STATEMENT OF

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ON

A NEW, OPEN MARKETPLACE:
THE EFFECT OF GUARANTEED ISSUE AND NEW RATING RULES

BEFORE THE

U. S. SENATE COMMITTEE ON HEALTH, EDUCATION, LABOR, & PENSIONS

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U.S. Senate Committee on Health, Education, Labor, & Pensions
A New, Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules
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Good morning, Chairman Harkin, Ranking Member Alexander, and members of the Committee. Thank you for the opportunity to speak about our work implementing the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans the additional tools to make informed choices about their health insurance. Thanks to the consumer protections and insurance market reforms in the Affordable Care Act, in 2014, millions of people without insurance will be able to obtain coverage, and millions more will have the peace of mind that the coverage they have cannot easily be taken away.

In March 2010, President Obama signed the Affordable Care Act into law, putting in place comprehensive reforms to improve access to affordable health insurance for all Americans and protect consumers from abusive insurance company practices. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parents' insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance because someone gets sick.

In 2014, these protections will be greatly expanded. Discrimination by insurance companies against individuals with pre-existing conditions will generally be banned for Americans of all ages, and consumers will have better access to comprehensive, affordable coverage. Beginning on October 1, 2013, Americans may begin shopping for and enrolling in a wide variety of high-quality health insurance plans for coverage in 2014 through the Health Insurance Marketplaces (also known as Affordable Insurance Exchanges). Regardless of whether they plan to purchase their insurance through a Health Insurance Marketplace or are covered by insurance through their work, in 2014, more Americans will have access to more affordable health insurance.

What We Have Already Achieved: Better Access to High Quality Coverage

The Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS) has implemented strong consumer protections that hold insurance companies more accountable, give consumers more coverage options, and improve the value of that coverage. Today, more than 3.1 million additional young adults under the age of 26 are covered under their parents' plans. Nearly 71 million Americans now have expanded access to preventive services at no additional cost through their private insurance plans, and 27 million women now have guaranteed access to additional preventive services without cost sharing.[1]

The Affordable Care Act has also helped provide consumers with more rights and protections. In the past, health insurers could refuse to accept anyone because of a pre-existing health condition, or they could limit benefits for that condition, but the Affordable Care Act will provide consumers with the security that their coverage will be there for them when they need it.

Now, non-grandfathered individual health insurance plans and group health plans and group health insurance plans are prohibited from denying children coverage based on their pre-existing conditions, protecting 17.6 million children with pre-existing conditions from coverage denials. Additionally, insurance companies cannot drop or rescind people's coverage because they made an unintentional mistake on their application[2] and cannot place lifetime limits on the dollar value of essential health benefits. Group health plans, group health insurance plans, and non-grandfathered individual health insurance policies also are restricted in the annual dollar limits they can place on essential health benefits, depending on the plan year. We further protected consumers by establishing a set of uniform standards for external review of individual health plan decisions restricting an enrollee's access to benefits. Now, consumers enrolled in non-grandfathered group health plans and group health insurance coverage and individual health insurance policies can ask for an independent third party to review decisions made by their plans and insurance companies to deny preauthorization or payment for a service.

[1] http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib_prevention.cfm
[2] For an example see: http://www.healthcare.gov/law/features/rights/cancellations/index.html

In the past, often because of cost, Americans used preventive services at about half the recommended rate. Yet chronic diseases, such as heart disease, cancer, and diabetes – which are responsible for 70 percent of deaths among Americans each year and account for 75 percent of the nation's health spending[3] – often are either preventable or, with early detection, treatable. Now, all non-grandfathered plans cover certain preventive services without any cost-sharing for the enrollee when delivered by in-network providers. This protection will help Americans gain easier access to services such as blood pressure, diabetes, and cholesterol tests; many cancer screenings; routine vaccinations; pre-natal care; and regular wellness visits for infants and children.

In the past, when consumers shopped for health insurance, they had to read a patchwork of non-uniform and intricate disclosures about matters important to consumers, such as what benefits are covered under what conditions and the cost sharing associated with those benefits. That structure made the process inefficient, difficult, and time-consuming. Because of the difficulty in obtaining comparable information across and within health insurance markets, consumers had trouble finding and choosing the coverage that best met their health and financial needs, as well as the needs of their families or their employees.

Now, health insurers and group health plans provide a clear summary of benefits and coverage in a uniform format and in plain language that is designed to be easily compared across health plans by the millions of Americans shopping for private health insurance coverage. If people are looking to buy private health insurance, they can compare plans at www.HealthCare.gov, which provides information about what public and private health insurance coverage is available to consumers based on where they live. Starting in October 2013, consumers will also be able to use www.HealthCare.gov to shop for coverage beginning in 2014 under qualified health plans and to determine whether they are eligible for premium tax credits and reduced cost sharing, through the Health Insurance Marketplace.

