Testimony of
Commissioner Sandy Praeger on behalf of
The National Association of Insurance Commissioners

Before the
U.S. Senate Committee on Health, Education, Labor and Pensions

Regarding:
Health Insurance Exchanges and Ongoing State Implementation of the Affordable Care Act

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Introduction

Good morning Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee. My name is Sandy Praeger, and I am the elected Insurance Commissioner for the State of Kansas, Chair of the Health Insurance and Managed Care Committee of the National Association of Insurance Commissioners (NAIC), and Co-Chair of the NAIC's Health Insurance Exchanges Subgroup. I thank you for holding this hearing on implementation of the Patient Protection and Affordable Care Act (PPACA) and for your invitation to appear today on behalf of the NAIC. The NAIC represents the chief insurance regulators of all 50 states, the District of Columbia, and five U.S. territories, whose primary roles are protecting consumers and promoting vibrant and competitive insurance markets.

The last time I appeared before this committee, on November 3, 2009, health reform had not yet been enacted, and I offered the assistance of state regulators through the NAIC as you weighed and debated the difficult issues inherent in trying to achieve the goal of extending health insurance coverage to those with preexisting conditions while controlling costs and improving quality. Today, I would like to thank you for recognizing the important role played by state regulators and for ensuring that when it came to implementation of this law, we would have a seat at the table. I would also like to renew our offer of assistance, both to the Administration in implementing PPACA, and to this and other committees as you fulfill your oversight responsibilities.

State Activities in Year One

Over the past year, one of the main focuses of my department and other state Departments of Insurance has been to lay the groundwork for implementation and enforcement of the immediate reforms that took effect for plan years beginning on or after September 23, 2010. These provisions include:

- Prohibition of lifetime benefit limits;
- Restrictions on annual benefit limits;
- Prohibition of rescissions;
- Coverage of preventive services without cost-sharing;
- Extension of dependent coverage up to age 26;
- Internal and external review;
- Prohibition of pre-existing condition exclusions for children; and
- Disclosure of justifications for premium increases

While PPACA defers to state regulation as a default position, in order to enforce these protections state regulators must be granted the authority to do so under state law. While some states have blanket language in their insurance codes requiring insurers to abide by all applicable federal requirements and empowering regulators to enforce them, most do not. Consequently, one of the first tasks facing the states after enactment of PPACA was securing this authority. In order to assist the states in this task, the NAIC developed model language for adoption by state legislatures that meets the federal minimum standards and provides state regulators with the authority they need to enforce the provisions. Most states have been reviewing their statutes to determine which changes they must make, particularly with respect to the external appeals process and rate review requirements. Some states are taking a wait-and-see attitude pending resolution of the challenge to the constitutionality of the law.

For enforcement purposes, early state efforts have been centered on the form review process. Health insurers are required to file the contract, or "form," of each policy that they sell with state regulators, who then review the form to ensure that it meets all requirements of state law and regulation. As these forms are filed, regulators have been verifying that every policy sold in the state meets all applicable early implementation provisions. This process has been expedited through the use of a regulatory checklist, developed by the NAIC, that each insurer must complete identifying where in each policy the relevant language complying with PPACA is located. Even with this assistance, conducting the form review necessary to implement these provisions was a Herculean task for the dedicated regulators in my department and in those of every state around the country, as we worked to ensure that health insurance policies sold or

renewed reflect the applicable provisions required by the law. In addition, state regulators are monitoring consumer complaints to ensure that insurers are living up to the amended terms of their policies and are providing the benefits that they have promised to policyholders, and taking action where necessary.

Early Implementation Challenges

While we at the state level have done our very best to ensure that implementation of these provisions is accompanied by as little disruption as possible, some unintended consequences have arisen over the past year, posing some challenges for regulators.

