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PUBLIC STATEMENT

IMPLEMENTATION OF FEDERAL HEALTH CARE REFORM

Submitted to
House Insurance Committee
The Honorable Anthony DeLuca, Chairman

Submitted by
Blue Cross of Northeastern Pennsylvania

Thursday, May 27, 2010

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Introduction

Blue Cross of Northeastern Pennsylvania (BCNEPA) respectfully submits the following statement to the House Insurance Committee for purposes of the May 27, 2010 public hearing on federal health care reform. BCNEPA has long been an advocate for meaningful reforms that would help ensure access to affordable and high quality health care while also addressing rising health care costs. BCNEPA has also historically supported a level playing field whereby uniform market rules apply to all health insurers. One positive aspect of federal health care reform is that it seeks to establish that level playing field over time through new market rules such as guaranteed issue of coverage, no pre-existing condition exclusions, no rescission of coverage except in cases of fraud or material misrepresentation, and a prohibition on using health status to rate a health insurance policy. However, these level playing field changes needed to be made in conjunction with a strong coverage mandate and appropriate pricing incentives to encourage the young and healthy to buy health insurance, thus making coverage more affordable for everyone. Unfortunately, federal health care reform contains a weak coverage mandate and ineffective pricing incentives for the young and healthy, all of which need to be understood as we move forward through the implementation phase of the new federal law.

Nonetheless, the Patient Protection and Affordable Care Act (signed into law on March 23, 2010) and the Health Care and Education Reconciliation Act of 2010 (signed into law on March 30, 2010)—hereinafter referred to as "federal health care reform"— have established a foundation upon which all stakeholders can begin to build. It is clear, however, that much more work remains. BCNEPA is focusing current efforts on effective and timely implementation of federal health care reform. The impact of reforms of this magnitude will only begin to be understood as insurers, providers, and regulators start to implement the required changes. State governments, health care providers, health insurers, and most importantly consumers will all face unique challenges during implementation.

In this statement, BCNEPA will offer to the Committee some insights into key elements of reform, an indication of some of the costs associated with compliance, and some thoughts on what remains to be done, including the need to examine the health care delivery system for ways to stem the escalating cost of delivering health care services.

Core Elements of Federal Reform

There are a handful of reforms that are scheduled to take place almost immediately. One that has been widely discussed recently is creation of a temporary high risk pool for the uninsured. BCNEPA has been engaging in discussions with both the Pennsylvania Insurance Department and the General Assembly that have focused on potential ways to construct the high risk pool to most effectively serve uninsured Pennsylvanians and to make the most efficient use of federal dollars available under this initiative. The U.S. Department of Health and Human Services estimates that federal health care reform will provide Pennsylvania with approximately $160 million to subsidize a high risk pool for eligible Pennsylvanians until January 1, 2014. In addition to the high risk pool, other immediate reforms include development of a federal web portal that will house information on health insurance plans and products throughout the country and a tax credit program for eligible small businesses to help cover some of the costs of providing employees with health insurance coverage beginning in the 2010 tax year.

The federal reform law also includes a number of core insurance reforms that are to be implemented in the near term. A common misconception pertaining to these insurance reforms is that they all will take place immediately and this is not the case. A number of the insurance reforms will become effective beginning with individual and/or group renewals that occur on or after September 23, 2010 — or six months from the date of enactment. Examples of these "six-month" reforms are: expansion of dependent care coverage up to age 26, elimination of pre-existing condition exclusions for children under age 19, and benefit changes such as prohibition

of lifetime dollar limits and restrictions on annual dollar limits, all of which will increase health insurance premiums.

Some of the insurance reforms that become effective in the later years include the creation of state based health insurance exchanges, a requirement that insurers provide guaranteed issue insurance coverage, and a mandate that Americans purchase health insurance or face a modest financial penalty. The reforms cited above represent but a few of the new requirements included in federal health care reform. For the Committee's convenience, attached to this testimony is an executive summary of the law as prepared by America's Health Insurance Plans.

Implementation Progress, Costs and Benefits

Implementation is well underway at BCNEPA evidenced by the fact that we, along with the other 38 Blue plans across the country, have made the decision to accelerate the timeline for implementing the expansion of dependent age to 26 by allowing our individual and fully-insured group customers to elect to allow any child who would have aged off the policy to remain covered up to the age of 26, if that child had coverage as of May 31, 2010. Concurrently, BCNEPA has been analyzing our current product offerings to identify where changes will need to be made to become compliant with all of the six-month insurance reforms (i.e. those taking effect with plan renewals beginning on or after September 23, 2010).

There are a number of key elements in federal health care reform that will not be effective until four, five, or even eight years after enactment. Some of these key elements include but are not limited to:

- A tax on pharmaceutical and medical device manufacturers (2011 and 2013);
- New rating rules for the individual and small group insurance markets (2014);
- Expansion of Medicaid eligibility to 133% FPL (2014);
- A tax on health insurers (2014); and
- An excise tax on high-value health plans ("Cadillac tax") (2018).

