TESTIMONY IS EMBARGOED UNTIL 2:30 PM, WEDNESDAY SEPTEMBER 12, 2012

The Committee on Ways and Means, Subcommittee on Health

Statement of Michael F. Consedine,

Pennsylvania Insurance Commissioner

Washington, District of Columbia

September 12, 2012

Good Afternoon Mr. Chair and distinguished members of the Committee. My name is Michael Consedine and I am Pennsylvania's Insurance Commissioner.

As some of you may know, I had the privilege of presenting testimony in front of your colleagues on the Committee on Energy and Commerce in March of last year about our experiences in Pennsylvania with the first year of implementation of the Affordable Care Act ("ACA"). In that testimony, I described Pennsylvania's early experiences with the ACA as traversing a path that was marked by a lack of clear direction and troubling indications of the terrain ahead.

Unfortunately, in the eighteen (18) months that have followed, very little has changed – we still lack clear direction and the flexibility promised us has not materialized, something that at this point poses a significant barrier to our ability

to make informed decisions on issues that could impact the lives of millions of Pennsylvanians.

To date, the Department of Health and Human Services (HHS) has failed to issue numerous regulations regarding how states are to implement the ACA. Most of these outstanding regulations address critical issues on the operations and requirements of key components of the ACA, like health insurance exchanges.

The lack of detailed information from HHS has put Pennsylvania, and many other states, in a very difficult position. We are traveling down a road, directionless, while knowing the road will end soon – January 2014 is right around the bend. Pennsylvania, like many other states, needs final rules and guidance on Exchanges in order for us to determine what course is the best for our state.

These concerns and the absence of clear guidance prompted me to write a letter to Secretary Sebelius two weeks ago outlining twenty-six (26) specific questions that we in Pennsylvania felt needed to be answered in order for us to make an informed decision on exchanges. I have submitted a copy of that letter to the committee for inclusion in the record. As of the date of this testimony, HHS has not responded to our letter.

Pennsylvania is not an outlier in feeling directionless on this road. Recently, I was asked to chair a National Association of Insurance Commissioners ("NAIC") working group charged in part with collectively identifying the universe of unaddressed issues with exchanges in order to help states begin to better understand the impact the operation of a federal exchange may have on their insurance markets. We have yet to hold our first meeting, but already twenty-two (22) states have signed up to participate in this working group. A poorly executed federal exchange launch and transition from current market rules to the new ACA rules could result in severe market disruptions and a weakening of states' control over their insurance markets.

Continuing without answers to these crucial issues is like driving down a winding road, at night, without any headlights – nothing good will come of it. As chair of this working group, my hope is that we may provide the needed direction, guidance, and support for all the states that are travelling on this road together so that we as regulators can help our states make informed decisions and minimize disruptions to insurance consumers and our markets. We sincerely appreciate the efforts of Congress in aiding us at this critical juncture.

The road to exchange implementation is also a toll-road – no matter what exit a state takes, it will cost something. However, without answers to our questions, the total costs are unknown but seemingly growing every day. I will not recount for the Committee every question we have asked HHS, but I'd like to take a few moments to highlight just a few examples of why states like Pennsylvania have struggled to make decisions on exchange implementation.

The final rule on "exchange establishment," one of the few regulations actually released, had approximately 100 references to "future" or "forthcoming" guidance or regulation. To date, I am unaware of <u>any</u> of those regulations being published. States are missing details regarding fundamental aspects of exchange operation, like application requirements, citizen and income verification and appeals processes – the list goes on and on. How is a state expected to develop its own processes to interface with an exchange if the requirements for those functions have not been identified?

States are also being asked to make a "selection" of an essential health benefits benchmark plan by the end of this month, but no rule, proposed or final, has been released outlining the details of this process either. Will a state's "selection" really be the selection or can HHS modify a state's choice or, worse yet, override the

selection and replace it with another benchmark? At this point no state can answer those questions because there is no regulation. All we know is that the ACA clearly intended for the decision on essential health benefits to be made by the Secretary -- so at this point any inference that states have binding decision-making authority on the issue appears to be an illusion.

