that work requirements for Medicaid will result in people losing coverage, in many cases simply because of the new layers of red tape and bureaucratic errors. Taking someone's health care away because of a paperwork error is too high a price to pay. A person whose hours are reduced or who received an incomplete pay stub, for example, could lose access to needed medical treatments if their benefits are cut. Even people who should be exempt from the requirements to work –because of a disability or serious mental illness, for example – may end up losing their coverage because they don't have the right paperwork or don't know how to file it.

Work requirements also don't make financial sense. The state will be responsible for the massive costs associated with a program targeted at less than 5 percent of Pennsylvania's Medicaid population. We should be thinking wisely about how we spend our dollars. If the goal is to increase access to good jobs, additional funding for childcare and transportation -- common barriers for low-income individuals seeking employment -- would need to be included. Simply imposing work requirements with no additional supports will do little to increase workforce participation.

Most Medicaid recipients who can work already work. Nationally, sixty percent of adults under 65 on Medicaid are already working, and 78 percent have at least one worker in the family. Nearly 80 percent of those not working are in school or cannot work due to illness, disability, or caring for others in their family.

CONCLUSION

Even without action by the federal government to address the rising costs of healthcare, there are concrete, proven actions that state lawmakers can take now. By pursuing policy solutions such as prescription drug transparency, an all-payer claims database, an end to surprise medical billing, creative solutions that will make Medicaid even more effective and efficient (that don't include work requirements), and consumer protections that limit the harms of short-term and association health plans, state lawmakers can expand Pennsylvanians' access to high-quality, affordable health coverage and protect them from the harmful decisions being made in Washington.

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Submitted Testimony for Record: Safe Nurse Staffing

House Democratic Policy Committee Hearing

April 4, 2018

Medical errors are rarely discussed because there is a subconscious expectation, from the patient, that they will not occur. Patients expect competent healthcare professionals that are partners in our treatment and care. However, the chilling reality is that preventable medical errors are the third leading cause of death in the U.S. Preventable medical errors claim the lives of 400,000 people each year or 1,000 people each day. Additionally, 10,000 serious complications occur daily. Errors cost our nation 1 trillion dollars per year.

Nurses are the infrastructure for patient safety and have been instrumental in improving the quality and safety of our healthcare system over the last decade. Hospitals and healthcare providers must be partners in this endeavor as we serve patients together and build a culture of safety. The current lack of policy directed at creating safe nurse staffing measures in hospitals contributes significantly to these alarming statistics.

Nurses are our advocates when we are most vulnerable. We have an expectation that when we enter a healthcare facility, the nurses will provide the necessary oversight and coordination of care sufficient to meet our needs. Studies reveal that patients consider these as qualities to essential to care: (1) involvement in decisions and respect for preferences; (2) clear, comprehensible information and support for self-care; (3) emotional support, empathy and respect; (4) fast access to reliable health advice; (5) effective treatment; (6) attention to physical and environmental needs; (7) involvement of (and support for) family and caregivers; and (8) continuity of care and smooth transitions.

It is difficult to address patient safety without acknowledging current nurse staffing shortages, as well as its impact on patient safety within our acute care settings. Providing this level of quality care takes time and manpower. Nurses are working in a healthcare context where they attempt to reconcile cost-efficiency and accountability with their desire to provide the level of care that meets their patients' needs and expectations.

[MORE ON BACK]

What does short staffing look like for our hospitalized patients? Call lights take longer to answer. It may be difficult to locate a nurse to discuss our plan of care in a timely fashion. Wait times for procedures and medications may be prolonged.

Nurses are taking care of patients who are sicker and who have co-morbidities, such as diabetes and heart disease. Nurses are working longer hours. Nurse fatigue leads to burnout, high turnover, inconsistency in patient care and increased medical errors. The cycle goes on and on with the end result occurring time and time again, worse patient outcomes.

HB 2092, Safe Nurse Staffing, does not create a mandatory nurse-patient ratio. It simply requires hospital administrators to enlist professional nurses to work with them to establish, implement and monitor professional nurse staffing standards within their facilities. It is important to note that this would give hospitals the flexibility to adjust staffing as needed. Professional nurses on the staffing committee play a vital and active role in nurse staffing decisions. The hospital can use the nurse expertise in the best interest of patients, the care team and hospital.

The Commonwealth of Pennsylvania is a diverse state in many different ways. This is especially true when it comes to the type of care patients receive when visiting a hospital. HB 2092 ensures that patients will be receiving the greatest possible care. Creating a mandated, statewide ratio does not consider hospitals' individuality and patient care needs.

Both nurses and physicians agree that inadequate staffing is a major concern to healthcare. It is essential for patients and policy makers to understand that with the implementation of the proper safe staffing regulations, greater patient outcomes will follow.