[3] CDC Report: Chronic Diseases: The Power to Prevent, the Call to Control
http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf

Before the Affordable Care Act, Americans watched their premiums double over the previous decade, oftentimes without explanation or review. In an effort to slow health care spending growth and give all Americans more value for their health care dollars, the Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring an insurance company to justify a rate increase of 10 percent or more, shedding light on arbitrary or unnecessary costs.

Now, insurers must provide clear information so consumers can understand the insurer's reasons for significant rate increases. Since the rule on rate increases was implemented,[4] the number of requests for insurance premium increases of 10 percent or more plummeted from 75 percent to an estimated 14 percent. The average premium increase for all rates in 2012 was 30 percent below what it was in 2010. Available data suggests that this slowdown in rate increases is continuing into 2013.[5] Americans have saved an estimated $1 billion on their health insurance premiums thanks to rate review. Even when an insurer decides to increase rates, consumers are seeing lower rate increases than what the insurers initially requested. More than half of the requests for rate increases of 10 percent or more ultimately resulted in issuers imposing a lower rate increase than requested or no rate increase at all.

Furthermore, the rate review program works in conjunction with the 80/20 rule (or the Medical Loss Ratio rule),[6] which requires insurance companies to spend at least 80 percent (85 percent in the large group market) of premiums on health care, and no more than 20 percent (15 percent in the large group market) on administrative costs (such as executive salaries and marketing) and profits. If they fail to do so, they must provide rebates to their customers. Insurers that did not meet the 80/20 rule in 2011 have provided $1.1 billion in rebates that benefited about 13 million Americans, at an average of $137 per family.[7]

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[4] Health Insurance Rate Review – Final Rule on Rate Increase Disclosure and Review: http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf

[5] ASPE Research Brief: Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm

[6] MLR Final Rule: https://www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act

[7] 45 CFR Part 158: http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=5872c7e9a4bcec4584dd3255841e647a&rgn=div5&view=text&node=45:1.0.1.2.74&idno=45

Looking Forward to 2014

We are proud of the accomplishments of the last three years, and we look forward to the most promising reforms of the Affordable Care Act that are set to start in 2014. Soon, a variety of consumer protections will take effect and will end many insurance practices that make health care coverage too expensive or unavailable for many consumers.

End to Pre-Existing Condition Discrimination and Limits on Care

Today, in most states, adult consumers with pre-existing conditions can be denied individual health insurance coverage, can be charged significantly higher rates based on their conditions, or can have benefits for pre-existing medical conditions excluded by insurance companies. Beginning in 2014, new protections will help Americans of all ages maintain health insurance coverage, regardless of their health status.

As many as 129 million non-elderly Americans have some type of pre-existing health condition, and up to 25 million of those individuals do not have health insurance.[8] Pre-existing health conditions range from life-threatening illnesses such as cancer, to chronic conditions such as diabetes, asthma, or heart disease. Because of pre-existing condition discrimination by health insurers, many individuals with pre-existing conditions today have limited choices. For example, individuals may not be able to change jobs, start their own businesses, or retire because of fear of losing health insurance coverage. People with pre-existing conditions could also lose coverage if they get divorced, move, or age out of dependent coverage.

In 2014, Americans will no longer need to worry about this. Non-grandfathered health insurers in the individual and small group markets will no longer be able to use health status to determine eligibility, benefits, or premiums. With limited exceptions, all non-grandfathered plans and policies in the individual and group markets will be required to enroll individuals, regardless of health status, age, gender, or other factors and will be prohibited from refusing to renew coverage because an individual or employee becomes sick.

[8] ASPE Report: At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans
http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml

In addition, some people with cancer or other chronic illnesses today run out of insurance coverage when their health care expenses reach a dollar limit imposed by their insurance company or group health plan. Beginning on January 1, 2014, group health plans, group health insurance plans, and non-grandfathered individual health insurance policies will be prohibited from imposing annual dollar limits on essential health benefits. This change will help ensure that Americans will no longer worry about hitting a prohibitive dollar amount, which could force a consumer to either pay out of pocket for health care costs above the dollar limit or forgo necessary care.

Guaranteed Core Benefits and Comparison Shopping

All non-grandfathered plans in the individual and small group markets will cover essential health benefits,[9] which include items and services in ten statutory benefit categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These benefits must be equal in scope to a typical employer health plan. To this end, the essential health benefits will be defined in each state by reference to a benchmark plan. Soon, consumers will be able to select an insurance plan with confidence that it will cover key health care services when they need them.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets also must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer would be responsible for 30 percent of the costs of the essential health benefits the plan covers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider participation, and other factors, will help consumers make more informed decisions.

More Affordable Coverage

Before the Affordable Care Act, health insurance premiums had risen rapidly, straining the pocketbooks of Americans for more than a decade. Between 1999 and 2010, the cost of

[9] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

coverage for a family of four rose 138 percent.[10] These increases have forced families and employers to spend more money, often for less coverage. Before the Affordable Care Act, women could be charged more for individual insurance policies simply because of their gender. A 22-year-old woman could be charged 50 percent more than a 22 year-old man. Many young people and people with low-incomes often could not afford health insurance, leaving millions of Americans without coverage. Before the Affordable Care Act, premium rates charged to older Americans could be more than five times the rate for younger Americans.