HHS has been similarly silent on how it intends to pay for a federal exchange or what costs states should expect to incur – whether entering into a partnership or merely interfacing with the federal exchange. Again, how can a state determine the scope of interaction between any one state agency and the federal exchange if we don't know how HHS intends to operate it? One thing is for sure though, interfacing with a federal exchange will require making modifications to states' IT systems – this takes time, and the shorter the time the more costly and resource intensive it will be for a state.

States are required to live within their fiscal means, which requires thoughtful budget planning – without answers to these outstanding questions it is impossible for states like Pennsylvania to adequately prepare. These questions are just a few of the many outstanding issues to which states, like Pennsylvania, need answers if we are to make informed decisions.

In the end, the unfortunate but consistent delay of information from HHS will hurt Pennsylvania individuals and businesses the most – they are the passengers in this journey that is supposed to bring them to a destination of affordable and accessible health care. A poorly implemented federal exchange, however, will put those passengers at risk. Two years after the ACA's implementation, we see health care premiums in Pennsylvania continuing to rise, with no promise of reductions in sight, and we see an increase in the bureaucracy surrounding health insurance regulation. My concern as a state insurance regulator is that we are not driving to the destination promised by the ACA, but instead heading towards a cliff. As I told Secretary Sebelius in my letter, Pennsylvania's focus remains on getting health care reform **done right, not just done quickly, and certainly done in a manner that does not put Pennsylvanians at risk**. Even though the lack of information from Washington is producing roadblocks to effective exchange implementation in many states, it will not stop Pennsylvania from continuing its own work towards achieving meaningful and sustainable health care solutions in our state.

Thank you.

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ATTACHMENT

Commissioner Consedine's Letter to Secretary Sebelius dated August 23, 2012

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG

THE COMMISSIONER

August 23, 2012

The Honorable Kathleen Sebelius
Secretary, United States Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Dear Secretary Sebelius,

On June 28, the United States Supreme Court issued its opinion in *National Federation of Independent Business v.* Sebelius, 132 S.Ct. 2566, 2012 WL 2427810, 2012 U.S. LEXIS 4876 (*"NFIB")*. In its review the Court examined the constitutionality of two provisions of the Patient Protection and Affordable Care Act ("PPACA"): the individual mandate to purchase health insurance and the expansion of the Medicaid program. Despite the individual mandate being upheld as a tax, states are now confronted with a series of critical choices relating to the implementation of PPACA, such as whether or not to build a health insurance exchange or expand their Medicaid programs. The changes being made as a result of PPACA are fundamental and potentially disruptive to Pennsylvania's marketplace, which is why we must be mindful of the consequences, both fiscal and policy, associated with any form of implementation by Pennsylvania. In order to be able to provide the Governor with the necessary information to make a prudent and informed decision on these matters we need – in a timely manner – detailed information and substantive responses from the federal government on many outstanding issues relating to health care reform implementation.

To date, HHS has been slow to provide states with detailed and necessary information on a number of key issues affecting health insurance exchanges and other PPACA-related issues. In light of the *NFIB* opinion, an even greater number of questions remain to be answered relating to the optional Medicaid expansion and its impact on exchanges and other provisions of PPACA.

On July 10, Republican Governors sent a letter to President Obama listing some of these outstanding questions. To date, the response received from your agency lacks the clarity we need to make informed decisions on these issues. Significant concerns remain pertaining to what type of burden the operation of an exchange in Pennsylvania will place on our taxpayers and the state's budget, particularly after the first year of operation when federal grant monies are no longer available. Although the goal of the PPACA with respect to expanding coverage is laudable, we are concerned that the expanded government bureaucracy for an insurance exchange as contemplated by the law may not permit a sustainable approach to improving the affordability and accessibility of health care in Pennsylvania.