With some reforms already underway for more immediate implementation and others years away, the full impact of federal health care reform will likely not be seen for many years. However, some cost impacts already known to us include:

- A health insurer tax ($58.8 billion nationally in the first five years);
- A tax on manufacturers of pharmaceuticals ($28.0 billion in the first 10 years); and,
- A permanent 2.9% excise tax on medical device manufacturers.

These taxes represent just some of revenue needed to help finance the reforms designed to improve access such as the individual premium subsidies, the federal high risk pool, and the small employer tax credits. However, while these provisions do generate new federal revenues to offset some of the costs associated with expanded access, these taxes will ultimately be spread throughout the health care system with the consumers bearing a majority of these increased costs through higher insurance premiums and higher prices for pharmaceuticals and medical devices. In addition to the new direct taxes being added into the system, the health care system will continue to face the increasing administrative costs associated with health care reform compliance.

BCNEPA is working to diligently ensure full compliance as cost-effectively as possible. With the addition of new medical loss ratio requirements as well as rate review and other requirements, insurers will face added pressure to control costs. Insurers will also have less flexibility to account for these increasing administrative costs due to restrictions on how much premium dollar can be used to pay administrative costs. BCNEPA is concerned that such a situation will inevitably lead health insurers to reconsider offering quality improvement services that have developed over the last decade, such as wellness and disease management programs. As per unit prices of medical services continue to rise, it will be difficult for health insurers to maintain

capital investments in quality improvement services and absorb increased administrative costs of compliance while achieving the statutorily required loss ratios. BCNEPA will remain engaged with partners such as the US Department of Health and Human Services, the Blue Cross Blue Shield Association, America's Health Insurance Plans, and the National Association of Insurance Commissioners to advocate for responsible implementation of the many administrative requirements in federal health care reform.

While an ultimate outcome of federal health care reform is likely to be a significant increase in the number of individuals covered by health insurance, this does not translate to a "windfall" for the health insurance industry as some may suggest. Strict rate review requirements, countless system and other operational changes, providing guaranteed issue coverage to individuals regardless of health status, additional benefit mandates, restrictions on cost sharing options, and a myriad of new taxes will create a challenging environment in which to continue to bring affordable product offerings into the marketplace.

The Massachusetts Experience

Many have celebrated the numerous benefit expansions contained in federal health care reform that are likely to increase the number of individuals covered by health insurance. However, the cost of adding these new coverage benefits has been often overlooked. Offering benefit enhancements, like expanding eligibility for dependent coverage to age 26, to populations who previously did not have access will increase premiums. Enhancing access and expanding benefits in a health care system that is already costly, without addressing the core cost drivers of delivering such care, means someone will have to pay for the new benefits. The individual consumer will ultimately bear the cost of these reforms whether it's through higher premiums, increased cost sharing, lower wage growth, increased waiting times to get treatment, or increased taxes. We have seen direct evidence of such outcomes in Massachusetts which enacted similar reforms to those contained in the federal health care reform laws.

Today in Massachusetts, the state's health care delivery system and insurance market are in a state of flux. The mass influx of individuals into the system coupled with its failure to reform the delivery system has lead to critical shortages in available physicians and increased waiting times for treatment – Boston now has the highest waiting time for treatment in the country. The insurance market in Massachusetts is also experiencing turmoil. Regulators continue to reject actuarially based rate increase requests for individual and small group policies because the increases are not aligned with the public policy expectations of the regulators. The lack of sufficient rates to cover the rising cost of delivering care has resulted in massive losses for the states' top four health insurers. Continued losses of this magnitude will result in only two outcomes: 1) insurers will leave the market, or 2) inadequate rate action will lead to insurer insolvency – either way the consumer is the one who loses.

The Pressing Need to Reduce Costs

The reality of what is occurring in Massachusetts in the wake of reform should serve as a wake-up call for the entire country. In order to achieve a sustainable health care system the growth rate in the cost of care must be normalized. This won't be achieved until all stakeholders, including state governments and the federal government, come together to seriously discuss and decide how to reduce the rising cost of health care delivery. Studies have consistently shown that the majority of cost increases in health care are a direct result of per unit price increases in health care services, the increased use of those services, and the expanding use of expensive medical technologies. Federal health care reform fails to seriously address any of these cost drivers.

Federal health care reform makes an attempt to address these issues by including pilot projects aimed at realigning the reimbursement methodologies to incent collaboration and quality outcomes, but these are merely overtures and are not sufficient to thoroughly address the problem. Pilot projects included in reform apply only to the Medicare program, are of short

duration, and apply to a limited number of physicians and hospitals. In order to effectuate meaningful change, there must be a system-wide effort, in both the private and public delivery sectors, to move towards collaborative, accountable and quality-focused care delivery.

As we focus on implementing the many insurance reform provisions of the new federal law, BCNEPA urges the Committee to recognize and appreciate the importance of addressing health care cost drivers. Absent a dual focus on reform *and* cost containment, we are likely to find ourselves re-visiting provisions of the federal reform package before it is fully operational.