Pennsylvania's New Health Insurance Landscape: PPACA and its Impact on Regulation

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Executive Summary

I. Introduction

Americans pay more per capita for health care than any other country, yet we consistently get poorer health outcomes than many other countries which pay only a fraction of what we pay. The predominance of the health insurance industry as the financing mechanism for health care in the US has resulted in escalating health care costs, large numbers of uninsured individuals, complex claims procedures, and a disturbing lack of information on the part of policyholders regarding their own policies. Costs are escalating because of the saturation advertising engaged in by the companies (the top five private insurance companies spent $367 million, or 0.14% of premiums, on advertising in 2011).[1] the spiraling executive compensation packages, the bloated reserve funds of the non-profits, and the fact that the shares of the for-profit insurers are among the favorites of Wall Street investors. This makes it clear that *a substantial portion of the perennial rate increases are not*

[1] "Insurers Increased Advertising Budgets in 2011, but Are Keeping a Close Eye on MLR (with Chart: Health Insurer Advertising Spend by Media Type)." *Welcome to AIS Health.* Web. 14 June 2013. http://aishealth.com/archive/nhpw050712-03

going to cover rising costs of paying for benefits, but rather are going towards activities that are of no benefit to the policy holder. Pennsylvania is no exception, and has experienced more than its share of excessive premiums charged by insurance companies. To analyze the problems, this paper looks at the history and structure of the insurance industry, examines the legal authority of the Pennsylvania Insurance Department and its regulatory practices, and explains the impact of the new federal healthcare reform law known as the Patient Protection and Affordable Care Act (PPACA, "Act").

II. Structure of insurance industry

The American health insurance industry developed over the past 80 years or so in response to the expenses associated with newly introduced medical treatments and technologies, which produced markedly superior results to the medicine practiced in previous centuries, and helped greatly increase life expectancies. The health insurance industry eventually developed three sectors: government, private, and non-profit. The government sector insures the bulk of the high-risk population including the elderly, the disabled, the very poor, military families, many veterans,

and numerous children. Indeed, some 30% of Americans are insured by a government run program. The private sector targets the young and the healthy for its comprehensive products and offers supplementary insurance to Medicare patients. The private sector also administers some of the policies paid for by the government, such as Medicare Advantage and the Child Health Insurance Program (CHIP). The non-profit sector provides insurance to high-risk people not covered by the government and with the ability to pay the higher premiums associated with "guaranteed issue" policies, and it also competes with the private companies for healthy people.

Programs through the government sector such as Medicare have produced the best results in terms of keeping down both administrative overhead and negotiating lower prices from providers. Administrative costs are kept down by the economies of scale in having, in the case of Medicare, one giant risk pool. Private and non-profit companies divide the rest of the insured population into numerous groups based on geography, employer, and product design. This process of division entails massive

redundancy, as so many administrative functions have to be duplicated for each group or plan. Also, it has been demonstrated that even the largest of insurance companies does not do as good a job in negotiating low prices with providers as does Medicare, which, representing almost 50 million seniors, has massive purchasing power. Moreover, the private insurance companies need to maintain profit margins typically around 5% of revenues in order to maintain their share prices. This alone is higher than the 2-3% administrative overhead maintained by Medicare. Higher executive salaries (CEO compensation for the leading companies averaged over $10 million in 2011, compared to less than $180,000 for Medicare's top administrator) and advertising costs also drive up insurance company's administrative costs compared to Medicare. Overall, as gauged by their medical loss ratios (i.e., the ratio of claims payments to premium revenues), private insurance companies overhead ranges 15-25% as compared to Medicare's 2-3%.[2]

[2] Bethely, Jonathan G.: "Medical-loss ratios of largest for-profit insurers: Health plans make more, spend less in 2005," American Medical News, March 6, 2006 (http://www.pnhp.org/news/2006/march/medicalloss_ratios_.php)

III. Legal framework for Insurance Regulation in PA

The Pennsylvania Insurance Department (PID) has consumer protection as part of its mission. It has the power to approve or reject health insurance premium rates for individual policies and most small group policies. However, it has not been able to stop a steady and steep increase in premium increases over recent years. Part of the reason for this is an over emphasis on ensuring the financial health of insurance companies at the expense of consumers. Another part of the problem is that its authority to prevent rate increases is limited, especially vis-a-vis the for-profit health insurers. However, in Pennsylvania, non-profit insurers dominate the market, yet the PID has not been able to rein in premium hikes among these insurers either. The PID must see to it that insurers maintain the fiscal health necessary to meet their contractual obligations. In order to do this the PID has a tendency to allow insurers to pass on any increases in health care costs to their policy holders on a plan by plan basis despite the huge surplus funds that these same non-profits are accumulating.

For policies over which the PID has rate approval authority, the process that a company seeking a rate

increase goes through is to file a rate increase request, possibly engage in back and forth negotiations regarding the extent and other conditions of the rate increase, and then if necessary modify the rate increase to address the PID's concerns. Only rarely is a rate filing outright rejected.

The PID has a staff of five actuaries who review most of the 120 or so rate filings that they receive per month. Rate filings are typically made on an annual basis, and the average review time is 49 days. Most, but not all, of the correspondence between the PID and the companies is made publicly available through an online database system run by the National Association of Insurance Commissioners (NAIC). These correspondences show that the PID actuaries reviewing the rate filings are primarily concerned with whether the increases are justified by the expenses that the companies are paying out to health care providers for the plan in question. Less attention is paid to the overall profits or surpluses generated by the company or its Medical Loss Ratio, and no attention is paid to the efficacy of insurer efforts to hold down provider costs (which is outside the PID's legal authority). The result has

been that insurance premiums have consistently risen at a clip significantly higher than overall inflation.

IV. Patient Protection and Affordable Care Act changes

PPACA was passed in order to remedy many of the problems that have surfaced regarding the health insurance industry. PPACA requires almost everyone to be enrolled in some sort of health insurance plan, provides subsidies to help those who cannot afford it, eliminates some of the worst features of the current health insurance system (e.g. pre-existing condition exclusions), and makes comparing policies easier. However, it fails to directly control the skyrocketing costs of health care services, making the subsidies that keep insurance affordable for lower and middle income people ultimately unsustainable.

PPACA exempts certain groups (e.g., members of Indian tribes and people with certain religious objections) from the requirement to maintain credible health insurance coverage. It also exempts people who, despite government subsidies, still cannot find insurance for less than 8% of their annual income. Because of the way that both the subsidies and the exemption threshold are indexed to inflation, it is very possible that the number of people

receiving this financial hardship exemption from the "personal responsibility mandate" will rise steadily, particularly for people living in certain regions with higher premiums. Because premiums for non-grandfathered plans can be determined only on the basis of region, age, and tobacco use, it is also likely that many of the exempted people will be older smokers.

