Government of the District of Columbia

Department of Insurance, Securities and Banking

Testimony of

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Commissioner

Implementation of Federal Health Care Reform in the District of Columbia

Committee on Public Services and Consumer Affairs
Muriel Bowser, Chairperson
Council of the District of Columbia

Committee on Health
David Catania, Chairperson
Council of the District of Columbia

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Good Morning Chairperson Bowser, Chairperson Catania, Members of the Committee on Public Services and Consumer Affairs, Members of the Committee on Health, and Committee Staff. I am Gennet Purcell, Commissioner of the Department of Insurance, Securities and Banking ("Department" or "DISB"). Thank you for providing the Department with the opportunity to discuss what the Department is doing to implement the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (collectively, "Federal Health Care Reform Acts" or "Acts") signed into law by President Obama in March 2010.

The Federal Health Care Reform Acts in short, put individuals, families and small business owners in control of their health care. It promises to reduce premium costs for millions of working families and small businesses by providing hundreds of billions of dollars in tax relief. It also reduces what families will have to pay for health care by capping out-of-pocket expenses and requiring preventative care to be fully covered without any out-of-pocket expense.

Federal Health Care Reform will continue to have a significant impact on health insurance in the District of Columbia. While the private insurance market and the oversight work of DISB comprise a large focus of the Acts, there are also provisions of the Acts that will impact the work of multiple District of Columbia agencies and impact our public health programs including Medicaid & Medicare, long term care, health care workforce development, and small businesses among other areas.

The health insurance reforms of the Acts aims to expand health insurance coverage to millions of Americans. Over the next four years, our insurance markets will see changes in the method and

manner that coverage is sold and provided, in the manner that coverage is financed, and also in the manner that covered services are paid for by insurers. These changes will require a large number of modifications to health insurance products and the regulations that govern them.

More than a dozen key provisions of the Acts are scheduled to take effect in 2010, including the creation of a temporary high-risk pool for people with pre-existing conditions that cannot afford to purchase insurance, and tax credits for small businesses that obtain health coverage for their workers. These changes continue through 2014, when the Act's major reforms to expand access to health coverage are fully implemented. My discussion today will focus on these changes. I have also provided the Committee with a comprehensive section-by-section analysis of the Acts which includes information on the status of implementing regulations.

Immediate Implementation Items in 2010

The Acts authorize the federal government, through the United States Department of Health and Human Services ("HHS") to provide coverage assistance to individuals who are uninsured because of a pre-existing health condition. This coverage assistance program is referred to as a temporary high-risk pool program. Congress has appropriated $5 billion for this effort which will be in place this year and will last until 2014, when the comprehensive reforms to the insurance markets will take place. The District of Columbia's share of the $5 billion (based on population and state costs) is approximately $9 million over this three and one half year period. HHS has given assurances that no District funds are required to implement this program. Coverage assistance can be provided by HHS either directly or through a state or non-profit

entity. DISB's sister agency, the Department of Health Care Finance ("DHCF") has submitted a proposal to HHS for the District to establish a high risk pool.

Changes Effective September 23, 2010 through 2014

Effective September 23, 2010, the Acts require private insurers to begin offering coverage, for both individual and groups, which include, at a minimum, the following benefit features:

- *No discrimination against children with pre-existing conditions*. The Acts prohibit health plans from imposing pre-existing condition exclusions on children. An interim final rule released on June 21st mandates that insurers must offer coverage to children under 19 regardless of their health status.

- *Extending coverage for young people up to age 26 through parents' insurance.* The Acts require health plans to allow single and married children to remain on their parents' insurance policy, at the parents' choice, up to the child's 26th birthday. As you know, the Council has already enacted an implementing requirement in District law that became effective in May of this year.

- *Ends Rescissions.* The Acts prohibit health plans from dropping people from coverage when they get sick, except in cases of fraud. Legislation under consideration today builds upon that prohibition by requiring an insurer to obtain prior approval from the Department before rescinding a policy.

- *Bans Lifetime Limits on Coverage and Restricts Annual Limits.* The Acts prohibit health plans from placing lifetime caps on coverage. However, the Acts authorize that annual limits may be placed on coverage until 2014 as permitted by HHS. The annual limits included in an interim final rule released on June 21st are $750,000 for the year beginning September 23, 2010, $1.25 million beginning September 23, 2011, and $2 million beginning September 23, 2012. In 2014, lifetime limits and annual limits will both be prohibited.

- *Free Preventative Care Under New Plans.* The Acts require new private plans to cover preventive services with no co-payments and exempt preventive services from plan deductibles.

