pennsylvania
INSURANCE DEPARTMENT

Testimony before the
House Insurance Committee:
"Federal Health Insurance Reform"

Presented by:
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Insurance Commissioner

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State Implementation of Federal Health Reform
Joel Ario, Pennsylvania Insurance Commissioner
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Hearing before the PA House Insurance Committee

Good morning. My name is Joel Ario and I am the Pennsylvania Insurance Commissioner. I appreciate the opportunity to testify today and provide an overview of federal health care reform. My comments today will focus both on some of the immediate implementation issues facing Pennsylvania and also on some of the broader benefits that this landmark legislation will offer our citizens as the full set of market reforms take effect in 2014.

High Risk Pool

The first benefit available under the Patient Protection and Affordable Care Act (PPACA) is $5 billion to provide temporary assistance between now and 2014 to uninsured Americans with preexisting conditions. The $5 billion is not enough to cover more than a small portion of the uninsured – that is why we need the broad reforms that take effect in 2014 – but it will provide important assistance to thousands of needy Pennsylvanians. That is why Pennsylvania has indicated an interest in managing our share of that money, which is estimated at $160 million over the life of the program. We made that decision with the assurance that this was not an entitlement program but rather a way to provide benefits to as many people as possible who currently are uninsured because they have preexisting conditions that make coverage unaffordable and/or unavailable.

The next step in the process is to make a formal proposal to HHS, describing who we intend to cover in the program, what benefits will be provided, and how we will manage the program if, as we anticipate, there are more applicants than can be served with the $160 million. HHS has provided specific guidance on several issues, including how the federal government will protect states and state contractors from financial liability, and that guidance limits our choices.

Within these constraints, we look forward to working closely with the General Assembly as we flesh out the details of our proposal. Although the proposal is due June 1, there will be time throughout June to work on the details of the proposal as we learn more from HHS about what is required and what is discretionary for us in managing this important program.

The establishment of this new program is the first of many changes that will take place over the next few years to create a bridge from the current health insurance system to a reformed insurance market.

Coverage for Young Adults

The PPACA allows young adults to stay on their parents' health insurance plans until they turn 26 with no additional charge beyond the standard dependent care premium. The law requires that insurance companies and employers providing dependent coverage make that coverage available to adult children of enrollees up to their 26th birthdays. This requirement becomes effective for "plan years" beginning on or after Sept. 23, 2010, but most of the larger insurance carriers in our marketplace have agreed to speed up their implementation and make this continuation of coverage effective as of June 1 for new graduates and other adult children currently on their parents' policies. This is precisely the kind of cooperation between the insurers and the government that will be critical to effective implementation of the PPACA.

I might note that Pennsylvania already has a state law allowing employers, at their discretion, to continue dependent coverage until age 29. This law will continue to apply to those reaching age 26, when the federally mandated coverage ends, though we continue to work with insurers who are charging substantially more for dependents under the state law than the dependent care premiums that they are limited to charging under the federal law.

Medical Loss Ratios

The PPACA requires insurers to meet minimum medical loss ratios of 85% in the group market and 80% in the individual market, beginning in 2011. Federal regulations to implement the new loss ratios are now in process.

"Medical loss ratio" refers to the percentage of each premium dollar that an insurance company spends on health care benefits – including clinical services and quality improvement – for its customers. For example, if an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims, the company has a medical loss ratio of 80 percent. A medical loss ratio of 80 percent indicates that the company is using 80 cents on medical claims and 20 cents of each premium dollar to pay administrative expenses, such as overhead, salaries, advertising, agent commissions, etc.

Insurance regulators are working through the NAIC to provide recommendations to HHS on the definitions and calculations that should be used in the medical loss ratio formula. One key issue is how to give appropriate credit to activities that improve quality while also preventing insurers from shifting administrative expenses to the medical side of the ledger.

Other Insurance Reforms

The PPACA requires insurers to implement some additional insurance reforms by September 23rd of this year, including a ban on rescissions except for fraud and the elimination of lifetime caps. Other provisions expand transparency and consumer information about benefit options, impose new disclosure requirements on carriers seeking "unreasonable" rate increases, and provide for small business tax credits.

In the next few years, while preparations are being made for the reforms that will occur with the implementation of health insurance exchanges in 2014, there will be many other reforms. For example, in 2011, employers will be required to disclose on W-2 forms the value of health benefits so that employees understand this benefit and its cost. And, in 2013, employers will be required to notify employees of health insurance exchange options for eligible employees

Small Business Credits

The PPACA helps small businesses in a number of ways. For example, it will end price discrimination against small businesses with sick workers. Currently, small businesses with just one sick worker can face significantly higher premiums, and having a worker fall ill can lead to a precipitous price increase -- raising premiums just when insurance is needed most. Community rating starting in 2014 will prohibit insurers from charging more to cover small businesses with sicker workers or raising rates when someone gets sick.