PPACA provides for two forms of subsidies: the first will be in the form of a refundable tax credit (that even people with no tax obligation can receive) that will be paid in advance and directly to the health insurance company that the taxpayer purchases a health plan from. To qualify one must have an income somewhere between 100% and 400% of the Federal Poverty Level (FPL). The actual premium rate with be on a sliding scale, starting at 2% of personal income for people just over 100% of FPL and ending abruptly at 9.8% of personal income for those just under 400% of FPL. Those earning just over the upper limit to qualify for subsidies will be prime candidates for exemptions to the personal responsibility mandate and many will go without insurance coverage.

The other subsidy is in the form of improvements

made to the terms of the policy so that people with lower income, particularly those below 200% of FPL, will pay much less out of their own pocket for health care services than higher-income people with the same policy. This will be done by lowering co-pays, co-insurance, deductibles, and out-of-pocket maximums. These out of pocket expenses can be major deterrents to seeking healthcare by low income people who have insurance, so the subsidies will make the policies more usable. Still, because the standards for what qualifies as "credible coverage" is inferior to the insurance that most people currently have in terms of out-of-pocket requirements, it is possible that the minimum required coverage will increasingly become more common, especially in employer-based insurance where there is already a trend towards greater employee burdens.

While the personal responsibility mandate is not universal, it applies to enough people to remove the "free-rider" problem so that pre-existing exclusions and medical underwriting could be banned. (Medical underwriting is the practice of using an applicant's health information to determine whether or not to issue a policy or what the premium of the policy should be.) Currently most

policies will not cover treatment for a pre-existing condition for the first year that the policy is in effect. Also many companies will simply not insure people who have certain pre-existing conditions, and if they do issue a policy it would be at a dramatically higher premium. The logic is that if people can buy a policy at any time to treat any condition, then they will wait until they have an expensive-to-treat condition before purchasing any insurance. Still, there are possible PPACA loopholes that can be exploited. Companies cannot deny treatment for a pre-existing condition, but they can to some degree say what kind of treatments will be covered. Also, there is a provision for offering discounts to people involved in "wellness programs" that could possibly be used to discriminate against people with certain conditions.

V. Conclusion

We make a number of recommendations to the PID and Pennsylvania lawmakers. Fundamentally, the PID should: (1) balance its duel mission of protecting insurance companies and consumers and (2) work to restrain premium increases. It has been too easy for insurers to pass on increasing costs to consumers by way of premium hikes.

By making it more difficult to pass on costs, companies would be more diligent about cutting their own costs and negotiating lower prices with providers, the way Medicare does. Third, the PID should share more information with the public, in particular regarding the discounts negotiated between insurers and providers. Some of this may require additional authority to be given to the PID by the General Assembly. Fourth, the ratemaking information that is currently disclosed should be made more obtainable. The current internet interface is so cumbersome to use that it acts as an obstacle to finding information that is intended to be in the public realm. It should not require perusing through dozens of pages to learn what percentage increase was approved for a given policy. Also, the public should be able to search for data on the policy by inputting the name of the policy rather than having to use a cryptic tracking number. Furthermore, the PID should regularly release aggregate data on things such as the number of rate filings, the premium increases requested and granted, and the number of people impacted.

As for PPACA, it is beyond the scope of this paper to recommend revisions to federal legislation that took

decades to finally pass, even in such an imperfect form. However, we have identified shortcomings and potential loopholes in the law that the PID should be aware of and prepared to respond to. These include the potential to exploit wellness programs in order to re-institute some effective form of medical underwriting. There is also the possibility that insurance companies will creatively classify certain expenses as promoting patient well-being that should be considered administrative in order to boost their medical loss ratio above the minimum required percentages. The PID will have to do its best to scrutinize insurers and their practices to make sure that loop-holes like these are not exploited. In addition, there is a need for disclosure regarding the in-network discounts that insurers negotiate with providers of medical services and goods. One of the aims of PPACA is to make comparison shopping possible, and the disclosure of actuarial values (the percentage of health care expenses that would be paid for by an insurance plan given its mix of deductibles, co-pays, coinsurance, and out-of-pocket maximums) and medical loss ratios is intended to give consumers the necessary information. However, one plan could have a superior actuarial value

and a superior medical loss ratio and still be an inferior policy for the consumer if it does not have good discounts negotiated with providers. If the PID needs additional authority in order to do the above they should seek it from the General Assembly.

Finally, this paper makes it clear that US health insurance system is insanely complex and unsustainable. Indeed, for many Americans, as measured by the number of uninsured and the number (45,000) of people who die each year due to going untreated, the system is unacceptably dysfunctional. It cries out for a real solution.

Therefore, while taking the steps we recommend herein to keep people healthy and solvent under the current system, Pennsylvania should at the same time lay the groundwork for a possible introduction of its own public health insurance system based on the single-payer (S-P) model as soon as it is legally able to do so without harming Medicare. While a national single-payer system would be preferable to a state system and is the only real solution to the US healthcare crisis, with the easiest route to that goal being the expansion of an improved Medicare system to all Americans, some national systems in other countries had

their origins in regional or local systems. Pennsylvania is large enough and has the health care infrastructure to make a state-wide health insurance fincancing system work. Whether the political will exists to do the right thing on behalf of Pennsylvania's citizens remains to be seen.

Section A – Introduction

It is hard to argue that the health care system is working for the American public. Life expectancy in the United States ranks 51st in the world, not only behind most of the developed countries of Europe and Asia but also behind some "third-world" countries like Jordan.[3] The United States has the 49th highest infant mortality. In 2000 the World Health Organization (WHO) ranked the American healthcare system 37th in the world. The report sparked controversy and in 2010 the WHO declined to rank national health care systems in its report.[4] Some may dispute the methodology of the WHO analysis, but the high price Americans pay for health care is a cold hard fact. The United States is by far first in per capita spending on health care, with per capita spending of $8,333 in 2010, far outstripping the $6,712 spent by runner-up tiny, but rich

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3 https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html

4 Taylor, Adam and Samuel Blackstone: "These Are The 36 Countries That Have Better Healthcare Systems Than The US," The Business Insider, June 29, 2012 (http://www.businessinsider.com/best-healthcare-systems-in-the-world-2012-6?op=1)

Luxembourg and the $5,915 spent by tinier, yet even richer Monoco, whose life expectancy is more than eleven years longer than America's. Even large, advanced economies like Japan, Germany, France, the U.K., Italy, Canada, Sweden, and Australia are spending about half or less what the United States is spending and getting better outcomes.[5]

Per capita total spending on health (PPP int. $, 2010)[6]

Country	Spending		Country	Spending
United States	8,233		Sweden	3,760
Luxembourg	6,712		Ireland	3,720
Monaco	5,915		Australia	3,685
Norway	5,391		United Kingdom	3,433
Switzerland	5,297		Finland	3,252
Netherlands	5,112		Iceland	3,230
Denmark	4,467		San Marino	3,178
Canada	4,443		Andorra	3,122
Austria	4,398		Japan	3,120
Germany	4,342		Greece	3,069
France	3,997		Spain	3,057
Belgium	3,975		Italy	3,046

[5] The World Bank: Health expenditure per capita, PPP (constant 2005 international $). Figures for 2010. Hhttp://data.worldbank.org/indicator/SH.XPD.PCAP.PP.KD?order=wbapi_data_value_2010+wbapi_data_value&sort=descH.

