The Committee on Homeland Security and Governmental Affairs
Statement of Mary Taylor,
Ohio Lt. Governor and Department of Insurance Director
Washington, District of Columbia
September 15, 2016

Mr. Chairman and distinguished members of the committee, thank you for the opportunity to testify before the Senate Homeland Security and Governmental Affairs Committee. My name is Mary Taylor and I am the Lt. Governor of Ohio as well as the Director of the Ohio Department of Insurance. Today, I will provide testimony regarding Ohio's experience related to the Affordable Care Act (ACA) – specifically in regard to premium changes, market shifts and other trends since 2013.

As the Director of the Ohio Department of Insurance, I am responsible for regulating Ohio's insurance market – the 7th largest in the United States. Ohio is home to more than 200 insurance companies and more than 1,600 do business in the state representing $76 billion in annual premium. In fact, because our market is so competitive, the most recent data shows Ohio's auto and homeowners insurance premiums are significantly below the national average and ranked 12th and 9th lowest respectively[1].

The Ohio Department of Insurance is made up of several divisions designed to help consumers, regulate the industry, and – when necessary – take enforcement action. The Department

[1] According to 2013 data – the most recent available from the National Association of Insurance Commissioners.

leverages these divisions to review all insurance products sold in Ohio, ensure the premium rates are actuarially justified, adequate, and non-discriminatory and assist consumers. The Department ensures companies are solvent while monitoring their conduct in order to protect consumers from practices that do not meet the highest standards.

Our mission at the Ohio Department of Insurance is to provide consumer protection through education and fair but vigilant regulation while promoting a stable and competitive environment for insurers. Our staff works every day to ensure consumers are protected and that the insurance market in Ohio is strong and vibrant. When it comes to health insurance, this mission has become more difficult because of the ACA.

In 2011, shortly after becoming the Director of the Department of Insurance, I commissioned reports to help inform decision making around whether or not Ohio should establish a state-based exchange under provisions in the ACA or if Ohio would be best served by having a federally facilitated exchange. One study (conducted by Milliman) looked at the pre-ACA market in Ohio and compared that to what a post-ACA market might look like. The second study (conducted by KPMG) looked at the work and funding needed to run a state-based exchange.

Both studies offered findings that were sobering for Ohio's health insurance market once the ACA was fully implemented. For one, running a state-based exchange would be costly to the state and ultimately to consumers without providing any additional flexibility to ensure the

exchange best met the needs of Ohioans. Second, Ohio's health insurance market would undergo significant change leaving consumers with fewer choices and more mandated coverage. Finally, because of changes to coverage options in Ohio, premiums were forecast to increase by 55 – 85 percent.

Based on these studies, our administration in Ohio decided not to run a state-based exchange seeing no benefit to burdening our taxpayers with the additional cost and no ability to impact the changes coming to our market that would ultimately drive-up the cost of health insurance. Further, the Milliman study provided strong evidence that premiums would go up in Ohio for consumers and small businesses. But these issues were just some of the challenges states would be facing as provisions of the ACA began to take effect.

In April 2013, I had the opportunity to testify before the U.S. House Energy and Commerce Subcommittee on Health. During my testimony, I discussed Ohio's experience with our high risk pool and the federal government. At the time, states were mandated by the ACA to have high risk pools to help provide coverage to the sickest populations in each state until other provisions of the ACA were fully implemented.

Ohio's high risk pool was administered by a private insurer, funded by the U.S. Department of Health and Human Services (HHS) and regulated by the Ohio Department of Insurance. Because of the unique nature of the arrangement, disputes arose over appropriate premium levels for the high risk pool with HHS refusing to accept the actuarially justified rates that the

Ohio Department of Insurance deemed necessary for coverage as well as disagreements over whether consumers qualified to purchase coverage. The disagreement over coverage eligibility led to a lawsuit and served as an example of the challenges state regulators were facing because of encroachment by the federal government.

I share this example because at the time of my testimony in 2013, I predicted states would face significant challenges as the ACA was fully implemented. I made the case that based on our experiences in Ohio with HHS on disputes over our high risk pool – disputes that would have never occurred prior to the ACA becoming law because states had previously always had authority in these areas – these types of problems would only increase as the law took effect.