The first of these challenges arose in response to the provision prohibiting the application of preexisting condition exclusions to children under the age of 19. Because preexisting condition exclusions were redefined to include denials of coverage, this provision has, in effect, required guaranteed issue of coverage for children. In response, some or all insurers in most states ceased new sales of individual market policies only to children, creating a situation where a parent whose employer does not offer family coverage is unable to purchase coverage for his or her children. In most cases, insurers continue to issue coverage to children as part of a family policy.

States have attempted to deal with this issue in two ways. First, they have issued regulations creating open enrollment periods in an effort to limit the ability of consumers to wait until children become sick before purchasing coverage for them. On October 13, HHS issued guidance clarifying that – subject to state law – insurers could limit their sales of child-only individual market plans to these open-enrollment periods. The second strategy that some states have adopted has been to require, through legislation, regulations, or sub-regulatory guidance, that carriers in the individual market continue offering child-only coverage. These strategies have been met with varying degrees of success in different states. State regulators remain vigilant with

respect to the availability of child-only coverage and will continue to search for ways to implement this provision in a way that minimizes disruption of the marketplace.

A second challenge involves restrictions on annual limits. There was initially some concern among state policymakers that the law's restrictions against low annual limits on benefits might interfere with state programs that either require or encourage insurers to offer more limited benefit packages that are more affordable to Americans who are currently priced out of the insurance market. Until 2014, when subsidies are made available to those under 400 percent of the federal poverty level, the loss of these programs could have the unintended consequence of increasing the numbers of the uninsured in those states. We were glad to see the creation of a process for states to apply for waivers that will allow these programs to continue until subsidies are available. Four states have applied for – and been granted – waivers for these types of programs.

It is critically important, however, that we maintain an environment that promotes coordinated and collaborative enforcement of the annual limits provision. The information available to state regulators regarding annual limits waivers has so far been limited to the name of the insurer, the policy's effective date, and the number of affected enrollees. To effectively enforce this provision, however, we will need more granular information about the waivers that will tell us which policies sold by these insurers have been granted waivers, and look forward to working with HHS to resolve this issue.

A third concern involves the federal medical loss ratio (MLR) and rebate program. Many states have been working with HHS to pursue adjustments to the MLR requirements in their individual markets, as allowed under the law. Last week we were pleased to see that the State of Maine was granted a two-year adjustment, with a possible third year extension, to the MLR for its individual market. While we understand the need for the review process to be grounded upon solid data,

several states have expressed frustration over the amount and relevance of specific data requested as part of the application process. State Insurance Departments are already stretched by the implementation process, and gathering large amounts of data that are not readily available and that does not necessarily provide meaningful insight causes additional strain.

A final issue is education of the public. In addition to the hard work that regulators have been engaged in to implement this legislation in a way that minimizes market disruptions, we have been engaged in an ongoing effort to educate the residents in the states about the changes that are going into place. Even before we started implementing this law, health insurance was a complicated and daunting topic for the vast majority of consumers. All states and territories have dedicated resources to educate and assist consumers and carriers as the law is implemented. Passage of PPACA and the subsequent implementation process have made consumer education all the more critical. Thirty-five states, the District of Columbia, and four U.S. territories have been awarded consumer assistance grants from HHS to educate consumers and to address their inquiries and complaints, though again, there has been some concern about the volume, type and relevance of the data required under the grant.

Next Steps for States

The majority of our current efforts are directed towards planning and establishment of state Health Insurance Exchanges. Kansas, along with 48 other states, the District of Columbia, and all of the U.S. territories, were awarded a $1 million Exchange Planning Grant at the end of September, which we are using to conduct an analysis of our health insurance marketplace and the work that would be necessary to develop and operate an Exchange in our state. We are now beginning the process of preparing to apply for an Establishment Grant that will allow Kansas to begin doing more extensive work to actually put the Exchange into place.