[6] http://www.guardian.co.uk/news/datablog/2012/jun/30/healthcare-spending-world-country

Source: World Bank

In addition to the high and rising price for health insurance, the growing legions of the uninsured have fueled a political debate going back decades. But even those who can afford insurance face problems. For instance, the myriad of different insurance companies and plans makes it almost impossible for health care professionals to know what a patient's insurer may or may not cover without burdensome research. And who among us has not had the experience of being stuck with an unexpected bill for something that we assumed or were told would be covered?

The unnecessary variety of types of policies also makes it very difficult for consumers to shop in any meaningful way. Even in areas where there is little

competition in terms of companies offering policies, there can be numerous plans, each with multiple deductable levels and other options. But this market clutter is not the only problem. There are so many aspects of a policy that must be compared, such as price, covered procedures, deductibles, coinsurance rates, copays, lifetime and annual maximums, and provider networks, that unless someone has a doctorate in multivariate analysis any decision they make about a policy is largely guesswork. And with the actual policies containing a hundred or more of pages of dense medical/legal jargon, very few people can even read one policy carefully, let alone a second for comparison.

All of this cries out for a simpler, less costly and a more consumer-friendly health care delivery system. The experience in numerous countries around the world indicates that a single-payer government health insurance entity that handles all payment transactions and allows patients to deal only with their doctor should be at the center of any rational and efficient system.

Unfortunately, President Obama took the S-P option off the table in the negotiations that resulted in the Patient Protection and Affordable Care Act (PPACA). He also

declined to pursue the so-called “Public Option”, a government run entity that would have competed with the private insurers.

It has been three years since the passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010. We had to wait until the summer of 2012 to find out whether the Supreme Court would uphold the law, which for the most part it did. People across the commonwealth and around the nation are still wondering just how this massive piece of legislation will impact consumers when the major components are implemented in 2014. Will it prove to be the long-awaited solution to our broken health care system or will it disappoint those who supported it in the hope that it would extend affordable healthcare to most people who currently lack it, while maintaining and improving services for the rest of us? Does PPACA represent a “government take-over” of the health care system or did it further entrench private health insurers? And what are the implications for the Pennsylvania Insurance Department (PID)? Will it allow the PID to do a better job of holding down health insurance premiums? Will it bog down the PID with new and

cumbersome responsibilities? What will the PID have to do in order to prepare?

On the surface, it would seem that PPACA will help make policy comparisons simpler by establishing categories for insurance policies of bronze, silver, gold, and platinum, based on the actuarial values of the policies and setting certain standards for what must be covered.[7] However, the policies may achieve these actuarial values through different combinations of co-pays, co-insurance, out-of-pocket maximums, and deductables. Moreover, the main categories that will be promoted – the silver in the individual market and the bronze in the corporate market – will require pretty significant payments from policy holders beyond premiums for any medical services, and will typically feature high deductables. Thus, while policies may become easier to compare, their quality will likely be lower than what many people have been accustomed to seeing as the more substantial coverage that was once common in employer-provided health insurance will

[7] Actuarial values are a statistical approximation of what percentage of covered medical costs will be paid for by the plan on average for a given population. The main factors in the computation of actuarial value under PPACA are deductibles, co-insurance rates, and out-of-pocket maximums.

increasingly be seen by employers as an unnecessary expense and strain on the bottom line.

In December 2012 Pennsylvania Governor Thomas Corbett decided against having the state run the insurance exchange called for by PPACA. Now that PPACA must be implemented but the Exchange in Pennsylvania will be run by the Federal Government, we must ask how well is the PID prepared to carry out its mission vis-à-vis PPACA? According to its own website, its mission is to "*safeguard consumer rights and ensure access to health and other vital insurance products.*" To accomplish this mission, the Department (among other things) monitors the financial solvency of insurance companies, licenses insurance companies and agents, and reviews and approves insurance policy language and rates.[8] It would seem that the Department has succeeded admirably in monitoring the financial solvency of insurance companies because the main providers of insurance in Pennsylvania are doing fabulously well. However, the Department has been less successful in the overriding mission of safeguarding

[8] Pennsylvania Insurance Department Website, "About" page. Accessed June 17, 2010. (http://web.archive.org/web/20100617022804/http://www.insurance.pa.

consumer rights and ensuring access to health insurance, unless by "access" one means the ability to apply for policies that can be denied or are unaffordable.

In order to see how the PID could do a better job of safeguarding consumer rights, we must first ascertain its current legal authority. Former Commissioner Joel Ario complained publicly about the Department's relative lack of legal authority compared to other states.[9] The PID has different degrees of authority depending on whether the policy is individual, small group, or large group. For instance, small group carriers are reviewed when there is a 10% or more change in rates. Meanwhile, *all individual policies are regulated*. The authority of the PID to disapprove rate hikes and "form" changes (i.e., changes to the terms of a policy), as well as its ability or lack thereof to oversee the operations and finances of the companies, will be examined later in this paper.

This paper will take an extensive look at the record of the PID over the past four and a half years in its

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gov/portal/server.pt/community/about/5230)

[9] Hhttp://ifawebnews.com/2010/02/23/ario-warns-of-unstable-pa-market-without-small-group-health-reform/H; Hhttp://www.portal.state.pa.us/portal/server.pt/document/768383/senat

interactions with insurance providers. In fact, thanks to the National Association of Insurance Commissioners' (NAIC) electronic filing system for rate and form changes, we were able to look at every rate and form filing that the PID approved during this period. During the 54-month period of January 2008 through June 2012, there were some 3500 rate filings approved by the PID for various health insurance products. (This number does not even count form filings that cover changes to the content of policies, let alone filings for other types of insurance.[10]) These filings are typically dozens, and often hundreds of pages long. These filings are also full of rate tables and actuarial data. One wonders to what extent these rate hike requests can actually be examined in depth by the Department's small staff of actuarial reviewers.[11] Although filings occasionally make reference to medical loss ratio (i.e., the proportion of premiums that actually go towards paying for health care), they do not examine in-network discounts. In-network discounts are the often dramatically lower prices that each

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e_appropriations_021710_pdfH.

