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

STABILIZING PREMIUMS AND HELPING INDIVIDUALS IN THE INDIVIDUAL INSURANCE MARKET FOR 2018: STATE INSURANCE COMMISSIONERS

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INTRODUCTION

Good morning Chairman Alexander, Ranking Member Murray, and Members of the Committee. Thank you for inviting me to testify this morning. I enjoyed meeting with this Committee in February and I look forward to today's conversation.

As you know, I am Julie Mix McPeak. I am Commissioner of the Tennessee Department of Commerce and Insurance (TDCI) where I also serve as the State's Fire Marshal. In addition to my responsibilities at home, I also serve as President-Elect of the National Association of Insurance Commissioners (NAIC), as an Executive Committee Member of the International Association of Insurance Supervisors (IAIS), and as a Member of the Federal Advisory Committee on Insurance (FACI). I have spent most of my career in insurance regulation, previously serving as the Executive Director of the Kentucky Office of Insurance, and have a strong affinity for the country's state-based system of insurance oversight.

My testimony today will highlight Tennessee's history with the Affordable Care Act (ACA) before discussing some immediate and longer-term solutions that Congress and/or the Administration can consider to stabilize the individual insurance market. Before I get started, I would like to thank you for holding today's hearing and for inviting so many state insurance regulators as we have all spent a significant number of days working in our states and working together to ensure stability in the health insurance markets of this nation.

TENNESSEE'S INDIVIDUAL MARKET

In an interview last year discussing 2017 filings and rates, I characterized Tennessee's individual health insurance marketplace as "very near collapse." In the 12 months since, our marketplace has not collapsed. Unfortunately, however, our market is not any more stable than it was late last year.

Tennessee in 2017 has continued to see health insurance carriers flee the market due, in large part, to the tremendous uncertainty surrounding the 2018 Plan Year as well as to substantial losses in recent years. Humana Insurance Company and TRH Health Insurance Company announced this year that they would not write ACA-compliant plans on or off of the Federally Facilitated Marketplace (FFM) in 2018. While we added one new insurance carrier, Oscar Insurance Company of Texas, that company will only be writing in one of the State's eight rate and service areas—the Nashville region and its surrounding counties.

BlueCross BlueShield of Tennessee (BCBST) has tentatively agreed to offer coverage in the Knoxville region and its surrounding counties. This is noteworthy because it means that, as of today, and subject to change until Qualified Health Plan (QHP) agreements are signed later this month, Tennessee consumers across the state will have at least one option through the FFM. While we feel very fortunate that all Tennesseans will have such an opportunity, I do not think that many people would argue that having a single choice in 78 of 95 counties and a total of three (3) insurance carriers offering ACA-compliant coverage in the State represents ideal marketplace competition.

Tennesseans will face substantial rate increases for yet another year. BCBST and Cigna filed rate increases that averaged 21 percent and 42 percent for the 2018 Plan Year, respectively. Those increases may be offset for the 88 percent of our FFM enrollees that receive advance premium tax credits (APTC), but for the other 12 percent of FFM enrollees and for the 37,478 individuals who purchase insurance off the exchange, these premium increases are substantial. And they are in addition to substantial rate increases absorbed by these populations over the last several years.

Tennessee began the ACA experience in 2014 with some of the lowest rates in the country. In fact, our rates ranked the second-lowest in 2014 and the fifth-lowest in 2015. During those same two years, Tennessee had the highest and second-highest risk scores in the nation, according to metrics developed and reported by the U.S. Department of Health and Human Services (HHS). Tennessee is also among the many states that had a Co-Op experience that did not end in success. Our Co-Op provided coverage through the end of 2015, but due to a multitude of factors was ultimately placed into Supervision by my Department. We have been working with HHS since that time and hope to soon complete the company's wind-down and we fully expect that the company will be able to repay the federal government a small portion of the federal monies allocated for its startup and solvency purposes.