In the summer of 2013, the Ohio Department of Insurance reviewed health insurance plans to be sold on the federal exchange for the first time. Any insurance company selling these products in Ohio must file those plans for review and approval with the Department of Insurance. Following the Department's review, we concluded that average individual premiums for health insurance products sold on the federal exchange for coverage in 2014 would increase 41 percent from the previous year[2].

The information received widespread attention that year considering the significant change in cost coupled with it being the first year the exchanges were open to consumers. However,

[2] Comparison based on premium data collected by the National Association of Insurance Commissioners (NAIC) for Ohio companies compared to final rates approved by the Ohio Department of Insurance in 2013.

much of the push-back to the data we released from the federal government and supporters of the ACA stemmed from access to subsidies. They argued consumers would rarely pay for these large increases because they would have access to large, federally funded tax subsidies to offset the cost.

However, as I – and many others around the country – pointed out those tax subsidies must be funded. The hundreds of billions of dollars in subsidies being spent across the country are taxpayer dollars. And some of the funding is pulled directly from the insurance industry to help make the system work. The imbalance in the system is further exacerbated by skyrocketing premiums. HHS put out a report in August of this year showing the faster premiums increase on the federal exchange, the more consumers will qualify for subsidies. The HHS study showed that a 50 percent increase in premiums for 2017 would allow more consumers to access the subsidies compared to a 10 percent increase in premiums[3].

Such a model is unsustainable and cannot stand under its own weight. That was the argument I made at the time, but without some of the realities we now know those arguments were often dismissed as hysteria or obstructionism. But as the ACA continued to be implemented, more of those concerns were demonstrated to be well founded. Just look at the current state of co-ops around the country.

[3] Information based on HHS report: *The Effect of Shopping and Premium Tax Credits on the Affordability of Marketplace Coverage* released on August 24, 2016.

Under the ACA, the co-op program was created to help foster competition across the country. It was deigned to help offer consumers more choices and in so doing, help lower the cost of insurance by making the industry adjust to added competition. However, I argued at the time that government should not be in the business of creating competition in a free-market environment. The foundation upon which a free-market system is built is freedom from government interference.

In Ohio, a co-op under the name Coordinated Health Mutual applied for and eventually received a license in 2014. It was unable to offer coverage on the first year of the exchange because it didn't receive a license soon enough. Ultimately, that delay probably helped the co-op avoid some of the tumult experienced by insurers during the first year of coverage and in our estimation helped ensure it could sell coverage for as long as it did. However, like many of the co-ops around the country, it fell victim to skyrocketing costs and a lack of revenue earlier this year.

In May, the Department of Insurance took control of Coordinated Health Mutual in order to run out the claims by its enrollees and liquidate the entity. Of the 23 original co-ops set-up across the country, only seven still remain in operation. The failure of these federally funded entities has cost taxpayers billions of dollars and left consumers – like those in Ohio right now – facing uncertainty as well as disruptions in coverage and treatment.

These realities are so frustrating because they have all been preventable. Commissioners around the country have been voicing concerns for years over the implementation of the ACA. We have regularly communicated to HHS that rules are too vague in places where specificity is needed and too prescriptive in places where flexibility is needed. A one-size-fits-all approach to health care doesn't work. The simple truth is that what Wisconsin needs is not the same as what Ohio needs or Mississippi or California, etc. States need the tools and the autonomy to address these important issues on a more local level.

With the failures of the co-op program and the uncertainty insurers are now facing due to languishing federal cost containment programs, the future is even bleaker than ever when it comes to the ACA. Risk adjustment, risk corridor and reinsurance programs were all created under the ACA to help insurers weather the initial years of ACA implementation.
Those programs have fallen short of the promises made in 2010 and – along with the mandate-heavy coverage now required by the ACA – are having an impact on consumers and state insurance markets especially when it comes to the amount of competition.

Prior to full implementation of the ACA, Ohioans benefited from a large selection of insurance carriers, with more than 60 companies selling health insurance products in Ohio. Based on the filings the Ohio Department of Insurance just reviewed and approved for the 2017 coverage year, Ohio's insurance market is set to go through more significant changes on top of those already experienced in the past few years that will negatively impact consumers.