[10] Rate filings are required when a company requests a change in premiums, while a form filing is for a change in the content of or application for a policy.

[11] Only twelve PID actuaries were listed on SERFF filings between

health insurance company negotiates with each provider. Insurers with relationships to providers or with considerable purchasing leverage often pay only a small fraction for goods and services compared to official, or "Chargemaster"[12] prices set by providers. Rather, the main focus seems to be on the underlying trend factor of several inputs such as the increased prices charged by medical providers and the cost of new and sometime expensive medical technology faced by the plans without examining the underlying reasons for these trends.

Still, as far as can be discerned from this publicly available data, the companies are not providing adequate backing for their claims of increasing costs, such as any kind of breakdown of their costs.[13] This raises the question

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January 2008 and July 2010.

[12] The Chargemaster is a comprehensive listing of hospital services, medical procedures, drugs, supplies, and diagnostic evaluations billable to a hospital patient or a patient's health insurance provider. They are used to generate patient bills. Every hospital system maintains its own chargemaster.For more on the Chargemaster, please refer to Brill, Steven (February 20, 2013). "Bitter Pill: Why Medical Bills Are Killing Us". Time (Time Warner).

[13] The 07/25/2012 filing for Highmark's Guaranteed Issue ClassicBlue Comprehensive Major Medical policy for its Central Region is a case in point. The filings included tables showing the company's ultimate monthly payments over a five-year, four-month period on a total and per contract bases. While it showed a near doubling of payments during the period, there was no indication of why payments were going up. No

of whether they potentially are using creative accounting to game the system. After all, if their premium hikes were merely keeping pace with their cost of providing healthcare benefits payments, their medical loss ratios (the proportion of premium revenue going for payments to providers of health care services) would have remained stagnant. Instead we have seen the huge decline in medical loss ratios that has been well documented over the past couple decades. Might it not be that some of the increase in expenses that is reflected in the underlying trend factor (the rising cost of providing coverage) claims that the insurers make to the PID is actually expenses that do not go towards healthcare benefits payments? As we shall see, the saturation advertising engaged in by the companies (the top five private insurance companies spent $367 million, or 0.14%

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price data for services was provided, nor was there any information on the volume of services used by policy holders. With the prospect that some parts of the Commonwealth could see their healthcare markets dominated by vertically integrated entities with both provider and insurer components, regulators need to consider pricing data. (Hhttp://www.insurance.state.pa.us/serff_filings/HGHM-128558324.pdfH)

By contrast, the National Association of Insurance Commissioners (NAIC) blanks form for reporting medical loss ratios includes more detailed categories for expenses. (http://www.naic.org/documents/index_health_reform_mlr_blanks_proposal.pdf)

of premiums, on advertising in 2011),[14] the spiraling executive compensation packages, the bloated reserve funds of the non-profits, and the fact that the shares of the for-profit insurers are among the favorites of Wall Street investors, make it clear that *a substantial portion of the perennial rate increases are not going to cover rising costs of paying for benefits, but rather are going towards activities that are of no benefit to the policy holder*. For instance, as will be shown in the next section, some 5% of the premiums collected by the investor-owned insurance companies go towards profits. Many companies have medical loss ratios lower then 80%, and under a provision of PPACA had to refund excessive premiums to policy holders.[15] Total overhead for private insurance companies

[14] "Insurers Increased Advertising Budgets in 2011, but Are Keeping a Close Eye on MLR (with Chart: Health Insurer Advertising Spend by Media Type)." *Welcome to AIS Health.* Web. 14 June 2013. http://aishealth.com/archive/nhpw050712-03

[15] Medical-loss ratios for 2005 (Source: Company 10-K, year-end filings with the Securities and Exchange Commission):
76.9% - Aetna
82.3% - Cigna
83.9% - Health Net
83.2% - Humana
78.6% - UnitedHealth Group
80.6% - WellPoint
Physicians for a National Health Program: “Medical-loss ratios of largest for-profit insurers”

ranges from 15-25%.[16] This compares to the 2% that Medicare pays for its entire administrative costs.[17] Even if their costs in terms of payments made for services are going up, there is still the issue regarding the insurers' financial ties with providers. For instance, how much incentive does UPMC Health Plan have to keep down payments made to the hospitals owned by its parent company, UPMC (University of Pittsburgh Medical Center). Likewise, the Highmark takeover of the perennially troubled West Penn Allegheny Health Systems could make Highmark more than willing to allow its financially strapped subsidiary to raise prices since the PID would allow those higher costs to be passed on to policy holders in the form of higher premiums. The same can be said for Geisinger Health Systems, which has its own health insurance plan.

Furthermore, because PPACA limits medical loss

(http://www.pnhp.org/news/2006/march/medicalloss_ratios_.php)

[16] Bethely, Jonathan G.: "Medical-loss ratios of largest for-profit insurers: Health plans make more, spend less in 2005," American Medical News, March 6, 2006 (http://www.pnhp.org/news/2006/march/medicalloss_ratios_.php)

[17] Medicare Spending and Financing: A Primer, 2011, p.5 (http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7731-03.pdf)

ratios to 80% (or 85% for large group plans),[18] the bigger the overall pie of premium revenue, the larger the absolute size is for the 15% or 20% slice allowed for administrative overhead under the requirements. Is that much really necessary for administrative overhead? Again, the medical loss ratio of Medicare is perennially around 97%, meaning that no more than 3% of its revenue is going towards paying overhead. Also, according to PricewaterhouseCoopers, even investor-owned health insurance companies were maintaining medical loss ratios of around 95% as recently as 1993.[19]

Of course, not all insurers are alike. The industry is divided into three segments: for-profit (private or investor-owned), non-profit, and government. These three ownership structures provide the managers of the insurers with different incentives. Stock options are a common

[18] Section 9016 of the Patient Protection and Affordable Care Act sets a somewhat more stringent target for non-profits like Blue Cross Blue Shield organizations in that they must maintain an 85% MLR to keep their tax-exempt status, and the formula for calculating their MLR is stricter in that it only puts health benefit payments in the numerator. (http://dpc.senate.gov/healthreformbill/healthbill05.pdf).