To summarize Tennessee's individual market experience over the last four years, our consumers have seen premium prices skyrocket while their choices have dropped substantially. Tennessee had around a dozen carriers offering individual health insurance coverage in 2010, and looking to 2018, the state has a total of three companies offering ACA-compliant plans (though consumers in

much of the state will only have one choice), and one company that sells non-compliant, underwritten plans. The companies' experiences and the state's population health, which we are working as a state to improve, have justified the rate increases. While we recognize that premiums for ACA-compliant plans were going to be pricier than non-ACA-compliant plans available before 2014 due to their more robust benefit offerings, policies that increase in price significantly year-over-year has been a tremendous affordability challenge for Tennessee's citizens.

Tennessee's current ACA trajectory, quite simply, is not sustainable into the extended future. We are thankful that consumers in all counties of Tennessee appear to have an FFM coverage option for 2018, and we are hopeful that that remains the case, but for how much longer, as we are running out of carriers? I appreciate today's hearing designed to create solutions to immediately inject some level of stability into the market and I encourage you to continue discussions to more broadly address America's health insurance and healthcare challenges.

TIMELINE & CSRs

Today's hearing could not be more timely as we are rapidly approaching a September 20 deadline for States and the Centers for Medicare & Medicaid Services (CMS) to make final determinations on 2018 rate filings. This deadline was pushed back by CMS on August 10 from an original August 16 due date with a recognition that cost-sharing reduction (CSR) questions added a layer of complexity to the rate review process. The states have addressed CSR uncertainty in a variety of ways, including by requiring carriers to file two sets of rates: one set of rates that assumes CSRs are

not funded and the other set of rates that assumes CSRs are funded by the federal government for the 2018 Plan Year.

Tennessee's marketplace carriers filed one set of rates assuming the CSRs are not funded. We asked carriers to identify the percentage of their rate request that is due specifically to uncertainty surrounding CSR funding. BCBST reported that 14 percent of its overall 21 percent average rate increase is due to CSR uncertainty, while Cigna reported its impact at 14.1 percent of its overall 42 percent average rate request. According to CMS data, approximately 120,000 Tennesseans are enrolled in CSR plans, representing almost 60 percent of our FFM market.

There is still potentially time for the Congress and Administration to provide stability to health insurance markets across the country by agreeing to fund CSR payments at least through the 2018 Plan Year. Such a stability measure could result in an immediate reduction in proposed premium rates for 2018 following coordination between the states and CMS.

The CSR funding issue is the single most critical issue that you can address to help stabilize insurance markets for 2018 and potentially bring down costs. And to be clear, this issue is not an "insurer bailout." CSR funding ensures that some of our most vulnerable consumers receive assistance for copays and deductibles that are required to be paid under federal law AND has the effect of reducing proposed premium increases that would otherwise increase the amount of APTC assistance provided by the federal government. In fact, as you know, last month the Congressional

Budget Office (CBO) reported that federal deficits would increase by $6 Billion in 2018 if CSR funding is terminated.

Should the federal government refuse to fund CSRs, premium rates will increase at rates that are otherwise unnecessary based on medical trend, inflation, and other cost considerations. This increase will impact the second-lowest silver plan rates, which in turn will increase the amount of available subsidy to FFM consumers. On the other hand, should the federal government agree to fund CSRs, and CMS works with the states, we could see proposed increases for 2018 be reduced by substantial margins. Those reductions could also result in the federal government paying out less in APTC than they would pay should currently filed rates be approved. Please act now to fully fund CSRs and provide that necessary certainty to our insurance markets.

INDIVIDUAL MARKET REFORMS

Reinsurance/Stop-Loss Mechanism

In addition to providing certainty regarding CSRs, the federal government can take additional action to stabilize markets. To stabilize markets, we need to grow risk pools with healthy individuals. To attract new, healthier risk to the market, we need to calm rates and backstop losses relative to the most expensive claims. Along these lines, Congress should consider establishing, at the very least, a short-term reinsurance mechanism that would effectively stop losses for individual claims at a specified amount. For a most immediate impact, this backstop mechanism must be federal as it would be impossible for many states to develop such a program for the 2018 Plan Year and a significant challenge for states to implement a mechanism for 2019

and perhaps 2020. States should have the option and full flexibility to set up their own programs to reflect their unique dynamics and market conditions, but the federal government should set up a default mechanism to stabilize markets during any transition to a state-run system.

