Testimony before US House Energy and Commerce Committee; subcommittee on Health

Tuesday March 23rd, 2020

Madam Chairman,

Thank you for the opportunity to testify, regarding Idaho's experience with Health Insurance, the ACA and short-term plans.

I am grateful for this hearing and discussion. At the core of this discussion is how you expand coverage *and* lower costs. I would like to speak briefly to Idaho's experience, the legislation being considered and additional ideas which would help towards that important goal.

A little disclosure, I am an officer of the NAIC. I am President elect this year. However, I am not here speaking as an officer of the NAIC but as a state regulator. I do wholeheartedly support the state based regulatory system. State based regulation works. I believe the solutions to the healthcare marketplace will be found in the state laboratories of creativity at the state level. And I support each state right to try approaches that meet their states market place. I also know that consumers are better protected at the state level. I will say as I talk to other state commissioners, many are facing the same dilemmas as Idaho.

Idaho prides itself on being creative and collaborative in finding solutions. It is that collaboration and our regulatory approach which led to the creation of our state-based exchange – one of the most successful exchanges in the country. It is that collaboration and innovation which has provided consumers with 6 competing carriers participating in the individual health insurance market. And it is that innovation which provided access to coverage at more affordable prices.

Idahoans, like many consumers in other states, are being priced out of the marketplace. The ACA plans have become too expensive and many do not qualify or cannot avail themselves of the subsidy. They want to have coverage but simply cannot afford it.

They are forced with the unenviable position of going without coverage or obtaining other products such as Health Sharing Ministries plans or short-term plans.

As prices for ACA plans continue to rise more and more of our citizens were forced out of coverage. Unfortunately the unintended consequences of some of the parameters of the ACA forces the young and the healthy of all ages out of the market place.

As more of the young and the healthy of all ages leave, prices continue to climb, more leave and our market is caught in a vicious cycle.

Since 2015 the number of insureds on the individual market continues to decline at a time when our population growth is one of the highest in the country.

Idahoans like the healthy couple in Twin Falls, Idaho ages 63 and 62 who when their health insurance exceeded $1,500 a month, who dropped coverage and bought a traditional STP for $750 a month and they are hopping from one plan to another until they turn 65. Obviously risky for them but also harmful for the risk pool.

Or like the couple from Rupert Idaho, whose employer, the school district, offers coverage but only pays for the teacher, whose spouse and children are without coverage because they don't qualify for a

subsidy and cant afford the nearly $2000 a month for the dependent coverage. Again, they are healthy and gambling they will remain healthy but also are not contributing to the risk pool, causing rates to be higher.

Or the family of in Oakley Idaho who dropped coverage when their premium exceeded $2500 a month. They cannot available themselves of the subsidy because their ranching income fluctuates daily and is completely unpredictable. They are now on a Health Sharing Ministering Plan, hoping the plan will meet their needs. Again, not participating in the risk pool or helping to hold rates down.

The question before Idaho, but really many states, was how do we provide a quality and yet affordable product to our citizens AND how to we improve the overall risk pool thereby improving rates for everyone? In short how do we attract the young and the healthy back into the ACA marketplace?

Given the existing parameters and opportunities of the ACA, Idaho decided to restrict the traditional short –term plans while to creating another product, an "Enhanced STP", which has all of the meaningful required health benefits of ACA plans.

In fact, of the 5 plans created by two carriers, 4 have a better actuarial value than ACA bronze plans and two have a better actuarial value than silver plans. The enhanced plans are guaranteed issue and guaranteed renewable. If sold during open enrollment are prohibited from pre-existing conditions clauses.

Additionally these plans could only be offered by carriers in our exchange alongside ACA plans AND importantly, are in the same risk pool with ACA plans.

By requiring Enhance plans to be part of the ACA pool, we protect ACA plans and lower costs to those in the ACA marketplace and attract the young and the healthy who are being forced out.

Many states, and their state regulators are appropriately trying to address the individual needs of their states. Please do not tie their hands. To date, 5 states have chosen ban STP's; 11 states limit them to 6 months; 9 states limit them to 3 months. Even those that allow them to cover up to the Federal limit (364 days) can and some have placed coverage requirements and consumer protections on them.

Madam Chairwoman and members of the subcommittee, in my opinion, I would respectfully suggest that in regards to short-term plans, I would first recognize all STP's are not alike.

Second, an STP is not junk insurance just because someone has dubbed it as such. As I said I have STP's that are better quality than many ACA plans.

Third, I would respectfully suggest that STP's fill a need. They help those who are in-between jobs or in-between insurance.

Forth, although they are rarely acknowledged for this, STP's assist in the early diagnosis of serious conditions which ultimately save money to the entire system, including ACA plans. Without this product consumer will be forced to go uninsured which will cost us all more as their condition goes undiagnosed and untreated.

Fifth, respectfully, I believe passage of HR 1875 would harm thousands of Idahoans and hundreds of thousands of Americans AND would not benefit the ACA or the Americans purchasing ACA products.

Passage of the HR 1875 would potentially kick Americans off of their plan and increase the uninsured, which will lead to cost shifting and higher cost to those who are buying ACA products.