I should note that Pennsylvania is one of two states that has not passed small group rating reform, though the House has passed such bills in both 2008 and 2009. The result is that we are seeing large rate increases for small businesses and the situation is likely to get worse as we approach 2014 and carriers seek competitive advantage in a market with no fair play rules. You've heard me speak out about the need for reform in this area and I do so again today.

On a more positive note, the PPACA does offer immediate help to certain small businesses through the Small Business Tax Credit. If a business qualifies for a tax credit, the tax credit is worth up to 35 percent of the premiums the business pays to cover its workers -- 25 percent for nonprofit firms. In 2014, the value of the credit will increase to 50 percent -- 35 percent for nonprofits. Businesses qualify for the credit if they cover at least 50 percent of the cost of health care coverage for their workers, pay average annual wages below $50,000, and have less than the equivalent of 25 full-time workers (for example, a firm with fewer than 50 half-time workers would be eligible).

The size of the credit depends on the average wages and the number of employees. The full credit is available to firms with average wages below $25,000 and less than 10 full-time equivalent workers. It phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Access Reform in 2014

Looking ahead to 2014, the most promising aspect of the PPACA is that it offers a package of access reforms that are based upon the Massachusetts model, which has proven successful in achieving a 97% coverage rate in that state. The reforms start with a ban on discrimination against sick people, which is one of the most popular parts of reform.

But the reforms do not end there, because experience has proven that tough insurance reforms cannot be fully effective unless they are accompanied by what Governor Romney called "personal responsibility" or an individual mandate that matches the insurers' obligation to cover everyone with an individual responsibility to purchase insurance and not be a free loader on the system.

To make the mandate affordable, the PPACA also includes a sliding scale of subsidies up to 400% of the Federal Poverty Level. Finally, the law facilitates streamlined access to coverage through health insurance exchanges for individuals and small businesses. The PPACA includes many provisions to promote the effectiveness of the exchanges, including development of four standardized benefits packages, a uniform enrollment form and easy insurance product comparisons, and multiple types of transparency and accountability on cost and quality.

Cost Control

Federal health reform has been criticized for not doing enough to control costs. In fact, the PPACA includes provisions that address virtually every viable cost control strategy suggested by either political party. Many of them have been missed by commentators, partly because most of them are starting out as small pilot programs, with provisions for scaling them up to the extent they prove effective.

For example, the bill addresses the need to align incentives and properly bundle charges. A successful model for this is the reimbursement for cardiac surgery by Geisinger Health System. Geisinger established an extremely valuable model by charging a case rate for cardiac surgery that provides no additional payment to Geisinger if patients are readmitted soon after their surgery. This approach replaced a fee for service approach with bundled payments in a manner that ought to be replicated throughout the health care system, and indeed, there are provisions in the PPACA for doing precisely that.

The legislation also has provisions addressing the use of best evidence standards, wellness incentives, and many other promising cost control strategies. None of this will be easy and progress is likely to be incremental, but we will make progress if only because cost control will increasingly be seen as a necessity in the face of current cost trends.

Insurance Exchanges

As noted above, a key aspect of the access reforms in 2014 will be insurance exchanges. Exchanges will provide the kind of support offered to employees by the human resources department of a very large employer – designed to help guide purchasers through choices among several health insurance products and, depending on how aggressive the employer is, organized to exert leverage over insurers in achieving better quality at a lower price. The exchanges can be state-based, either a government entity or a non-profit, with federal backup if states do not meet the standards to be developed by the Department of Health and Human Services (HHS). Exchanges must provide a coordinated application process

for Medical Assistance, CHIP and private health insurance, including a single online application.

Between now and 2012, HHS will develop minimum standards for the exchanges with NAIC consultation. States will be provided federal grants to move forward on exchange design efforts. In 2013, the Secretary of HHS must certify each state's exchange, with the fallback being a federal exchange or a federal contract with a non-profit. States will have the option to have separate exchanges for individuals and small businesses. The exchanges must be operational by 2014 and they must be financially self sustaining by 2015, presumably with small user fees added to premium costs. In 2017, the exchanges can add large employers.

Federal and State Collaboration

States have a major role to play in reform. HHS will provide a broad framework for reform, but successful reform will require the states to be active partners. As federal regulations are adopted, state legislatures will need to adopt state laws and state agencies will need to publish regulations and create new programs.

As you know, last week the Governor signed an executive order that begins to implement many of the key elements of the federal health care reform act. To work toward that goal, the order creates two bodies: an internal working group called the Commonwealth Health Care Reform Implementation Committee, and a separate panel of experts called the Commonwealth Health Care Reform Implementation Advisory Committee. The Governor's executive order was a critical first step, but it was just the start of a long process.

The Insurance Department looks forward to working with you during this exciting time. Thank you again for the opportunity to address you this morning and I will be happy to take any questions.