- *Independent Appeals Process.* The Acts mandate that plans include an internal and external appeals process to appeal claims denial decisions.

- *Grandfathered Plans.* Existing benefit plans are required to include most of the coverage changes discussed above, except the existing plans do not need to eliminate their lifetime limits. Existing plans also will need to limit any applicable waiting periods to 90 days. Starting in 2014, all pans, including grandfathered plans would be required to eliminate lifetime coverage limits.

The Acts contain new provisions with respect to medical loss ratios and also add an HHS review process for certain filed insurance rates. A medical loss ratio ("MLR") is the ratio of premium

dollars to medical claims payments and related expenses. Individual and small group plans must have medical loss ratios of no less than 80 percent, and large group plans must have loss ratios of at least 85 percent. There are provisions in the Acts that allows carriers to include "activities that improve health care quality" as part of their medical costs, and this will serve to encourage carriers to continue to improve the quality and efficiency of the health care system as a whole. Insurers that do not meet these thresholds must now provide rebates to policyholders. Insurers will be required to report medical loss ratios for 2010, starting in 2011, and can be liable for rebates starting in 2011.

The Department is working through the NAIC to provide HHS with comments on the MLR calculation and dividend determination. One key issue in the MLR calculation is how to give appropriate credit to activities that improve quality while also preventing insurance companies from shifting administrative expenses to medical costs. The proposal from the NAIC is likely to include that the MLR and therefore, dividend determination, be done for individual, small group, and large group plans.

The MLR percentages are not identical to the percentages included in Bill 18-792. As the Department mentioned earlier, it supports modifying the language of the legislation to be consistent with the MLR requirements in the Acts. The Department also intends to use the federal calculation of MLR and dividend determination as a starting point for regulations to define those for the District once the federal process is finalized.

The Acts also include provisions that allow HHS, in conjunction with states, to review "unreasonable rate increases." The term "unreasonable" has not yet been defined. However we have been working with the NAIC to make sure the role of regulators in reviewing rates is based upon actuarial soundness. That means that rates to be charged must be sufficient to cover the risks to be insured and thus ensure the continued solvency of insurers. HHS will provide $250 million in funding to states from 2010 until 2014 to assist state departments in its review of premium rate filings and provide ongoing information and recommendations to HHS. The first round of rate review grants has an application deadline of July 7, 2010. The grants offer up to $1 million to the states and the District of Columbia to enhance health insurance rate review. The Department is currently finalizing its grant application and intends to use the award to hire additional actuaries to improve and purchase software to enhance its review of premium rate filing methodologies, review process, and to provide quality rate information to our public.

Starting tomorrow, HHS is also expected to open for public use, a web portal that will assist consumers with identifying health insurance coverage options that are available in their states. The web portal obtained information from the Department on insurance products available in the District and collected detailed information from the insurance companies offering such products here to populate the information for the District Columbia in the web portal.

Insurance regulators also are required to recommend to HHS suggested forms of standard benefit and coverage disclosures by March 2011. Currently, such standard forms do not exist. Going forward, insurers will be required to use these new standard disclosures.

The Acts include some provisions that will benefit employers starting in 2010. These benefits include the following:

- *Small business tax credits.* Effective this year, small businesses of 25 employees or less and with average annual wages of $50,000 or less can obtain tax credits to make employee coverage more affordable. Tax credits of up to 35 percent of premiums will be available to businesses that choose to offer coverage, if the employer pays at least 50 percent of the premium. The business is eligible for full credit where average wages are $25,000 or less, and the business has 10 or fewer employees. The credits will phase out as the business and wages grow. The District has no role in administering this program, but we are monitoring it.

- *Early retiree reinsurance.* The Acts create a temporary re-insurance program, effective through 2014 to help offset the costs of expensive health claims for employers that provide health benefits for retirees age 55-64. Employers will now be able to receive reimbursement for up to 80 percent of the costs of benefits paid between $15,000 and $90,000.

  In order to be eligible for this assistance, employers must put programs in place to monitor and control chronic health conditions of its employees. This program is administered by HHS and applies to self-insured and fully insured plans. The District has no role in administering this program, but we are monitoring it. In addition, the District is currently evaluating its options for applying for funding as an employer under this program for District Government retirees. Funds for this program are available on a first come, first served basis, and must be applied for directly to HHS by the employer.

- *Exchanges and Benefits Standardization.* By 2014, the States and the District will be called upon to establish health insurance exchanges to assist consumers in obtaining coverage. In this same year, individuals who can afford coverage will be required to maintain health insurance coverage or pay a fine to the federal government.