[19] PricewaterhouseCoopers, "Beyond the sound bite: Review of presidential candidates' proposals for health reform," 2008, quoted in the Main Street Alliance (http://mainstreetalliance.org/wordpress/wp-content/uploads/Ensuring-

component of the compensation package for private insurance company executives. The prospect of massive personal gains should share prices rise naturally influence managerial decisions in for-profit firms. After all, the whole logic behind offering stock options is to incentivize executives to manage firms in such a way as to increase share prices. Non-profits, which lack share prices, offer high managerial pay based at least in part on bottom-line criteria. In the governmental sector, where managerial pay is fixed and share prices absent, there must be a very different incentive structure. This paper will look at how the different types of insurers spend their money and how effective they are at controlling costs.

Since 1993 we have been seeing rapid increases in health insurance premiums, far outstripping inflation due to rising overhead costs. Even the so-called non-profit insurers pumped huge amounts of money into advertizing, sales commissions, and executive compensation. Some of the Blues renounced their non-profit status and joined the for-profit health insurers in chasing ever-higher returns for

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Value-for-Premiums.pdf).

shareholders.[20] Meanwhile, the industry's loss ratio fell steadily, reaching 81% in 2009, according to PricewaterhouseCoopers. The situation in Pennsylvania may well be worse. Among the 34 states with minimum requirements for medical loss ratios, it has the weakest, with a requirement of an initial 50 percent ratio and a 60 percent renewal ratio.[21] Not surprisingly, Pennsylvanians have received proportionally more than the average American in terms of rebates that health insurance companies with low medical loss ratios had to pay out to their policy holders under the terms of PPACA, with per capita rebates the 13th highest out of the 50 states.[22]

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[20] The number two private insurance company WellPoint was formed out of Anthem BlueCross BlueShield, which includes parts or all of the BlueCross BlueShield associations of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Parts of Virginia, and Wisconsin. Also, BlueCross & BlueShield Puerto Rico became Triple-S Management Corporation.

[21] America's Health Insurance Plans "State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations" p.30 (http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf)

[22] PPACA requires that health insurers with lower than 80% medical loss ratios start offering policy holders rebates starting in 2010. Pennsylvanians, who make up 4.1% of the U.S population, received 4.7% of these rebates. (http://www.statehealthfacts.org/profileind.jsp?cat=17&sub=219&rgn=40)

Regarding PPACA, this paper does the following:

1. It will examine the major provisions of the law in order to determine how effective it will be at implementing the kind of changes intended, namely
    a. making health insurance premiums more affordable,
    b. reining in health care bills,
    c. eliminating egregious anti-consumer contract terms such as pre-existing condition clauses and recissions, and[23]
    d. Reducing the number of uninsurerd.
2. It will analyze what impact the various regulations and accompanying subsidies will have on consumers in different situations in terms of income, age, and health status.
3. It will look at the possibility of insurers taking advantage of loop holes in order to avoid the intent of the law, as well as possible unintended consequences. It will also look at other shortcomings of the reform, such as the failure to introduce meaningful measures to hold down costs.

[23] Recission is the practice of nullifying existing policies as if they had never been in force due to often unintentional technical errors in the application. Recissions are typically triggered by a major claim, and although premiums are returned the policy holder is left without

4. Finally, the paper will make recommendations for what the PID should do in order to
    a. keep Pennsylvanians healthy leading up to 2014 and beyond.
    b. carry out its new responsibilities under PPACA and be ready with plans in case PPACA fails to accomplish its stated goals.

It is our view that despite PPACA's reforms and subsidies, for-profit health insurance companies and so-called non-profits (that are becoming increasingly indistinguishable from their stock-issuing counterparts) will largely be left in control of allocating health care, and *the regulatory measures included in the Act will be insufficient to prevent a continuation of the decades-long trend of health insurance premiums, co-pays, and deductibles far outstripping underlying inflation or growth in wages.* In fact, the various indexing measures included in the Act (e.g. measure adjusting income requirements for subsidies and for exemption to the personal responsibility mandate), as well as its wording, make it clear that there is an underlying assumption that health care costs will continue to rise faster

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coverage and facing large bills.

than wages or inflation. The health care system is already in crisis and health care inflation is clearly unsustainable. Given this gloomy outlook, coupled with the fact that PPACA does not address out of control costs, the federal government should already be working on a real solution to the problem. At the least, it would behoove the PID to look into a single-payer alternative that would control costs when the legal obstacles for states implementing their own single payer systems are removed. Of course, such a state system must be designed to protect Medicare.

Indeed, a recently released economic impact study found that a single-payer health care plan will save Pennsylvania families, businesses and tax payers $17 billion annually while providing comprehensive health care to all. Commissioned by Health Care for All PA, a statewide non-profit organization, the study was conducted by University of Massachusetts - Amherst professor of economics Gerald Friedman, Ph.D.[24]

[24]Friedman, Gerald: "The Pennsylvania Health Care Plan: Impact and Implementation." (http://healthcare4allpa.org/wp-content/uploads/2013/03/EconomicImpactStudy3513.pdf)

Section B – Structure of the insurance industry

The economic role of insurance companies is to spread risk. Specifically, insurance spreads the cost of uncommon events in life such as a car accident, the premature death of a breadwinner, a fire, or a serious illness or injury that can have such a large economic impact on a family that they could become insolvent if they had to bear the cost alone. Of course, the work of fairly distributing risk requires some resources, so insurance entities require a certain amount of money for administration in addition to the funds to be redistributed. People pay premiums evey month but most people do not receive medical care every month, thus most insured people during most months spend more on premiums and out-of-pocket expenses than they would if they simply went uninsured and paid their own bills. Still, it is rational for people to be willing to pay extra in order to avoid the risk of being overwhelmed should they be unlucky. In other words, the purchase of health insurance converts an unpredictable and potentially overwhelming loss of income/assets to a certain but manageable one.

However, as has been noted above, there is a great

discrepancy between health insurers regarding the proportion of premium dollars directly used for medical and related claims versus other purposes, (e.g., CEO's salaries and advertising). Why do the discrepancies arise, what impact do they have on the quality of health care, and just what are those extra dollars being spent on if not medical bills? In order to shed some light on these questions, it is useful to examine the structure of the industry, the ownership systems, the incentive environment for managers in different segments of the industry, how administrative dollars wind up being spent, and how these costs could be controlled.

The health insurance industry for all practical purposes is less than 100 years old. That should not really come as a surprise, because modern health care is itself a recent phenomenon. While every culture has had its healers and many herbal remedies predate human literacy, in the last 100 years the beneficial impacts of modern medicine are significantly greater than experienced previously. This can be demonstrated by the dramatic improvements in indicators such as life expectancy, infant mortality, maternal mortality, and the incidence of chronic diseases.