Phone: (717) 783-0442
1326 STRAWBERRY SQUARE
HARRISBURG, PA 17120
Fax: (717) 772-1969

Therefore, in order to allow Governor Corbett to carefully evaluate the decisions facing Pennsylvania, we must receive specific answers to the many important questions left unanswered. In order to assist us in providing our Governor with that information, I respectfully request that you provide detailed responses to the following questions in an expedited manner. Although this is not an exhaustive list of questions about the insurance provisions in the ACA, it captures currently recognized questions and primary concerns confronting the Commonwealth the answers to which will help us determine the correct course for Pennsylvania.

1. The preamble to the final exchange establishment rule includes approximately 100 references to "future" or "forthcoming" guidance or rulemaking. Please provide a detailed timeline of when each of these documents will be released.

2. The exchange establishment final rule had a number of key provisions that were issued as "interim final", impacting such areas as eligibility standards, transmission of information on the advance premium tax credit (APTC) and cost sharing reductions (CSR), and the role of agents and brokers. When will HHS be issuing final rules on these topics?

3. Based on informal communications from HHS, states are being encouraged to make a decision regarding Essential Health Benefits (EHB) by the end of the third quarter of this year, though HHS has not issued any rulemaking (proposed or final) addressing the issue. When will such a rulemaking be released; will states have a reasonable period of time after the final rule is issued before they will be expected to declare their intent with regard to EHB?

4. When will HHS release its rulemaking or detailed guidance on the operation of the Federally-Facilitated Exchange (FFE)? When will a rulemaking or detailed guidance be issued on the specifics of a Partnership FFE?

5. What financial costs will a state face if it elects to default to an FFE? Will a state jeopardize any of the federal funding it currently receives if it does not participate in any necessary interfaces to enable an FFE to operate?

6. If HHS operates an FFE or Partnership FFE in the state, may the state charge the exchange or the federal government for the time spent by its staff on exchange matters, and also charge for any other expenses attributable to the FFE or Partnership FFE?

7. If the state enters into a partnership with an FFE, and the state wants to end the partnership because it is determined not to be in the best interest of the state (for financial or other reasons), what are the applicable requirements on the state to continue performing partnership activities?

8. If HHS operates an FFE in the state, what will it do to assure that it is not undermining the market outside of the exchange?

9. What restrictions or limitations, if any, will the operation of an FFE in a state have on that state's insurance regulator's authority to enforce other insurance laws, including consumer protection statutes, that are currently or may be applicable to health insurance companies licensed by the state?

10. When will the rulemaking detailing the operation of the multi-state insurance plans be released?

11. If HHS operates an FFE in the state, will the multi-state insurance plans be required to adhere to all applicable Pennsylvania insurance laws? Will the multi-state insurance plans be required to meet the same standards for qualifications as a Qualified Health Plan that other insurers must meet to be sold through an FFE?

12. Assuming that the state opts to allow HHS to operate either an FFE or a Partnership FFE, and the FFE (or Partnership FFE) is not financially self-sustaining, will the federal government (HHS) commit to not assess the state, or otherwise seek financial support from the state?

13. If a state decides to pursue either a Partnership FFE or state-based exchange, would implementation of either of those options dictate that the state also must expand its Medicaid program in accordance with PPACA?

14. What will be the financial costs borne by a state that performs plan management functions in a Partnership FFE? Will the state be expected to independently finance activities performed pursuant to the partnership agreement? Will HHS provide financial support to states to cover the cost of performing plan management partnership activities?

15. How much autonomy will a state have if it elects to participate in a Partnership FFE? Will states be able to deviate from the anticipated but yet to be released Standard Operation Procedures when performing activities covered under the partnership agreement?

16. Will a state need to access the Federal Data Hub if operating in a Partnership FFE? If yes, will HHS charge a state to access the hub, and how much? If no, will HHS guarantee that a state will never face a charge to access the Federal Data Hub?