In 2016, 17 health insurers sold products on Ohio's federal exchange during open enrollment. In 2017 – assuming all companies approved to sell on the exchange by the Ohio Department of Insurance enter into contract with HHS – only 11 companies will offer exchange products. This dramatic decrease in participation can be put into better perspective when looking at a county-by-county comparison of Ohio.

In 2016, every one of Ohio's 88 counties had at least four insurers selling exchange products during open enrollment. In 2017, 19 counties will have just one insurer selling exchange products and 28 counties will have just two[4]. This is not the competition and choice the country was promised in 2010 – to say nothing of the rate increase that Ohio has seen since the implementation of the ACA.

Based on the final rates approved for 2017, the average premiums for individuals buying on Ohio's federally run exchange have gone up 91 percent since 2013[5]. A near doubling of the premium will undoubtedly harm some Ohio consumers as open enrollment gets underway later this fall. Yet, the passage of the ACA came with assurances that costs would go down, consumers would have more choice and if you liked your doctor and wanted to keep your doctor you could. Unfortunately, that is all becoming more and more difficult for consumers.

[4] Ohio county-by-county data found in attachment to testimony.
[5] Premium comparisons for Ohio found in attachment to testimony.

As the cost of offering health insurance becomes more expensive for insurers and with the companies facing losses from selling exchange products which is compounded by a lack of adequate cost stabilization mechanisms as originally promised by the federal government, they have to find ways to stay competitive.

Because health insurance under the ACA's more stringent requirements is more expensive, provider networks in Ohio and across the country are becoming narrower. The more a health plan can narrow a provider network, the more ability that plan has to contain costs and remain competitive. The result leaves many Ohioans to shop on Healthcare.gov this fall facing fewer options and coverage that may not include their preferred doctor. And in some cases the nearest hospital may not be in their insurer's network. Putting aside rising premiums and the exploding subsidy costs needed to offset higher premiums, this is an issue that has real and significant impacts on consumers.

At the Ohio Department of Insurance, we have worked to address these issues exacerbated by the ACA by ensuring consumers have access to better, more timely information when it comes to health insurer networks. Insurers are required to update their information in a more timely fashion as well as provide safeguards to protect the consumer from making decisions based on outdated network directories.

These changes – implemented in Ohio before CMS could address the problem – also make it easier for consumers to access information as to whether their provider is in network while

they shop. These efforts, however, cannot change the fact that some Ohioans may purchase a plan this fall that does not include their doctor or their hospital.

I think most of us agree Americans should be able to purchase health insurance without facing barriers because of pre-existing conditions. We agree more can be done to improve the system to increase accessibility and promote better outcomes for patients. However, the ACA is not living up to promises made in regard to what our health care system would look like long-term.

We need to increase access by reducing costs instead of forcing everyone to buy more expensive coverage that in many cases they don't need or don't want. We need to empower states to design systems best suited for their populations instead of forcing one-size-fits-all mandates that in some areas are simply unworkable. We need to decentralize the power of Washington bureaucrats who – quite frankly – do not understand insurance or how to regulate it as my colleagues and I and our predecessors have done for decades.

In Ohio, we have ideas to help improve our health system without destroying the free market as the ACA has done. We believe there is a better, more inclusive way to design reforms that increase access without driving up costs, but we need the flexibility to do it. It is my hope that with different leadership and the help of Congress, states can once again have the power to implement positive change.

Thank you for the opportunity to testify before the committee and I am happy to answer any questions you have.

ATTACHMENT

Comparison 2017 to 2013

Weighted Average Annual Premium

Comparison 2017 to 2013 Weighted Average Annual Premium

Individual Market

	Weighted Average Annual Premium
2013*	$2,650.17
2017**	$5,065.30
% Change	91%

Small Group Market

	Weighted Average Annual Premium
2013*	$4,041.66
2017**	$7,847.92
% Change	94%

*2013 Weighted Average Annual Premium was calculated from issuer reported annual premium and number of covered lives in the NAIC Supplemental Health Care Exhibit for 2013, Comprehensive Health Coverage. Issuers with zero premium or zero lives were removed from the census. Average weighted by number of lives as reported by the issuer.