In 2014, new rules will help make health insurance more affordable for more Americans.[11] Most health insurance companies will be prohibited from charging higher premiums to certain enrollees because of their current or past health problems. Most insurance companies will no longer be able to charge women more than men based solely on their gender. Most insurers will be limited in how much more they can charge older Americans than young Americans, so that insurance becomes more affordable for most Americans.

At the same time that insurance prices become more fair, many individuals will also have new help paying for their health care coverage through premium tax credits and cost sharing reductions. When coverage through the Health Insurance Marketplace starts as soon as January 1, 2014, many middle and low-income Americans will be eligible for a new kind of tax credit that can be used right away to lower monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the premiums, so consumers pay less out of their own pockets. The amount of the tax credit for which an eligible individual qualifies depends on the individual's household income. Individuals are eligible for premium tax credits if, among other things, they:

- Are not eligible for affordable health insurance coverage designated as "minimum essential coverage" (*e.g.*, government-sponsored coverage and employer-sponsored coverage);

[10] Kaiser Family Foundation. Employer Health Benefits 2010 Annual Survey http://ehbs.kff.org/pdf/2010/8085.pdf
[11] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

- Meet the requirements to enroll in a qualified health plan through the Health Insurance Marketplace[12];
- Are citizens of or lawfully present in the United States; and
- Have modified adjusted gross household incomes between 100 percent and 400 percent of the federal poverty level (e.g., $23,550 to $94,200 for a family of four in 2013).

Many people will find that they can now buy more comprehensive coverage at the same, or often even lower, out-of-pocket cost than they previously paid. Additionally, young adults and certain other people for whom coverage would otherwise be unaffordable may enroll in catastrophic plans, which have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing affordable individual coverage options for young adults and people for whom coverage would otherwise be unaffordable.

Additionally, CMS recently finalized a temporary reinsurance program designed to provide market stability and premium stability for enrollees in the individual market by reducing the impact of high-cost enrollees on plans. The temporary risk corridor program will provide issuers additional protection against inaccurate rate setting. The permanent risk adjustment program will provide increased payments to health insurance issuers that attract higher-risk populations. Taken together, these premium stabilization programs will make coverage more affordable.

Shopping in the Health Insurance Marketplace

CMS has been working with states and private insurance companies to ensure the establishment of Health Insurance Marketplaces through which millions of Americans will purchase affordable health care coverage. In order to build robust and competitive Health Insurance Marketplaces, CMS is working closely with issuers as they prepare qualified health plans that will be available to consumers within the Marketplaces. When consumers start to visit the new Marketplaces on October 1, 2013, they will experience a new way to shop for health coverage. The Marketplaces will make it possible for eligible consumers to use a streamlined application that can be completed online to apply for coverage through a qualified health plan, to qualify for premium

[12] These include additional eligibility requirements, e.g., applicant is not incarcerated (45 C.F.R. 155.305(a)(2)).

tax credits and reduced cost sharing, or to apply for coverage through Medicaid or the Children's Health Insurance Program (CHIP).[13]

The Marketplaces will also make it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality. By pooling consumers together, reducing transaction costs, and increasing transparency and competition, the Health Insurance Marketplaces for individuals and small groups should be more efficient and competitive than the consumers' current health insurance choices.

CMS is working to ensure streamlined and secure access to a variety of information sources that will provide essential support to consumers as they fill out the streamlined application. Through these streamlined processes, consumers will be able to fill out the application, receive information about whether they are eligible for premium tax credits or cost-sharing reductions or Medicaid coverage, and begin shopping for qualified health plans, all in real time, in one sitting. Consumers will then be able to research and compare the available qualified health plan options in the Marketplace so they can make informed choices about their coverage. Consumers also can use either the Marketplace website or a toll-free call center to choose health coverage that best fits their needs. Marketplace Navigators and other consumer assistance programs will provide information to consumers in a fair, accurate, and impartial manner. Additionally, where permitted by the state,[14] licensed agents and brokers, as well as online brokers, may help consumers and employers enroll in a qualified health plan through the Marketplace.

CMS and our state partners are working hard to ensure that people are aware of the new tools that will soon be available to them. On www.HealthCare.gov, people can learn about the Affordable Care Act, review health insurance basics, such as understanding what their coverage costs, and access an interactive checklist to help prepare them to shop for coverage in the new Marketplaces. CMS also expects that other Federal agency partners and members of the private sector will be involved in efforts to reach, engage, and assist potential enrollees.

[13] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html
[14] Per 45 CFR 155.220

Conclusion

CMS has worked hard over the past three years to improve the health insurance market for all Americans. We are very proud of what we have already accomplished and are excited about the new consumer protections that will help Americans in 2014. More work remains to ensure Americans have access to high quality, affordable health coverage. We look forward to continuing our efforts to strengthen health coverage options with the help of our partners in Congress, state leaders, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.