In Tennessee, TDCI recently issued a data call to our health insurance carriers to better understand the frequency of high cost claims. We requested claim cost numbers in specified increments beginning at $50,000 claims and extending beyond $5 Million. Preliminarily, and on the aggregate as we issued this data call under our confidential market conduct authority, we have identified that between 85 percent and 95 percent of claims incurred and reported in 2015 and 2016 respectively, fell between the $50,000 and $200,000 range. We are continuing to review the data.

Rate Bands

When I was here in February, I highlighted providing more flexibility related to rate bands as one area that Congress and/or the Administration could address in trying to bring younger, healthier individuals into the individual insurance marketplaces. In Tennessee, the majority of our FFM population is 45 years of age or older. We need younger, healthier risk to enter the market and balance the currently insured business that, as HHS has indicated, has resulted in a higher risk score than almost every other state's insured population.

As you know, the ACA has a 3:1 age band that requires premiums to differ based on age by no more than a 3:1 ratio. I said in my February statement:

> Providing more flexibility to insurance regulators and carriers in how individuals are rated, even while keeping prohibitions against discrimination based on preexisting conditions, may help stabilize insurance markets. Ratios closer to 5:1 or 6:1 would provide more rate flexibility in the market and when coupled with EHB flexibility may have the ultimate impact of growing the individual insurance pool in Tennessee.

I stand by that statement today and would add that a 5:1 or 6:1 ratio should be a ceiling rather than a requirement. Before the ACA, we saw rates that often provided a 5:1 age ratio in Tennessee. These rates were actuarially justified and allowed for more variability in rates for younger consumers. Should the ACA be amended to provide more flexibility, it is possible, if not highly likely, that younger consumers who today want to purchase insurance but decide to instead pay the individual mandate penalty due to higher prices would come back into the markets to give themselves a sense of comfort that insurance provides should they need medical services.

Yes, greater flexibility in age rating would mean lower prices for younger consumers. Yes, it could also mean higher prices for older consumers; but that's not necessarily the case and it is a situation that Congress could simultaneously address by adjusting APTC formulas. However, there is simply no denying that a bigger risk pool with a greater percentage of low risks will outperform a smaller risk pool with concentrated high risk. We should do what we can to grow our risk pools for the benefit of the many, including by expanding the range of individuals qualifying for an APTC to

apply to those individuals falling below 100 percent of the Federal Poverty Level (FPL) who may not otherwise have access to affordable insurance coverage as well as by opening up access to catastrophic plans to everyone, rather than for only individuals aged 30 and younger or those who can otherwise qualify under special circumstances.

HEALTHCARE COSTS

Health insurance helps consumers shoulder the costs of health care services. As the costs of health care services increase, so too must the costs of health insurance. This causal relationship is simple to understand, yet is too often not discussed in conversations of health insurance reform. While recognizing that today's focus is on immediate strategies to stabilize health insurance markets, I would be remiss if I did not urge the Committee to also begin a conversation about health insurance cost drivers, and specifically the costs of health care services.

Health insurance rate requests are subject to review by state insurance departments and in FFM states, the federal government. Health insurance rates are among the most highly regulated financial products in the country as they must be related to risk and are prohibited from being excessive or inadequate or discriminatory. In addition, federal law specifies "loss ratios" for health insurance products that require carriers to provide rebates to consumers if the carriers spend too much of their premium revenue on administrative costs. In Tennessee, the rate review process is an entirely public one. As soon as a rate is filed through the Department's electronic system, it is publicly accessible to anyone interested. Objections to the filings, and questions from the Department, are also publicly accessibly, as are responses from the companies. Insurance

consumers go on healthcare.gov to view a menu of policy options, complete with monthly premium prices. Rates are filed and approved on a Plan Year basis that prohibits rate changes during a year and provides consumers notice before a rate increase for the following year. Are there parallels to these protections applicable to the pharmaceutical industry? Is this level of transparency achieved in determining appropriate costs for medical services?

