Advance Written Testimony

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The Recent Health Care Law: Consequences for Indiana Families and Workers

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Introduction

Chairman Roe, Representative Bucshon, Members of the Committee, it is an honor to appear before you today to offer guidance on our nation's recent health care reforms.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA). This legislation institutes numerous modifications to the regulation of private health insurance companies and the structure of health insurance policies.

The Indiana Department of Insurance (IDOI) supports Indiana Attorney General Zoeller's effort to overturn or repeal ACA on the grounds that it is unconstitutional to mandate citizens to purchase health insurance or pay a penalty. However, this litigation is presently pending, and will likely remain pending for quite some time. In the interim, IDOI diligently prepares for the onslaught of ACA's new requirements. First and foremost, IDOI continually examines the law in an effort to minimize adverse effects to the nearly 1 million Hoosiers with fully insured coverage.

As of July 1, 2010, Governor Daniels formed an interagency task force to analyze the various components of ACA. The task force includes representatives from the Governor's Office, the Indiana Family and Social Services Administration (FSSA),IDOI, and the Indiana State Department of Health and State Personnel. Indiana continually attends meetings with the U.S. Department of Health and Human Services (HHS), the National Association of Insurance Commissioners (NAIC), consumer representatives, industry representatives, other regulators and insurers. Indiana carefully reviews each newly promulgated regulation that implements ACA's provisions and provides policy feedback to the government and other interested parties regarding how the provisions should operate or to warn of the consequences. In addition, Indiana has been awarded federal grants to assist with the implementation of health care reform. The State has conducted a financial analysis of the ACA's impact to the State budget and estimates indicate Indiana will have to pay between $2.6 and $3.1 billion over the next ten years to support the ACA.

The following is a summarized timeline of some of the more significant changes with a focus on the effect on Indiana families and workers.

High Risk Pools

Within 90 days of ACA's March 2010 enactment, states were required to establish a high risk health insurance program, or instead defer to the federal government's Pre-existing Condition Insurance Plan (PCIP). On April 22, 2010, the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) reported that an estimated 375,000 individuals across the U.S. would enroll in the PCIP by the end of 2010.[1] So far that has not been the case. As of March 31, 2011, the number of Hoosiers enrolled in PCIP was 177, and the total across all states was 18,313.[2]

The strict eligibility requirements are one reason for the low enrollment. According to PCIP's own website, "You must have been without health coverage for at least the last 6 months. Please note that if you currently have insurance coverage that

[1] http://republicans.energycommerce.house.gov/Media/file/Hearings/Oversight/040111/OImemo.pdf

[2] http://www.healthcare.gov/news/factsheets/pcip05062011a.html (posted May 6, 2011).

doesn't cover your medical condition or are enrolled in a state high risk pool, you are not eligible for the Pre-Existing Condition Insurance Plan."[3] Since Indiana's high risk pool, ICHIA, does not require a waiting period, most Hoosiers are forced to enroll in this program instead. Although a small portion of costs are funded through premiums, the bulk of the cost is covered through assessments and taxes. Insurers are assessed for 25% of the costs, while Hoosier tax payers fund the remaining 75%. Approximately 7,000 people are enrolled in this program that incurred approximately $110 million in claims during the 2009 calendar year. The establishment of PCIP may be intended to assist the uninsured and high risk, but the six month requirement stunts PCIP's potential to be of great assistance.

Changes to Annual and Lifetime Limits

Several of ACA's changes became effective September 23, 2010, including new rules controlling how health insurance companies can use annual and lifetime limits. ACA generally prohibits these limits, or in some cases restricts the amounts as part of a transitional period leading into 2014 when limits become fully prohibited. Limits enable insurers to properly estimate future costs, which facilitates appropriate pricing. Limits help ensure that companies remain solvent. Similarly, employers who are self-funded are less able to predict their annual medical costs because they are also subject to the annual and lifetime limits prohibition. Generally, health insurance costs are the second largest budget item for employers. Less certainty and fewer ways to control costs creates an incentive to discontinue offering health insurance. Insurance companies have reacted to this legislation by increasing premiums.

Mandatory Preventive Health Services Coverage and Essential Benefits

Effective September 23, 2010 under ACA, health insurance companies generally must cover preventive health services as defined by the federal government. The justification for this change in the law is that more Americans will visit providers earlier to use such services, decreasing the chance they will incur a costly illness later, thereby decreasing costs to insurers and therefore decreasing premium. However, the practical reality is different. Having additional preventive services

[3] https://www.pcip.gov/Eligibility.html

paid for by insurance has generally not been enough to incentivize Americans to become healthier or get checked out for health problems more often. Instead, the legislation has merely caused insurance companies to change their accounting and increase premiums to cover the new costs of the mandated services.