17. Will a state be charged to access the Federal Data Hub if it operates a state-based exchange, and how much? If no, will HHS guarantee that a state will never face a charge to access the Federal Data Hub?

18. Is the list of Consumer Assistance activities in a Partnership FFE, as shown in the General Guidance document (issued May 16, 2012), exhaustive? Will the state be expected to independently finance activities preformed pursuant to the partnership agreement? Will HHS provide financial support to states to cover the cost of performing consumer assistance partnership activities?

19. What are the specific expectations of HHS as they relate to the scope and level of in-person consumer assistance a state must provide in a state-operated exchange? In a Partnership FFE?

20. If the state initially defaults to an FFE (or Partnership FFE) and subsequently decides it wants to operate a state-based exchange, what are the requirements and timelines associated with transitioning from an FFE (or Partnership FFE) to a state-based exchange? Will there be federal financial support available to cover the costs associated with the transition?

21. The Insurance Department operates Pennsylvania's Children's Health Insurance Program (CHIP). The proposed methodology for modified adjusted gross income (MAGI) being advanced by HHS will result in families with high incomes being made eligible for free or subsidized CHIP (to give but one example, a family business may have significant net operating loss carryover that results in a negative reported taxable income). The same issue arises with respect to the state Medicaid program. Does HHS plan to revise its methodology to ensure that these programs (and their limited taxpayer funding) remain available for those individuals most in need, and only for those individuals?

22. Will a state be allowed to use a Premium Assistance Program/Health Insurance Premium Payment Program to pay for CHIP (or Medicaid) eligible children to be added to a parent's health insurance policy purchased through an exchange?

23. The MAGI criteria used by the IRS for its calculation of eligibility for APTC and CSR is different from CMS' MAGI criteria to be used for CHIP (and Medicaid) eligibility determinations. Will the IRS, CCIIO, and CMS be comparing the methodologies and either aligning them into a single approach or providing states with a template to be used for each specific type of MAGI determination?

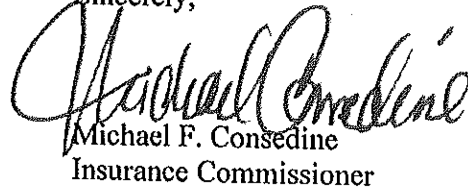
24. In Administrator Tavenner's July 13, 2012 letter to the Republican Governor's Association, she indicated that states do not need to declare whether they are expanding Medicaid eligibility or operating their own exchange in order to receive enhanced funding for IT systems changes. She also indicated that a state would not have to return any funding if it later decides not to take either step. The letter indicated that further guidance would be forthcoming. When will the guidance on this issue be released?

25. Will Pennsylvania be required to convert its CHIP income-counting methodology to MAGI for purposes of determining eligibility if Pennsylvania decides not to expand Medicaid to the optional adult coverage group?

26. Will HHS require a state-based exchange to maintain, for each Qualified Health Plan, a list of participating health providers who are accepting new patients? Will this be a requirement of a state under a Partnership FFE?

We look forward to receiving responses to these inquiries so that we may complete the analysis necessary to permit an informed decision. As has been previously communicated to you by Governor Corbett, Pennsylvania is committed to implementing health reform solutions that work for Pennsylvania – not a one-size-fits-all Washington solution. Given the extent and nature of the questions that remain open, we have determined that at this time it would be imprudent for us to continue extensive planning efforts until we receive answers to these items. Therefore, Pennsylvania will not be expending any of its Level I Establishment grant funding until such a time when the information we require to make an informed decision is provided to us by your Department. Pennsylvania's focus remains on getting healthcare reform done right, not just done quickly. As we await your response, Pennsylvania will be continuing its work towards achieving meaningful and sustainable health care solutions in our state.

Sincerely,



Michael F. Consedine
Insurance Commissioner