The State of Kansas was also fortunate to receive an Early Innovator Grant that will support some of the information technology work that must be done to get our Exchange up and running. Funds that we receive under this grant will be used to develop technology that will enable a single-door, end-to-end solution by extending the new Kansas Medicaid/CHIP eligibility system and integrating it with the Kansas Health Insurance Exchange. Under the terms of this grant, we will make this technology available to other interested states and are in preliminary discussions with the State of Missouri to partner on an Exchange and other aspects of this initiative. Depending on the interest of other states, we may also explore the possibility of creating a "cloud" solution for other states to have their own version of one or more of these healthcare applications.

Most states are engaged in the process of developing legislation to authorize the creation of an Exchange and putting in place the administrative structure that will do the bulk of the Exchange implementation work. In order to guide this process, the NAIC has developed the American Health Benefit Exchange Model Act, which provides a basic framework for states to use when developing authorizing legislation. It was our goal in drafting this model to preserve the flexibility for each state to develop an Exchange that is tailored to its needs and preferences while meeting the minimum federal guidelines. For this reason, while it identifies many of the areas where states may customize the model, it does not prescribe what a state should do. To fill the gap, state regulators, through the NAIC, are developing a series of white papers to provide state policymakers with additional information about some of these choices and associated issues. These papers will cover such topics as Exchange governance and financing; adverse selection threats; the importance of maintaining the role of agents, and exploring that in relation to the role of Navigators; additional Exchange functions; and interactions between the Exchange and a state's Medicaid and CHIP programs. We expect to finalize the first round of these papers by the end of this month.

As I mentioned, there is a fair amount of flexibility in PPACA when it comes to Exchange development, something that we advocated while this law was developed. Taking advantage of this flexibility, the first question most states are first considering is what policy goals they would like their Exchange to accomplish. Many states are looking to create a transparent marketplace to simplify the process of purchasing insurance coverage while providing consumers with the information they need to make informed comparisons between various options. This is the so-called "Utah model." Other states are considering using the Exchange to selectively contract with health insurance carriers in order to negotiate directly on behalf of consumers - the "Massachusetts model." This decision will help determine many of the other questions that states must answer in establishing their Exchanges.

There is also flexibility for states in the governance structure that they choose to establish. They have the option of housing the Exchange in an existing state agency (most likely the Insurance Department or Medicaid agency), a new agency, a quasi-governmental body, or a nonprofit entity established by the state. Each of these options has advantages and disadvantages associated with it, and one or another of them may be more appropriate to realize the specific policy goals set by the state.

Finally, there are additional functions that a state may wish the Exchange to perform for consumers. Some states may wish to require insurers participating in the Exchange to provide additional information to consumers about various aspects of their operations or benefits, while others may want to leverage creation of the Exchange to create an all-payer claims database that will provide valuable data on patterns of coverage and health care utilization in the state. Still others may choose to require insurers to offer additional levels of coverage beyond the gold and silver plans required by PPACA as a condition of participation. It should be noted that states will have the option of adding new functions in future years; they do not need to be included by January 2014.

Challenges in Establishing Exchanges

Despite all of this flexibility, significant challenges remain. Foremost among these is time. January 1, 2014 is less than three years away, and states must have made sufficient progress towards establishing an Exchange by January 2013 for the Secretary to certify that they will meet the deadline. While that may seem like a lot of time, it is not, and states are working hard to stay on target to allow consumers to purchase coverage by late 2013 that will become effective when the ball drops in Times Square ringing in 2014. While we have received some guidance from HHS that has been useful in taking some initial steps, the sooner we receive more detailed regulatory guidance the easier our tasks will be. I understand that this will be forthcoming in the next few months, and our members look forward to receiving it.

Guidance on the contents of the essential health benefits package, which will most likely be arriving in the first half of next year, will be a crucial piece of information for many states looking at benefit requirements for qualified health plans sold in the Exchanges. This information will be very important for carriers as they prepare to incorporate benefits into the coverage they sell and as they plan to offer coverage in the Exchanges. It will greatly impact premiums and the cost of subsidies.