In addition, beginning January 1, 2014, plans offered by small group and individual insurers must include essential health benefits package characteristics, including cost sharing limitations as eligible. In cases where existing insurance plans do not cover an essential benefit, those plans must adjust by adding the benefit and likely will increase the premium to cover its costs.

At this time we do not know what these benefits are. This adds additional uncertainty to the market and limits our ability to assess the impact of ACA.

Dependent Age Increased to 26

Effective September 23, 2010, insurers are generally required to continue coverage of a dependent up to the age of 26. This change was designed to reduce the number of younger dependents getting kicked off their parents' plan and foregoing coverage.

While the intent was positive, it has led to a situation where certain employers, who budgeted for covering dependents for a lesser amount of time, now have to react to the change. Insurers and employers with self-funded insurance have generally reacted by increasing premiums to cover the extra years of cost.

Indiana previously required dependent coverage for children up to age 24. For policies effective after September 23, 2010 or at renewal subsequent to that date, coverage must be extended to children under age 26. Notice to parents of dependents who were previously removed must be provided and children must be added at the next open enrollment if they aged off. Although a child may be underwritten when he or she is reenrolled, the child cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Dependent coverage is extended to age 26 for individual and group products with an exception for grandfathered group products. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package when it falls outside a federally established

threshold. Prior to January 1, 2014, if a young adult has the option of coverage through their employer, the parent's employer, if the plan is grandfathered, does not have to cover the young adult as a dependent on the parent's plan. Employers have suggested that extension of coverage will increase costs and have concerns about adverse selective tendencies since young adults can choose to stay on their parents' plans rather than take their employer plan, especially after January 1, 2014. This requirement imposes additional previously unanticipated risk upon employers who offer dependent coverage through their plans. Depending on the level of adverse selection, the result of this legislation may be that employers stop offering dependent coverage. Currently, there is a movement by employers to penalize employees whose spouses are covered as dependents on employer A's plan instead of receiving coverage through their own employer B. Usually, the penalty is an increased premium percentage or no employer contribution for the spouse's coverage.

Guaranteed Issue, Coverage, and Renewability

Effective September 23, 2010, insurers can no longer exclude benefits or limit coverage based on a preexisting condition for an individual under the age of 19. For plan years following January 1, 2014, this restriction applies to everyone. Also, beginning 2014 insurers selling new insurance can no longer discriminate on the basis of health status, medical history or claims experience. Moreover, beginning 2014, insurers must accept everyone that applies for coverage during open enrollment, the limited time period during each year determined by insurers when someone can sign up to an insurance plan. For plan years beginning January 1, 2014, all non-grandfathered, fully-insured plans must renew coverage or continue it in force at the option of the insured.

Currently, and within statutory limits, Indiana insurance carriers are permitted to exclude coverage temporarily for preexisting conditions. This enables carriers to insure for fortuitous rather than planned or known medical costs. ACA prohibits this practice for children under 19 currently and for all others in 2014. Indiana's small group market has had guaranteed issue for several years and will not be significantly affected by this, but the individual market will experience significant increases. Some carriers have suggested increases in the 50% range. We are

currently evaluating the inclusion of the high risk pool members into the individual market and the increase associated with such inclusion.

One of the consequences experienced in Indiana as a result of this legislation was that carriers stopped writing child-only policies. Carriers claimed that the law led to adverse selection, a fiscal situation that arises when a given pool of insured individuals is skewed, in that there is not an economically stable proportion of sick to healthy individuals in the pool, because healthy individuals leave, causing premiums to rapidly escalate for those remaining sick people. In an effort to curb this practice the government tried to limit plan-switching by restricting the time to switch, or the time in which to enroll, to only open enrollment periods, thereby preventing young individuals from waiting until they got sick to enroll. Indiana drafted Bulletin 181, requiring carriers wishing to sell child-only policies to do the following:

1. Hold an open enrollment period that must last at least 30 continuous days;

2. Designate that enrollment period;

3. Notify IDOI no later than December 1, 2010 of when the open enrollment period will occur so that IDOI may post on its website;

4. Post the open enrollment period on the insurer's website; and

5. Effect coverage within a reasonable period of time from enrollment.

Despite IDOI's efforts, IDOI is aware of only one company offering child-only policies in Indiana. Generally, children under 19 are left with the option of CHIP, PCIP and ICHIA to the extent they qualify. IDOI is currently exploring options to continue to encourage carriers to re-enter the market. However, the consequence of the law thus far is that consumer choice has narrowed and premiums have increased.