  Businesses with more than 50 employees that do not offer health coverage will face a fine of $2,000 for each employee if any worker receives subsidized insurance from the exchange. Exchanges also will offer subsidies and premium credits to individuals with incomes between 133 and 400 percent of the federal poverty level. Consumers in a jurisdiction that does not form an exchange will be permitted to utilize a national exchange.

  Exchanges will make information available to consumers and determine whether applicants are eligible for coverage, low-income subsidies, or other available programs such as Medicaid, and help consumers to enroll in coverage. Exchanges can be used for individuals and small businesses with up to 100 employees to purchase health insurance coverage. Starting in 2014, the exchanges will be offering standard benefit plans from participating insurers.

  HHS will define the provisions of standard benefit plans, including the essential or core benefits. States will be required to coordinate their existing mandates with the HHS-defined essential benefits.

Starting in 2014, businesses with more than 100 employees will be permitted to utilize the exchange. HHS will have grant funding available to states to support the cost of establishing an exchange.

- *Grant Opportunities.* The Federal Health Care Reform Acts also provide a wide range of opportunities for federal funding that we are actively pursuing to help support and expand current programs and functions. For instance, District agencies are currently finalizing grant applications for funding to support insurance rate review; expand operations at the Aging and Disability Resource Center operated by the DC Office on Aging and home visitation programs provided by the Department of Health.

The Department stands ready to work with the Council and other stakeholders, including consumers, insurance agents, and others to develop an exchange that is right for the District of Columbia. We are expecting that HHS will issue guidance for the exchanges later this year. The first step will be that the District of Columbia must indicate its intent to establish and operate an exchange. If the District chooses not to do so, the federal government will establish an exchange in the District.

We intend to implement the federal reforms with stakeholder input and advice. We plan to do all we can to garner input from key stakeholders with regard to implementation. To that end, the Mayor has established the Health Care Reform Implementation Committee ("HCRIC"), which I co-chair with Dr. Julie Hudman, Director of DHCF, to advise Mayor Fenty on implementation of the health care reform laws, and to coordinate its execution in the District of Columbia. The Department of Health Director, Dr. Pierre Vigilance, and the Department of Human Services Director, Clarence Carter also serve on the committee. In addition to

appointing the four agencies to the HCRIC, the Executive has emphasized a coordinated city-wide approach for implementation of the many facets of health reform. This is to include not just the insurance and human services agencies but also new partnerships with DC Human Resources (DCHR), the Department of Small and Local Business Development (DSLBD), the Office of the Chief Technology Officer (OCTO) and a number of other sister agencies who are touched in some way by provisions of health reform.

The HCRIC has been meeting and has established a regular schedule of one monthly meeting, which will be announced and open to public participation and which will be supplemented by a monthly conference call. Additionally, the HCRIC will establish subcommittees which would include members of consumer groups, industry and other interested parties to assist the Committee with its work. DISB and DHCF have already held a few preliminary meetings with various stakeholders and anticipate many more in the coming months and years as we progress through the various stages of health reform implementation.

The Department has reserved a section of the DISB web site for information related to federal health care reform and the HCRIC is developing a city-wide dedicated web site to provide information to District residents and businesses to provide a one-stop resource for everything they need to know about health care reform in the District of Columbia. The first version of this site is available at www.healthreform.dc.gov and over the next month we will be adding additional content and functionality to this site.

Outside of local government, the District is coordinating planning efforts with multiple county, state and federal partners, including the Council on Governments, our neighboring states of

Maryland and Virginia, the US Department of Health and Human Services (DHHS), the Social Services Administration (SSA), and the Internal Revenue Service (IRS). Any reform of this size and scale will rely heavily upon strong partnerships with the community, so we are prioritizing engagement and collaboration with area providers, insurers, advocates, community based-organizations, and resident consumers themselves.

Undoubtedly, DC Council will play a central role, both in terms of instituting legislative amendments like the bills being discussed today as well as assisting in spreading the word about insurance reform and new options for coverage to your constituents. We look forward to working with both of these committees and the Council as a whole to swiftly bring about these changes for the many DC residents that will benefit from health reform in DC.

In conclusion, we are working diligently to implement the many reforms that are effective this year. We have committed to participation in a temporary high risk pool program, and the Department is developing a proposal to participate in the first round of rate review grants. The Department's staff continues to analyze the federal law and, where we can make a difference, we will work to implement the law in the District as effectively and efficiently as possible.

This concludes my testimony. Thank you again for the opportunity to present the Department's views and I will be happy to answer any questions.