Madam Chairwoman, I would embrace STP's for what they should be and could be. Work with the states in setting appropriate parameters on STP coverage and have STP's participate in the same risk pool, thereby attracting and retaining the young and the healthy in the risk pool. Doing so will protect the ACA and those who benefit from it.

Madam Chairwoman and members of the committee, while I applaud the committee on creativity, I would respectfully suggest that some of the proposals introduced would not provide additional access to coverage nor lower cost.

The exception is HR 1878, state reinsurance programs have proven successful in many states. Idaho has created its on High Risk Reinsurance Pool. The pool in essence acts like a reinsurer for high risk expensive conditions. The pool covers a portion of claims cost while the carriers contribute by paying premium and assessments. The state participates by contributing a quarter of the states premium tax above $45 million. Idaho has not received a 1332 waiver for this effort and found the process to be cumbersome and difficult.

However, several other larger states have been able to obtain 1332 waivers. I would respectfully suggest reinsurance pools which are invisible to the consumer but focus on high risk conditions would obtain the largest impact on rate reduction.

In closing, I would respectfully suggest a couple of additional ideas which would lower costs for ACA plans for your consideration.

- Fix the family glitch, by allowing for dependents to qualify for APTC subsidy if the spouse employer is not paying for or assisting in the dependent's premium. The cost in doing so would be offset be lower ACA premium costs and cost sharing.
- Make a modest adjustment in the age slope from a slope of 3 to 5. Adjusting the age slope to 5, actuarially would not increase or impact rates on the upper end but would dramatically lower rates on the young. Attracting younger ages to the risk pool is critical to the stability of the ACA marketplace.
- Lastly, I would respectfully suggest that every state is unique with unique challenges for health insurance. I would encourage state flexibility and collaboration. I thank you for working with your state insurance commissioners in meeting those needs.

Madam Chairwoman, I thank you for your focus and your efforts and allowing me to testify.

HOW IDAHOANS ARE INSURED

The Chart below indicates the number of Idaho residents who had some type of major Medical coverage at the end of each year. Numbers do not include those who were covered by plans that provide less than major medical coverage-for example, dental or vision only, accident only, or specific disease. Enrollment in health care ministries is also not included.

It should be noted that some individuals may be enrolled in more than one form of coverage.

Coverage Type	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Individual	99,232	105,573	99,889	96,182	86,823	119,975	128,224	124,589	110,136	104,977	102,009
Small Group	105,258	95,443	89,109	106,424	88,851	80,270	78,906	75,977	80,382	86,132	91,245
Mid-Size Group	*	*	*	*	32,441	35,583	35,237	31,460	34,015	31,773	32,616
Large Group	212,780	201,726	200,587	188,355	176,082	165,179	141,859	130,856	134,386	150,642	139,486
Fed. Govt. Plans	46,734	48,222	50,956	41,451	41,967	41,374	42,024	41,456	42,990	42,562	44,365
MEWAs/Trusts	3,372	2,113	5,370	2,275	4,446	1,804	951	1,063	1,015	1,118	1,275
Short Term	1,323	1,520	1,785	2,006	5,170	4,071	4,305	3,769	2,976	3,564	5,550
Medicare Advantage	50,399	47,608	51,912	59,215	66,076	85,629	81,688	79,687	93,892	102,216	113,219
Self-Funded Plans	202,697	283,091	316,440	271,144	266,109	328,432	407,158	336,214	328,717	334,462	340,242
Total from DOI Data	**721,795**	**785,296**	**816,048**	**767,052**	**767,965**	**862,317**	**920,352**	**825,071**	**828,509**	**857,446**	**870,007**
Medicare (original)	171,563	182,189	156,638	160,017	166,318	170,694	175,191	183,997	188,702	216,772	220,052
Medicaid	202,035	220,137	229,193	239,385	249,184	276,577	287,742	305,170	301,796	286,235	273,478
CHIP	25,112	25,222	25,071	24,017	26,083	15,824	20,241	20,136	21,880	23,814	25,846
TRICARE	49,006	51,057	51,881	49,807	50,016	50,750	50,455	52,245	52,483	53,867	55,350
VA Care	34,385	35,883	37,114	39,283	39,928	41,266	42,592	44,122	44,935	46,683	47,051
Total Public Programs	**482,101**	**514,488**	**499,897**	**512,509**	**531,529**	**555,111**	**576,221**	**605,670**	**609,796**	**627,371**	**621,777**
Total Major Medical	**1,203,896**	**1,299,784**	**1,315,945**	**1,279,561**	**1,299,494**	**1,417,428**	**1,496,573**	**1,430,741**	**1,438,305**	**1,484,817**	**1,491,784**

* For 2009 – 2012, mid-size employer enrollment included with large group employer enrollment.

Department of Insurance data is based on the Department's annual Health Insurance Survey and Self-Funded Health Plan Survey. Data on public programs was obtained from CMS.gov (Medicare, Medicaid and CHIP), Health.mil (TRICARE) and the Allocation Resource Center (VA Care).