Statement of Christopher F. Koller
Health Insurance Commissioner, State of Rhode Island
before the
Committee on Health, Education, Labor, & Pensions
United States Senate
January 27, 2011

Consumer Protections in the Affordable Care Act

Chairman Harkin, Ranking Member Enzi and members of the Committee. Thank you for the opportunity to testify on this important topic. My name is Christopher F. Koller and I am the Health Insurance Commissioner for the State of Rhode Island. My testimony will be divided into two parts:

- A review of the process for implementing the consumer protection portions of the Affordable Care Act in states in general and Rhode Island in particular.
- An assessment of the effects to date of their implementation, and future implications.

By way of background: The Office of the Health Insurance Commissioner was created by statute in 2004. It is a cabinet level post and encompasses all aspects of commercial health insurance oversight in the state. We have a four fold statutory charge which is broader than that given for the oversight of other types of insurance:

i. Guarding the solvency of insurers;
ii. Protecting the interests of consumers;
iii. Ensuring fair treatment of health care providers ; and
iv. Seeing the health care system as a whole and directing insurers towards policies that promote system improvement.

This broad charge reflects the belief of the RI legislature that health insurance is fundamentally different in nature and social value from other types of insurance such as life or property and casualty. To the best of my knowledge there are no other insurance commissioners focused solely on health insurance in the country.

I am the first Commissioner and assumed the post in 2005. Since then, our Office has focused on enforcing existing statutes, establishing a consistent, fair and transparent rate oversight system, and setting standards for health plan actions to improve the underlying performance of Rhode Island health care delivery system. I will speak of these activities in more depth later.

1. Implementation of Consumer Protections
   Secretary Sebelius has given you an over view of consumer protections in the ACA . I believe my role is to speak to the experience of their implementation. As I begin, I want to note that my testimony reflects the experience of an Insurance Commissioner. While I participate actively in the National Association of Insurance Commissioners and am proud of their service in the states, and to Congress as it debated the ACA, nothing I say should be construed as an official position of NAIC.

As a rule, regulators found it most appropriate to view this as an implementation task, not a set of public policy questions – we have had a job to do. Thus, a priority of state insurance regulators has been on the measures - given existing state statute - a state must have in place to meet the statutory deadlines imposed in the ACA, many of which centered on commercial policies issued on or after October 1. The following have been the broad areas of enhanced consumer protections we have addressed:

1. First dollar coverage of preventive care benefits
2. Elimination of lifetime and (in certain cases) annual limits
3. Coverage of dependent children up to age 26
4. Elimination of pre-existing conditions exclusions for children.
5. Elimination of rescissions in individual coverage.
6. A process for consumers to appeal insurance company denials.
7. Disclosure by health plans of justification for rate hikes.
8. Development of minimum Medical Loss Ratio standards.
9. Develop Pre-existing Condition Insurance Plans (varies by state).

In implementing these measures, regulators have relied wherever possible primarily on existing activities to review and approve health plan subscriber contracts ("forms") and other consumer disclosures. In effect, we are modifying our checklists of what contracts must contain and permissible language. While this is not a nominal task, in our experience it has not been overly taxing. We have been greatly aided by the collaborative work of NAIC and good faith efforts by the Division of Consumer Insurance and Information Oversight to communicate continually to states what is needed and by when.

Efforts that involve changing processes other than forms review – such as refining the appeals process, developing medical loss ratio standards and implementing the PCIP statute - have been more varied by state and somewhat more challenging. In the wake of tight state budgets, the rate review and consumer assistance grants provided to states as a part of ACA have been greatly appreciated and the money wisely spent.

My message on implementation to date of consumer protections can be summarized with the following points:

- Guidance and standards for the ACA has to come from the Federal government. It should be marked by clarity, consistency, constancy and sensitivity to local markets. While that process has not worked flawlessly to date, it has been marked by professionalism on the part of states and federal agencies and fidelity to the statute.

- ACA wisely left implementation and enforcement of these reforms to the states. We are closer to consumers, providers and health plans and can work more effectively than a federal agency. States are working hard with limited resources to put these protections into place.