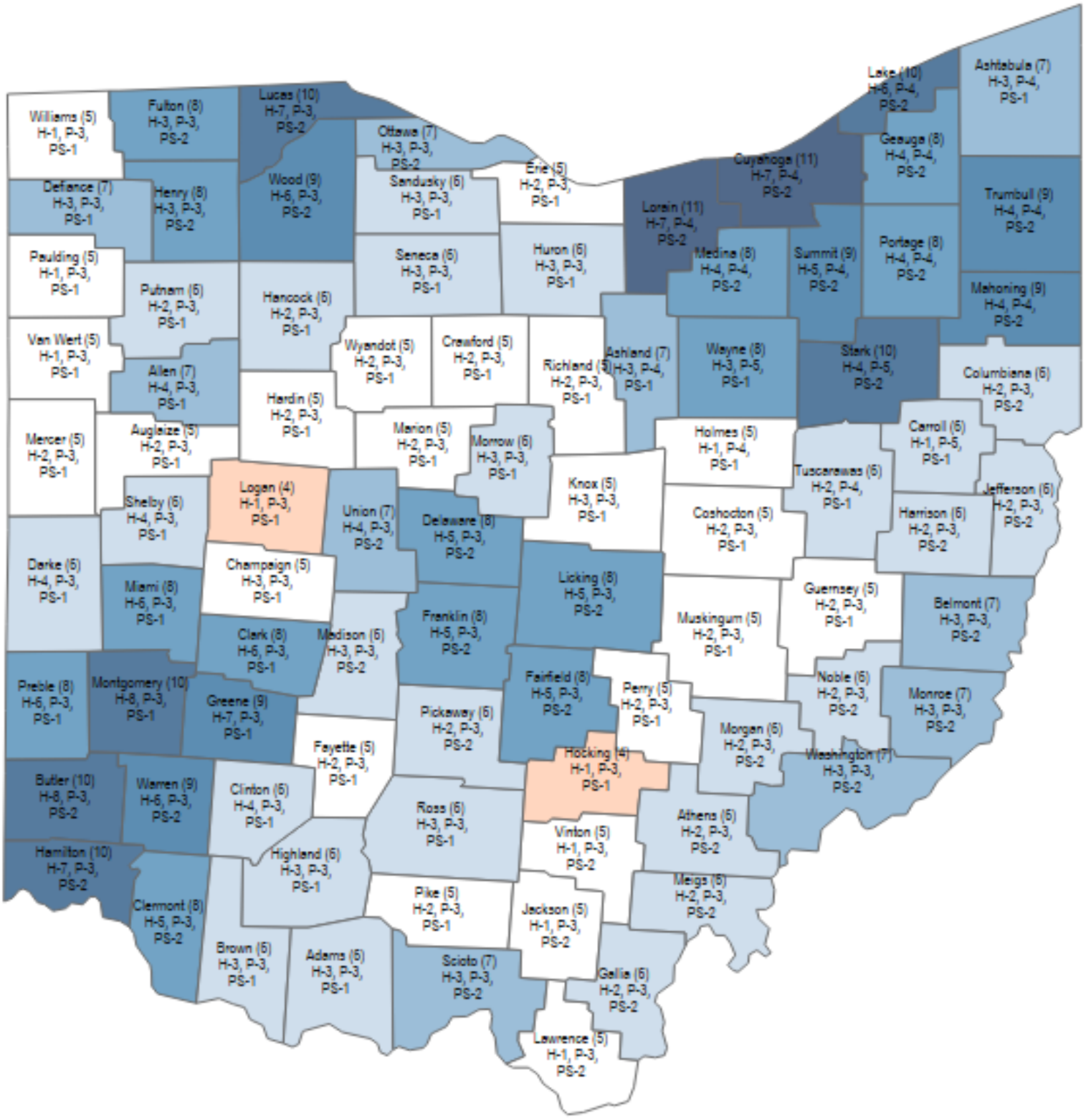
**2017 Weighted Average Annual Premium was calculated from the monthly rates in the 2017 Rate Data Templates as of 8/23/2016 and weighted by the member months assumed by the issuers listed in the URRT. Trend was not incorporated into the calculation. Average weighted by member months assumed by the issuer.