States must make sure that they have sufficient resources to develop and establish Exchanges. Federal establishment grants are absolutely essential in this regard. Without them, in our current fiscal climate, it is unlikely that we would be able to put these programs into place and would be forced to allow the federal government to operate them for us. We are working hard to be good stewards of the federal funds we receive and to use them as efficiently as possible, but there will likely be some additional costs that states must cover on their own, and after 2014 each Exchange must be self-sustaining.

One of the more daunting challenges that we will face in getting an Exchange up and running will be the development of critical information technology systems and infrastructure. These systems will have to interact with state Medicaid eligibility systems, many of which are decades old and will require a substantial investment to work with the newer Exchange systems, as well as federal systems at the Departments of Health and Human Services, Treasury, Homeland Security, the Internal Revenue Service, and the Social Security Administration. As I mentioned earlier, Kansas has received an Early Innovator Grant to perform some of this work, and we look forward to sharing it with other states as they move forward in establishing their Exchanges.

General Implementation Challenges

Finally, I would like to briefly discuss some of the more general implementation challenges that we are working on. Adverse selection is a major concern in any health reform effort. While Congress was attentive to this issue in designing PPACA, there are still some potential sources of adverse selection that we are watching very closely. Perhaps the largest open question regarding adverse selection will be the effectiveness of the individual mandate. There is also concern that the expansion of the small group market to include businesses with 51-100 employees could encourage a significant portion of these businesses to self-insure if they have a younger and healthier workforce and do not wish to subsidize businesses with older and sicker employees through an insurance risk pool. If their level of claims begins to rise, they could then return to the fully-insured small group market in order to share this increased level of risk with others. This dynamic could cause the cost of coverage for small employers to rise.

We are concerned that changes to the regulations governing a health insurance plan's grandfathered status could exacerbate the risk of adverse selection and complicate state enforcement of PPACA's market reforms. These changes will allow a group health plan to maintain its grandfathered status even though it has purchased a new health insurance policy. Again, we expect that businesses with younger and healthier workforces will disproportionately

take advantage of this option, as the current rules are more advantageous to them than those that will take effect in 2014. Because PPACA prohibits grandfathered plans from being pooled together with non-grandfathered plans, this could exacerbate any adverse selection that occurs in the small group market. State regulators are concerned that allowing a group health plan to maintain its grandfathered status after purchasing new coverage will create a secondary market for grandfathered coverage that could encourage fraud and will make it difficult for state regulators to easily determine whether or not a plan is exempt from PPACA reforms.

A third potential problem area could arise if Multi-State Plans, which will be sold alongside other plans in the Health Insurance Exchanges, are allowed to operate under rules that are significantly different from those that govern their competitors. If they are, we are concerned that they could cherry-pick the best risks and that their enrollees could unwittingly be left without important consumer protections provided by state law. We have had some initial discussions with the Office of Personnel Management, which is very much aware of this potential pitfall and is working to address it. We will, however, continue to watch this issue very closely. State regulators have testified before the Consumer Operated and Oriented Plan (CO-OP) Advisory Board against reducing solvency and consumer protection requirements on these new plans. They must play by the same rules as other carriers that are similarly situated or consumers could be harmed.

Fourth, any time major changes to health insurance markets are implemented we watch carefully for market disruption and do our best to minimize that disruption. If large numbers of carriers exit the marketplace, particularly prior to 2014, competition will suffer and availability of coverage may become a concern. Thus far we have not seen empirical data indicating a major market exit, though we will remain watchful for problems that might arise.

Finally, as I have noted in my previous testimony before this Committee, the success of this entire enterprise depends upon bringing health care costs under control. Health insurance premiums are largely a reflection of the underlying cost of care and levels of utilization. While PPACA contains numerous provisions designed to start moving the system towards lower costs and higher quality care, it is not yet clear to us how effective those measures will be. Continued attention by this committee and policymakers at the local, state, and federal levels will be necessary to tackle this formidable challenge.

Thank you again for the opportunity to testify here today. I appreciate the Committee's recognition of the states' crucial role in implementing this law and reiterate my offer of assistance going forward. I look forward to any questions you might have.