2. Effectivenesss of Consumer Protections

You have heard from individual consumers who can speak more powerfully to the effects of the ACA than I could. I would like to speak to two systemic effects of the Act: the importance of rate oversight and state level variation.

In Rhode Island we have in place a comprehensive health insurance rate review process that requires health insurers to file the rate factors they anticipate they will use in all lines of business the coming year. These are posted publicly, analyzed, compared and debated before my Office renders a decision, which insurers have the option of appealing. The effect is to increase accountability, and to shift the focus of the conversation from "how can I cost shift to improve my rate", to "what is driving underlying health care inflation and how can it be addressed". A sample of recent rate review analysis is enclosed in my testimony.

As a result, businesses in Rhode Island now have a public agency asking health insurers and providers the hard questions of what has to be done to reduce system costs, not merely shift them. Rhode Island is systematically investing in primary care, in health information technology and in provider payment reform, and leveraging the opportunities provided in those areas through the ACA and ARRA.

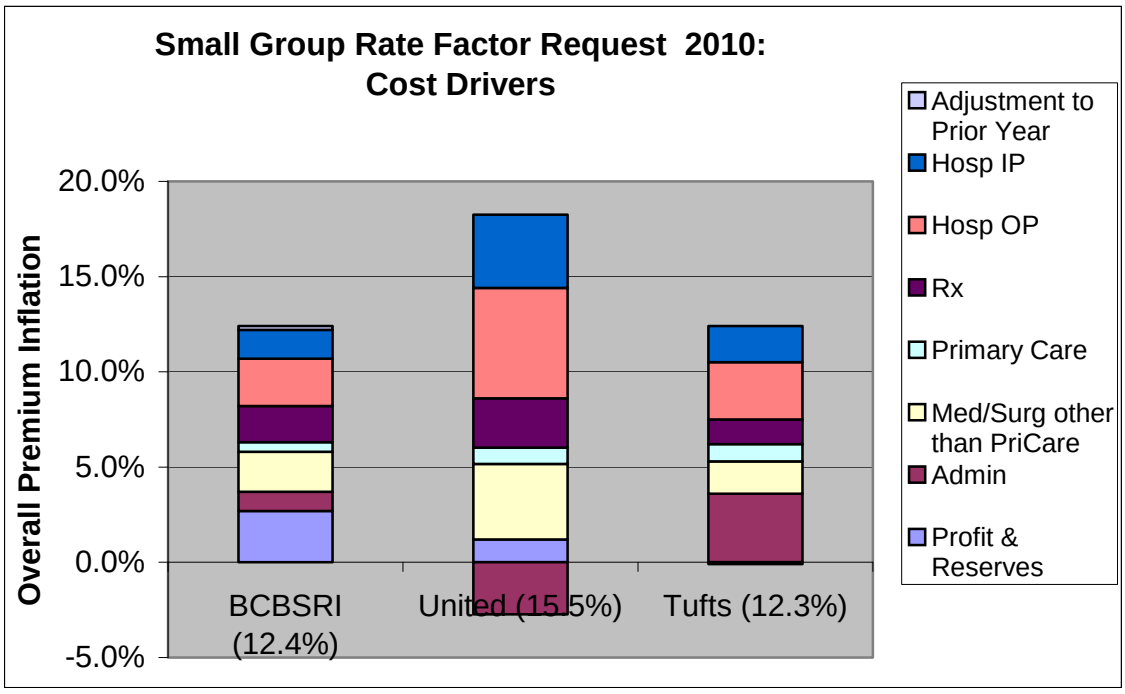
In the case of the increased consumer protections in ACA, having this rate process in place meant that health plans in RI had to state publicly how their costs would be effected by these changes in benefit levels and subject them to public scrutiny and analysis. OHIC could then make final, plan-specific decisions, and Rhode Islanders could be assured they were implemented systematically.