Grandfathering

ACA allows for plans in effect on March 23, 2010 to be considered grandfathered. This affects the application of some of the September 23, 2010 market reforms. For example, the following do not apply to grandfathered health plans: mandated

coverage for preventative services, mandated patient protections (i.e., OBGYN referral prohibition, in-network pediatrician considered child's primary care provider (PCP) and emergency services costs are the same for in-network vs. out-of-network), guaranteed availability and renewability of coverage, mandated cost-sharing limits, no discrimination based on health status and mandated coverage for clinical trials. Additionally, grandfathered plans will not be subject to the 2014 pricing restrictions. This means that the actuarial review process for insurance premiums at renewal will be split between grandfathered and non-grandfathered plans. In addition to increased and tiered actuarial duties, it has been suggested that IDOI will be the first arbiter of the grandfathering determination. This means increased reporting for carriers and additional rate and form review responsibilities for Compliance. Several insurers have reacted by requiring employers to provide coverage that is consistent with the new ACA reforms, rather than allowing employers to choose. Instead of increasing employer choices, which the law touted, employers' options are constrained.

International Statistical Classification of Diseases and Related Health Problems (ICD-10)

ICD-10 provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease. Under ICD-10, every health condition can be assigned to a unique category and given a code. On August 21, 2008, HHS proposed new code sets to be used for reporting diagnoses and procedures on health care transactions. Under the proposal, the ICD-9-CM code sets would be replaced with the ICD-10 code sets, effective October 1, 2013.

Although this may lead to improved health data tracking and positive healthcare outcomes, it carries a significant price tag for insurers. ICD-10 is sufficiently detailed to describe complex medical procedures, which becomes increasingly important when assessing and tracking the quality of medical processes and outcomes. The goal of such tracking is to improve patient outcome and quality of care. IDOI recognized this significant conversion cost in a letter submitted to the National Association of Insurance Commissioners (NAIC). This is the organization that was tasked by HHS with defining the medical loss ratio rebate

calculation. In that letter, IDOI stated in pertinent part: "Such conversion costs, although significant, will be short-lived and therefore, affect the medical loss ratio calculation for a brief period, but leave lasting quality improvement potential. Given the benefits to patient care, ICD-10 conversion costs should be included as a health care improvement cost and included in the claims numerator." The final model adopted by the NAIC did not allow the inclusion of ICD-10 costs in the medical loss ratio (MLR) numerator as part of Quality Improvement Costs. Therefore, carriers must bear the cost of this conversion as part of their 15-20% administrative costs. Smaller carriers will likely be more significantly affected, since larger carriers can spread the cost over multiple companies.

Changes to the External Review Process

As of 2010, states must have internal and external review standards. The federal law requires strict compliance with certain provisions published in an HHS regulation, 42 USC § 300gg-19(b), that largely comported with the NAIC Model Act on External Review. Indiana's own external review statutes are highly analogous to the federal requirements, but it was determined through correspondence that Indiana was not in exact compliance. The State was able to get Senate Bill 461 passed and successfully amend Indiana's external review laws to be in compliance with the federal requirements. However, even with these changes, HHS has not yet confirmed that Indiana is in compliance. This is leading to uncertainty in the insurance market because insurers cannot determine their own compliance with Indiana Code. Sadly, this type of back and forth with HHS has been typical of the health care reform process thus far; chaotic, frenetic and rushed implementations. All of these issues combine together to create an uncertain insurance market, causing insurers to hesitate before participating or continuing to participate in Indiana's insurance market, reducing consumer choice of insurance.

Other Changes with Lesser or Unclear Impact

- September 23, 2010: plans that provide for emergency services cannot require prior authorization. Any cost-sharing requirement for emergency services provided out of network cannot exceed cost sharing requirements for in network emergency services.

- Beginning in 2014, insurers may not discriminate against providers operating within the scope of their practice.
- Annual HSA contributions are limited and there are deductible limits on small employer plans that may limit participation in popular high deductible health plans.
- States must track trends in increasing premiums and report this information to HHS. Such tracking and reporting may be funded initially in the form of grants, but long term the costs will be passed to the states.
- Waiting periods cannot be greater than 90 days.
- Carriers requesting a rate increase greater than 10% must file with both the state regulator as well as the federal government. Some insurers in certain states may be subject to a dual review process unless a state has an adequate review process. IDOI has requested that HHS recognize that it has an effective rate review process to avoid this dual review.

ACA provisions related to insurance increase the coverage requirements, mandate previously uncovered costs of individuals and dramatically increase reporting and administrative requirements. All result in increased costs that will likely be passed to consumers in the form of premium increases.

Exchanges

ACA mandates that over the course of the next few years, states must implement a health care exchange or the federal government will create one for each state. On January 14, 2011, Governor Daniels issued an Executive Order directing FSSA to work with IDOI and other applicable state agencies to conditionally establish and operate a health benefit Exchange, as a not-for-profit entity. The Order provides that a State-based exchange protects Hoosiers from undue federal regulation, maintains the existing free market and ensures that Hoosiers retain coverage choices. The Executive Order stops short of committing to the Exchange, as there is little guidance at this point in time from the federal government regarding how the Exchange should operate. Nor do we have any information on how the federal Exchange will operate. The Order does allow the State to move forward in its

planning and allows the State to prepare for the Exchange should we decide that it is in Hoosiers' best interests to commit.