Table 1. U.S. Life Expectancy at Birth, by Sex, in Selected Years[25]

Years	Total	Males	Females
1900-1902	49.2	47.9	50.7
1909-1911	51.5	49.9	53.2
1919-1921	56.4	55.5	57.4
1929-1931	59.2	57.7	60.9
1939-1941	63.6	61.6	65.9
1949-1951	68.1	65.5	71.0
1959-1961	69.9	66.8	73.2
1969-1971	70.8	67.0	74.6
1979-1981	73.9	70.1	77.6
1989-1991	75.4	71.8	78.8
2002	77.3	74.5	79.9
2003	77.5	74.8	80.1

[25] **Source:** For data through 2002, the Congressional Research Service (CRS) compilation from National Center for Health Statistics (NCHS), United States Life Tables, 2002, *National Vital Statistics Reports*, vol. 53, no. 6, Nov. 10, 2004. For 2003, NCHS, Deaths: Final Data for 2003, *National Vital Statistics Reports*, vol. 54, no. 13, Apr. 19, 2006. (http://aging.senate.gov/crs/aging1.pdf)

The above table from the National Center for Health Statistics (NCHS) illustrates the dramatic improvement in life expectancy over the past century, an improvement that the NCHS ascribes to "an enormous scientific breakthrough — the germ theory of disease." Before the advent of modern medicine, even our elites could have their lives unnecessarily snuffed out due to the ignorance of the best medical practitioners that society had to offer. Examples include the cases of Presidents Washington and Garfield, both of whom died as the result of treatments administered by their physicians for conditions that should not have been fatal. By the late 19th Century, improvements in anesthesia, sterilization, and diagnosis helped set the stage for significantly healthier and longer lives. Additional improvements in diagnosis and treatment during the 20th Century have continued this trend. However, it required a vast and increasing investment of resources to maintain this new health care infrastructure, and this cost necessarily had to be borne by members of society in one way or another. With the expense of crucial care potentially overwhelming any family's ability to pay, health insurance became a necessity.

Health insurance in America has its roots in accident insurance, pre-paid arrangements with individual hospitals, and policies to replace lost wages due to sickness (which was usually the main economic impact of ill health before the advent of modern medicine). The Blue Cross system started to take shape in the late 1920s, but was a relatively minor player in the provision of health services. At that point in time, doctors and hospitals played a much smaller role in people's lives. For instance, in 1929 most Americans were born at home rather than in hospitals. Of course, death during childbirth of either the baby or the mother was not at all uncommon. By the end of World War II, many employers (largely motivated by a desire to attract workers despite wartime wage freezes in a tight labor market) were offering health insurance as a fringe benefit, and in 1946 President Truman unsuccessfully proposed a system of national health insurance.

The initial growth in health insurance coverage came from various non-profit Blue Cross and Blue Shield plans, but many private life and fire insurance companies jumped on the bandwagon and by 1951 they had surpassed

the Blues in terms of policies issued.[26] By 1955, 70% of Americans had some sort of health insurance. [27]

In 1965, the Medicare and Medicaid programs were initiated, providing health insurance to the elderly, disabled, and very poor. The three-prong division of health insurance into private, non-profit, and government sectors was thus established. Still, many remained without health insurance – between 15 and 20 percent for the past few decades – due in no small part to the rising price of insurance premiums.

1. Ownership issues

The question then arises: do different ownership paradigms affect the efficiency and effectiveness of the three segments of the health insurance sector? Let's take a brief look at who actually owns the insurance companies. The Blues or non-profit companies, like Highmark and UPMC, do not issue shares and do not have owners in the traditional sense. We will discuss them later. As for the

[26] Funding Universe: "Blue Cross and Blue Shield Association History" (http://www.fundinguniverse.com/company-histories/Blue-Cross-and-Blue-Shield-Association-Company-History.html).

[27] Blue Cross Blue Shield Association: "History of Blue Cross Blue Shield" Timeline, 1950s (Hhttp://web.archive.org/web/20101222060239/http://www.bcbs.com/about/history/H, accessed August 5, 2013).

for-profit companies (in 2011 the top ten in terms of sales were UnitedHealth Group, WellPoint, Humana, Aetna, Cigna, Coventry Health Care, Health Net, Assurant, Universal American, and Amerigroup), they are owned by their shareholders.

So who are these shareholders? For the most part, they are the same list of characters found at most shareholders' meetings on Wall Street – mutual funds, investment banks, pension funds, hedge funds, etc. The same names pop up over and over on the rosters of the top ten private insurance companies.[28] For instance, Vanguard Group Inc., the largest mutual fund company (as of 2008), is a major share holder in each of the top ten private insurance firms. Its position ranks between the number two and number seven shareholder in each of the firms, its shareholding ratio ranges between 2.08% and 4.69% of the outstanding shares of the companies, and its total investment in these ten insurers is $3.98 billion.[29]

[28] The top ten companies include. Unitedhealth Group Inc., Wellpoint Inc., Aetna Inc., Humana Inc., Cigna Corp., Health Net Inc., Coventry Health Care Inc., Amerigroup Corp., and Universal American Financial Corporation. The top ten could be rounded out by WellCare Health Plans, Assurant, or the Centene Corporation, depending on the time of the measurement or aspect being measured.

[29] All health insurance company shareholder information taken from J3

Fidelity Investments (FMC), America's number three mutual fund company, has an even bigger stake in the health insurance industry. It is the top share holder in three of the top ten companies (Cigna, Health Net, and Centene), the number two shareholder in three others (Coventry, Amerigroup, and industry leader UnitedHealth), and ranks fifth, seventh, ninth, and thirteenth in the remaining firms. Its shareholding ratios range from 1.73% up to 12.43%, and its total investment is $4.43 billion.

The big three mutual fund companies are rounded out by the American Funds family, whose investments are managed by its Capital Group siblings, Capital World Investors and Capital Research Global Investors, which together have $3.95 billion concentrated in just four of the top ten health insurers. This includes a 4.94% combined share of UnitedHealth (number two), a 10.53% stake in Aetna (top), a 4.13% share of Humana (number four), and a 0.63% share in Cigna.

These big three of the mutual fund industry control more assets then the next 25 largest mutual fund firms put together. Still, smaller mutual fund management firms have

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Information Services Group (Hhttp://www.j3sg.com/index.phpH). Data

significant investment in health insurers. The following 20 firms combine for $10.86 billion in investment in the ten insurers, with combined shareholding ratios of from 4.35% up to 22.41%: American Century Companies, Barclays PLC, Dimensional Fund Advisors, Dodge & Cox, Eaton Vance Management, Federated Investors, Hartford Investment Management, Invesco Ltd, Janus Capital Management, Jennison Associates, Legg Mason Capital Management, Lord Abbett & Co, Oppenheimer Funds, Pioneer Investment Management, T Rowe Price Associates Principal Financial Group Inc, Putnam Investment Management, Russell Frank Co, Schwab Charles Investment Management, and United Services Automobile Association.