ATTACHMENT

County Comparison 2017 to 2016

Insurer Offerings in Ohio

2016 PY Individual Market On-Exchange Availability



of Carriers:

- = 4
- = 5
- = 6
- = 7
- = 8
- = 9
- = 10
- = 11

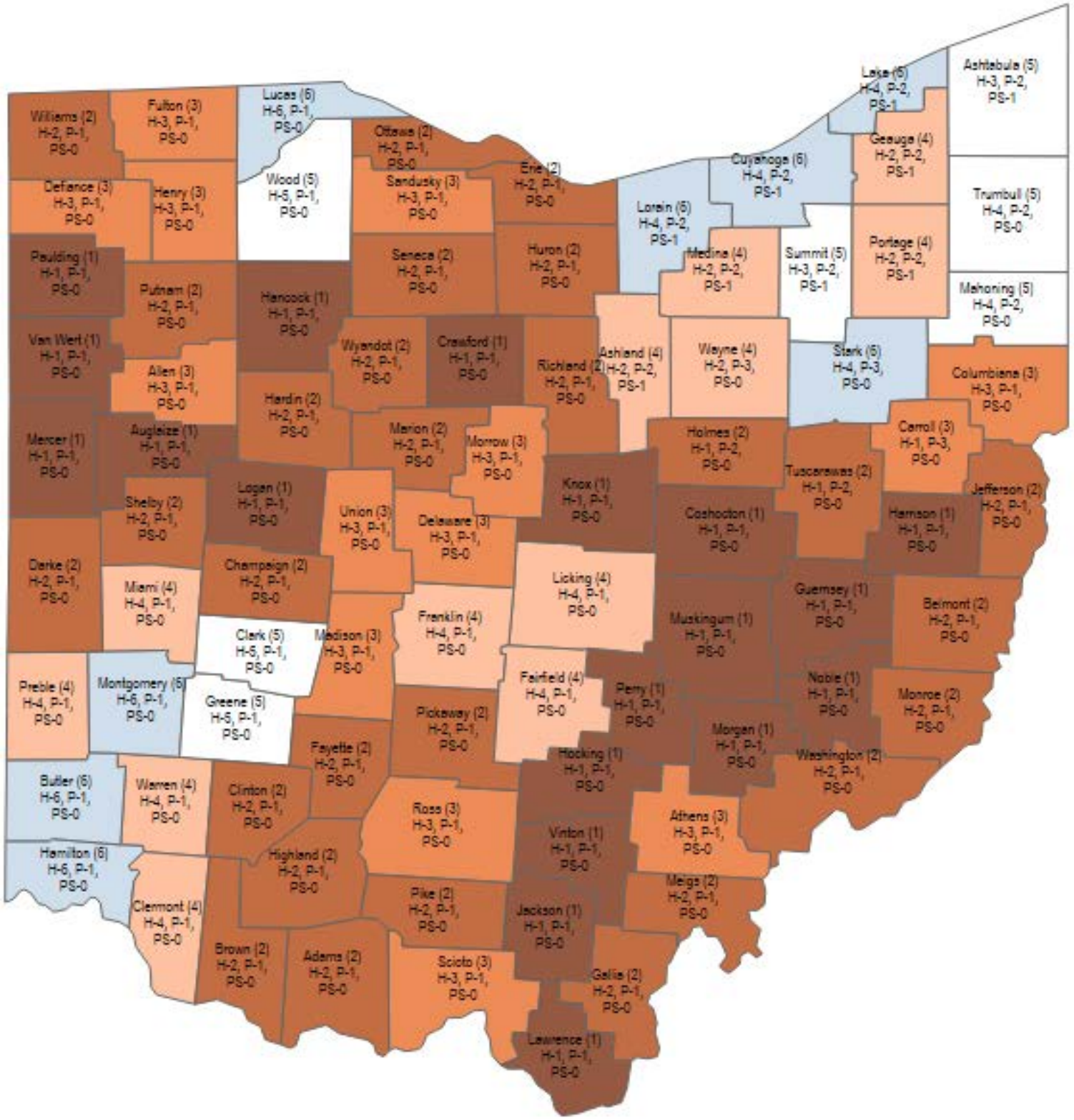
Product Type:

H = HMO

P = PPO

PS = POS

2017 PY Individual Market On-Exchange Availability as of 8/16/2016



<u># of Carriers</u>:

- = 1
- = 2
- = 3
- = 4
- = 5
- = 6

<u>Product Type</u>:

H = HMO

P = PPO

PS = POS