Medical and particularly pharmaceutical costs and transparency, balance and surprise billing, and air ambulance costs, services, and billing, contribute to the cost of health insurance. As we continue our conversation on stabilizing health insurance markets, I would encourage you not to lose sight of key cost drivers and to look for incentives and wellness programs that may help improve the overall health of our shared constituents.

CONCLUSION

Thank you for the opportunity to visit again with this Committee. Health insurance markets remain "near collapse" in several states and are certainly challenged in many others. But insurance regulators are a resilient group, and we stand ready to work with you to provide immediate and long-term stability to our markets.

Consumers around this country need and deserve access to quality health insurance coverage at affordable rates. Working together we can get back to a place of vibrant, competitive markets where insurers look to expand, rather than contract, their operations. The Congress should first focus on two critical elements to make that possible: CSRs and Reinsurance. Fully funding CSRs

will provide immediate certainty to our markets, and very possibly bring requested rate increases down, and a federal backstop for high-dollar claims will calm troubled markets. After addressing these issues, the Congress should focus its attention on a broader conversation of our nation's health and strategies to improve health outcomes while reconsidering tenets of the ACA that have led to challenged and potentially unsustainable markets across much of the country.

Thank you again for this conversation. I look forward to your questions.

 Commissioner Julie Mix McPeak was appointed by Governor Bill Haslam to lead the Tennessee Department of Commerce and Insurance in January 2011.

Before being named to lead the department, she practiced as Counsel to the Insurance practice group of law firm Burr & Forman LLP. She also served as the Executive Director of the Kentucky Office of Insurance (KOI). Before her appointment as Executive Director, McPeak spent nine years as an attorney for KOI, the final five as general counsel. She also served as general counsel to the Kentucky Personnel Cabinet.

McPeak , who brings more than 20 years of legal and administrative experience in state government, is the first woman to serve as chief insurance regulator in more than one state. As a firefighter's daughter, McPeak brings a sincere passion and commitment for the fire service, which she has demonstrated by her hands on leadership as State Fire Marshal.

Her leadership as TDCI Commissioner garnered recognition from Business Insurance Magazine which honored her as one of the 2013 Women to Watch.

McPeak is President-Elect of the National Association of Insurance Commissioners (NAIC). The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. An active NAIC participant for nearly 20 years, McPeak has served on the NAIC's Executive Committee since 2013. She was elected in November 2015 as NAIC Secretary-Treasurer and elected NAIC Vice President in February 2016.

In addition to her leadership duties with the NAIC, McPeak is also an Executive Committee member of the International Association of Insurance Supervisors (IAIS.) In June 2016, she was elected by her fellow IAIS members to serve as vice chair of the

group's Executive Committee. She also serves as a member of the Federal Advisory Committee on Insurance (FACI).

McPeak served as co-counsel for the Kentucky Association of Health Plans v. Miller, a case heard before the Supreme Court of the United States, regarding ERISA preemption and state "Any Willing Provider" statutes. McPeak is a frequent author and lecturer on insurance issues, having addressed members of the American Council of Life Insurers, the National Association of Mutual Insurance Companies, the National Alliance of Life Companies and the Million Dollar Roundtable. McPeak authored chapter 9: "Licensing of Insurers" for New Appleman on Insurance, Library Edition and co-authored the article, "The Future of State Insurance Regulation: Can it Survive?" featured in Risk and Management Insurance Review.

McPeak is a member of the Tennessee Bar Association, Kentucky Bar Association, and the Nashville Bar Association. She has been a member of the American Bar Association, Tort and Insurance Practice section, where she served as Vice-Chair of the Insurance Regulation Committee and a member of the Federal Involvement in Insurance Regulatory Modernization Task Force. McPeak has also served on the Board of Directors of the National Insurance Producer Registry.

McPeak received her J.D. from the University of Louisville, School of Law in 1994. She is a 1990 graduate of the University of Kentucky, where she received her B.B.A., With Distinction, in Marketing.