The most important single owner is Wellington Management. Unlike the mutual funds, which offer managed bundles of insurance instruments to individual consumers, Wellington Management is an asset management firm. It is a private limited liability partnership that manages investments for "public funds, central banks, insurance entities, endowments, foundations,

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as of March 31, 2010 filings, accessed on July 23, 2010.

mutual fund sponsors, retirement plan sponsors" and other types of institutional investors. Wellington Management has $5.26 billion invested in nine of the top ten insurers (all but number eight Amerigroup), and is the top shareholder in UnitedHealth and Coventry and the number two shareholder in Humana, Cigna, and Health Net. Its shareholdings in these companies are as high as 13.58%.

The various BlackRock firms, which are leaders in the asset management industry, own $4.56 billion in the shares of the leading health insurers, with shareholding ratios ranging from 1.01% up to 5.97%. State Street Corporation, another firm offering financial services to institutional investors, has $4.04 billion worth of shares of the top ten health insurers. It ranks between the number three and number fourteen shareholder in each of the top ten insurers with shareholding ratios ranging from 0.89% up to 5.52%.

Investment banks purchase stocks not only on behalf of clients but also using their own funds. The notorious investment bank Goldman Sachs was also a shareholder in all ten companies, although at a lower level. Its ownership position ranks between being the tenth and

fifty-ninth shareholder, and its shareholding ratio ranges between 0.23% and 2.86% of the outstanding shares of the companies, and its total investment in these ten insurers is $1.06 billion.[30] Morgan Stanley had $1.23 billion invested in the ten firms, while JP Morgan Chase has $1.10 billion invested in eight of the top ten. Another bank, Wells Fargo, is among the top 100 shareholders in each of the ten companies, with investments totaling $814 million.

Foreign financial firms are also well represented. The French insurance giant AXA has large shareholdings in each of the companies and is among the top 20 shareholders in eight of them. Its total investment in the firms is $1.81 billion. China Investment Corp, Credit Agricole, Credit Suisse, Deutsche Bank, HSBC Holdings, Korea Investment Corp, Mitsubishi UFJ Trust & Banking, Royal Bank of Canada, Sumitomo Trust & Banking, and UBS are also well represented among the shareholders of the ten leading private insurance companies. These ten foreign financial firms combine for an ownership stake of $2.25 billion.

[30] However, it had dumped shares in nine of the ten companies (all but Unitedhealth Group Inc.) during the period ending March 31, 2010, selling off about a quarter of its shares in Humana and Amerigroup

So who owns the private insurance companies? It is the mutual funds, investment firms, private banks, and foreign financial institutions listed above. They own more than 50% of the shares of the ten top private insurance companies. One might ask what difference it makes if mutual fund companies, for instance, have such large stakes in the major health insurance companies. After all, aren't they simply intermediaries between the insurance companies and mutual fund customers, who are just regular people? If an individual is paying high premiums for health insurance, but the profits thus generated are recycled back to him in the form of mutual fund dividends, then isn't it just a wash?

Well, mutual fund customers may be indirect owners of the companies, but do these individuals really participate in the management, even in an indirect way? Mutual fund managers may have a voice in the running of health insurance companies via general shareholders meetings, but to the extent they have any influence it is wielded in accordance with their fiduciary responsibility to seek the highest return on investments. They certainly do

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Corp (AGP) and two thirds of its shares in Centene Corp (CNC)

not seek to protect the health care interests of mutual fund customers. Moreover, there is no effective vehicle for mutual fund customers to see to it that mutual fund managers will cast their shareholder votes in such a manner as to protect customer interests as health insurance policy holders. Consider this statement from Wellington Management:

"Many of our clients ask us to vote company proxies on their behalf for their portfolios. We take this responsibility very seriously. Our goal in corporate governance matters is simple: to support decisions that will maximize the long-term value of securities we hold or may hold in client portfolios."[31]

Their simple goal is to maximum the value of securities, i.e., share prices. For better or for worse, a government bureaucrat overseeing the management of Medicare would not make the same statement. Refusing to issue policies to people with pre-existing conditions maximizes the value of securities. So does rescinding

[31] Wellington Management website

policies for recently diagnosed people. So does hiking premiums, at least to the extent that it does not lead to losing business to the competition. But remember, Wellington and its Wall Street counterparts own the competition as well. With each major player in Wall Street having assets spread across the health insurance industry and with those players between them holding a majority of the shares of insurers, can there really be anything like market competition between insurers? These Wall Street financial firms, as the owners of the companies, have selected executive teams and boards of directors that reflect their priorities of maximizing long-term share prices instead of maximizing competition. As we shall see later in this section, they have been successful in this effort. Moreover, the executives hired to run the insurance companies typically receive the bulk of their pay in stock options, which become more valueable when shareprices rise. Shareprices are linked to profits. This incentive system links the executives' priorities with those of the shareholders, which is maximizing profits. Again, this is

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(Hhttp://wellington.com/What_We_Do/Corporate_Governance/H)

very different from the priorities of a government administrator.

Indeed, the ownership pattern at the 10 largest health insurance companies is very similar to that at other large corporations. Vanguard, for instance, is one of the top five shareholders at 25 out of the largest 26 U.S. corporations. The same can be said for Blackrock. Fidelity is almost as prevalent, being one of the top ten shareholders at 24 out of the largest 26 U.S. corporations, and being the top shareholder in four of them. And the other names mentioned above as health insurer shareholders, including Wellington, J.P. Morgan, and Goldman Sachs, are also prevalent in the shareholder lists of the largest U.S. corporations. In other words, the private health insurers are owned by the same institutional investors that own Exxon Mobile.[32] So there is no reason to believe that the health insurance companies are going to be managed with any less of an eye on the bottom line than other large Wall Street-owned corporations. Mutual funds and other institutional investors should not be expected to care about

[32] "The 2010 Institutional Investment Report: Trends in Asset Allocation and Portfolio Composition," by Matteo Tonello and Stephan Rahim Rabimov

the health care interests of the individuals who entrust them with their retirement funds anymore than they care about their environmental interests.