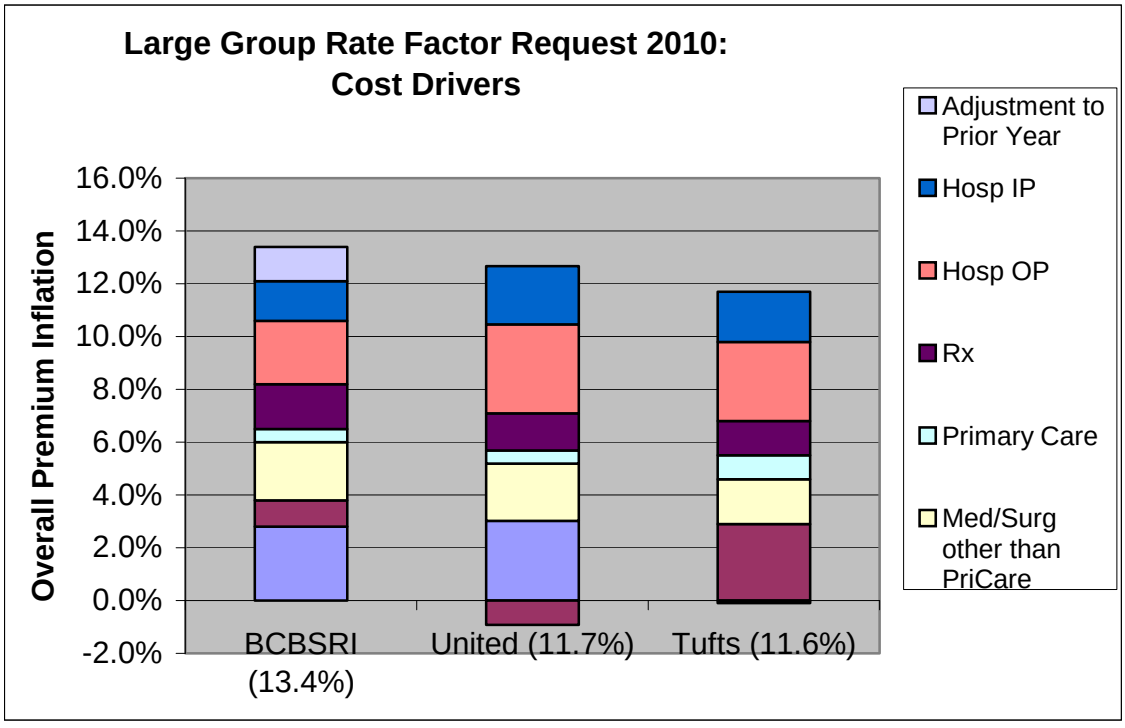
My second point is on state level variation in regulation. Rhode Island has had to take relatively small steps to implement these consumer protections – our legislature has concurred with the Congress and previously had in place an appeals process, dependent coverage to age 25, and the disallowance of rescission language. Looking ahead we already have adjusted community rating in the small group market, as required by ACA and very limited allowance of pre-existing conditions.

These reforms have been implemented steadily over the past decade. They have not always been easy – particularly as the rules for pricing have become more transparent and defined – and have required patience, persistence and continual oversight. But they have made our health insurance market more stable, our pricing rules less susceptible to special deals that merely shift costs and reward the connected, and our vulnerable citizens more protected in the market. Small businesses in particular now know exactly the short and long term steps that must be taken to reduce the rate of increase in their premiums.

I should caution that even as the efforts of OCIIO to work flexibly with states continues, members of Congress will hear from constituents about the implementation of ACA. Indeed, any adverse event experienced by anyone in the commercial insurance market will be attributed to the Act, regardless of its true origin. You are less likely to hear from people who have benefited individually from these protections and from the more stable, accountable system of private sector commercial health insurance that is resulting. But I urge you to keep them in mind - because this is what you have created with the Affordable Care Act. I have no doubt that in statute and regulation we did not get everything right, and we will have to make corrections as we proceed. However, I am also certain that the trajectory of the ACA is the right one for citizens and we in Rhode Island look forward to the benefits it will continue to bring.

Attachment 1:
RI Office of Health Insurance Commissioner





Analysis: Projected increases in hospital inpatient and outpatient costs drive most of the rate factor increases requested by all three health insurers. Projected administrative cost increases are relatively large drivers for Tufts, while profit and reserve increases are significant for United and BCBSRI.