Indiana has received a federal exchange planning grant and a Level 1 establishment grant. We are using those funds to study the Exchange, which includes an information technology gap assessment, a study of the uninsured in Indiana and potential users of the Exchange, Exchange design options, and actuarial modeling. Our more recent funding will be used to identify the high and detailed level requirements, the information technology needs and design of an Exchange, and to identify the operating costs of an Exchange.

In addition, on September 15, 2010, Indiana released The Affordable Care Act Stakeholder Questionnaire and collected responses through September 30. 478 responses were received and 409 responses were used in the analysis. All respondents indicated they were concerned about the cost of the legislation to their respective industries and businesses, and 80% indicated they were concerned about the health care system's ability to cope with the pent-up demand. Additionally, there was very little stakeholder support for a federally administered Exchange. Insurers preferred a State administered Exchange and businesses preferred a not-for-profit administered Exchange.

The State released a questionnaire on Exchange design issues in March 2011where 2,600 responses were received. The survey mainly covered technical issues and market regulations, however, the write-in comments received from all respondents showed dissatisfaction with the Exchange. Respondents desired the guarantee of greater transparency and personal responsibility in the health care market place and they felt the ACA did not provide for these needs. In terms of design and Exchange goals, over half of the respondents supported making the Exchange a competitive environment for insurers--ensuring that the Exchange drives quality improvement and cost containment--and creating an Exchange that increases the portability and continuity of health care coverage.

Finally, 95 employers responded to the question of whether they would continue to offer health insurance, of which 66% said they would maintain coverage, 3% would drop coverage, and 31% were undecided.

Medical Loss Ratio Limitations and Rebates

Under the law, no later than January 1, 2011, insurers of group health plans must report to the United States Department of Health and Human Services (HHS) regarding medical loss ratios (MLR) and must offer a premium rebate to participants if the loss ratio is below 85%. The federal government is redesigning MLR, a longstanding equation for determining whether an insurance company is properly paying out a sufficient amount in claims in relation to its revenue from premiums. Generally, a loss ratio is the amount of claims paid divided by premium collected, although the equation is significantly more complex under the law and considers several other criteria. What the law is saying here, essentially, is that certain insurers have to pay out 85% of their revenue from selling insurance. If the insurers do not end up paying out that much, then at the end of the year, they have to issue rebates, which are like refunds, to insured individuals. Furthermore, there are several situations where insurers operating in various states enjoy significantly different MLR thresholds, or use a different calculus in determining MLR.

Indiana has historically followed the MLR model published by the National Association of Insurance Commissioners that established a baseline MLR of 55% with higher amounts for certain insurance. With this new law, insurers have to plan to pay more in claims either to initially meet the threshold or pay a rebate for not meeting it. Consequently, insurance companies are busy recalculating profit margins and using this new law to justify increasing premiums.

ACA requires that individual and small group insurers have an annual medical loss ratio of 80% and 85% for large group insurers. The annual medical loss ratio involves a more complicated calculation than the traditional lifetime loss ratios utilized for the purposes of rate review. The simplest example of the annual medical loss ratio for the purposes of rebate calculation is the equation below:

Claims + Health Quality Expenses / Premium – Taxes (except for taxes on investment income/capital gains)

Although it has not been indicated through regulation, it appears that the intention is to place the burden for reviewing the rebate calculation on IDOI, similar to the

rebate calculation for Medicare supplemental products that IDOI's actuary currently reviews. This new responsibility is in addition to the increased rate filing requirements for small and large group products.

Currently, IDOI is reviewing whether applying the 80%/85% will disrupt the market if applied to all insurers in 2011. In particular, smaller domestic insurance companies may be at an increased risk for insolvency and insurers that offer high deductible/HSA plans may have difficulty meeting this as well, which could affect the consumer-driven product market. Thus far, nearly 10% of the insurers operating in Indiana's individual market have withdrawn, and many others are threatening withdrawal in the near future. The private market's reaction to even these early requirements is ominous. 2014 is steadfastly approaching. Consumer choice is dwindling. Health insurance premiums are rising.

In an effort to promote consumer choice and protect the insurance market, Indiana has applied for a waiver from the federal MLR requirements. This way Indiana can continue to apply its own criteria when reviewing rates for compliance, as IDOI and other regulators have the best knowledge of the market and will do what is best for Hoosiers. Obtaining the waiver will allow IDOI to have more autonomous control over its insurance market so that it can continue pursuing its top priority of protecting Hoosiers' interests and health care options in the face of ACA's churning sea of legislative amendments and its resulting economic fallout.