Company	**2009 Sales**	**2009 Profits**
1.UnitedHealth Group	$87.1 billion	$3.8 billion
2.WellPoint	$65 billion	$4.7 billion
3.Aetna	$34.8 billion	$1.28 billion
4.Humana	$31 billion	$1 billion
5.Cigna	$18.4 billion	$1.3 billion
6.Health Net	$15.7 billion	-$49 million loss
7.Coventry Health Care	$14 billion	$242 million
8.WellCare Health Plans	$6.9 billion	$39.9 million
9.Amerigroup	$5.2 billion	$149.3 million
10.Universal American	$5 billion	$140 million
Total for ten majors	**$283.1 billion**	**$12.6 billion**

http://www.suite101.com/content/largest-us-health-insurance-companies-a235788

Company	**2011 Sales**	**2011 Profits**
1.UnitedHealth Group	$101.9 billion	$5.14 billion
2.WellPoint	$60.7 billion	$2.65 billion

(http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1707512).

3.Humana	$36.8 billion	$1.42 billion
4.Aetna	$33.8 billion	$1.99 billion
5.Cigna	$22.0 billion	$1.33 billion
6.Coventry Health Care	$12.2 billion	$543 million
7.Health Net	$11.9 billion	$72 million
8.Assurant	$8.3 billion	$546 million
9.Universal American	$7.5 billion	$398 million
10.Amerigroup	$6.3 billion	$196 million
Total for ten majors	**$301.4 billion**	**$14.93 billion**

http://money.cnn.com/magazines/fortune/fortune500/2012/full_list/index.html[33]

Share prices

During the decade between Oct 2, 2000 and Oct 1, 2010, the Dow Jones Industrial Average rose by 4%. During that same period, six of the seven major insurance companies that were listed on the market at the beginning of the decade vastly out-performed the market: United

[33] Since the time these tables were published number three Aetna announced a merger with number seven Coventry Health care in August 2012 and number two WellPoint announced a merger with number nine Amerigroup in July 2012. Also, in January 2012 number five Cigna bought HealthSpring, a large insurer not on the top ten list. Young, Jeffrey: "Aetna-Coventry Merger Reflects A Changing Industry After Health Care Reform" Huffingtonpost.com, August 20, 2012 (http://www.huffingtonpost.com/2012/08/20/aetna-coventry-merger_n_1810821.html)

Healthcare's shareprice rose by 168%, Aetna's rose by 111%, Humana's rose by 331%, Health Net's by 56%, Coventry's by 209%, and Univesal American's by 242%. Only Cigna's share price declined, and only by 1%.

Moreover, any notion that the PPACA reforms are going to harm the health insurance industry is not shared by Wall Street. A comparison of the companies' share prices on March 17, 2010, just as the administration was making its final push for passage, and March 22, the day following passage, shows that all ten major health insurance companies out-performed the market:

	Shareprice as of 3/17/2010	Shareprice as of 3/22/2010	Percent Change
Unitedhealth Group	$ 32.75	$ 33.30	1.7%
Wellpoint	$ 61.94	$ 64.39	4.0%
Aetna	$ 31.74	$ 34.64	9.1%
Humana	$ 48.23	$ 49.32	2.3%
Cigna			7.0%

	$ 34.83	$ 37.28	
Health Net	$ 24.60	$ 25.81	4.9%
Coventry	$ 25.03	$ 26.13	4.4%
Amerigroup	$ 30.25	$ 32.82	8.5%
Universal American	$ 14.92	$ 15.45	3.6%
Centene	$ 19.66	$ 24.14	22.8%
Dow Jones Industrial Average	10734	10786	0.5%

(share price source: http://bigcharts.marketwatch.com/historical/)

Most of these companies have continued to outperform the Dow Jones Industrial average, often by several times.

	Shareprice as of 3/22/2010	Shareprice as of 10/9/2012	Percent Change
Unitedhealth Group	$ 33.30	$ 57.47	72.6%
Wellpoint	$ 64.39	$ 62.02	-3.7%
Aetna	$ 34.64	$ 42.20	21.8%

Humana	$ 49.32	$ 74.79	51.6%
Cigna	$ 37.28	$ 49.18	31.9%
Health Net	$ 25.81	$ 23.68	-8.3%
Coventry	$ 26.13	$ 42.77	63.7%
Amerigroup	$ 32.82	$ 91.57	179.0%
Universal American	$ 15.45	$ 9.40	-39.2%
Centene	$ 24.14	$ 35.62	47.6%
Dow Jones Industrial Average	10786	13474	24.9%

(share price source: http://bigcharts.marketwatch.com/historical/)

2. Non-profit Insurers

At the ten major for-profit private health insurers in Pennsylvania, the shareholders elect the board of directors, which in turn oversee the management of the firms. In the case of non-profit insurers like the Blues and UPMC, there are no shareholders, so the board of directors is the highest governing body.

Highmark has 20 directors (as of the summer of

2012), consisting of six doctors, six from finance, two lawyers, two from the community, one tax accountant, one academic, and one from real estate. The two people who might be thought of as representing community interests were Doris Carson Williams of the African American Chamber of Commerce of Western Pennsylvania and Victor A. Roque of the Hill House Association (who is a former President of Duquesne Light).

Independence Blue Cross has 33 directors (as of the summer of 2010), with only one doctor. There are three government officials serving on the board, seven lawyers, and four people from the world of real estate. Two interesting features of the Independence board are that there are five labor union officials on the board, and six of the board members are appointed by local or state government bodies. There is also one academic on the board. The rest of the board is from the fields of finance, commerce, and industry.

In the case of UPMC Health Plans, it is a fully-owned subsidiary of UPMC. Until 2005, UPMC withheld the names of its board of directors from the

public.[34] By 2010 UPMC had obtained an unusually large board (52 members) because much of its growth has come from mergers and acquisitions, and with each acquisition it picks up new board members.

By 2012 UPMC had scaled down its board to just 24 members. Bottom line fields accounted for a clear majority, with six from industry, three from real estate, three from finance, and two from commerce. In addition, there were four from the legal profession, three from academia, two from community organizations, and just a single person from the medical profession.

One might say that the make-up of the UPMC board is reflected in the activities of the company. UPMC has been criticized for gobbling up so much real estate, particularly in Pittsburgh's highly developed Oakland district. As a non-profit company, UPMC does not pay real estate taxes, and so each new parcel it purchases reduces the municipal tax base. The prevalence of financial advisors, investment firms, accountants, a non-profit merger and acquisition specialist, real estate professionals, and lawyers on the board seem to indicate that not only

[34] Hhttp://www.pittsburghlive.com/x/pittsburghtrib/s_296516.html

does the non-profit UPMC want to make money, but it is very interested in pursuing money-making ventures not necessarily related to health care.

One could raise questions regarding just who UMPC is trying to make money for with its real estate dealings. Some of UMPC's land purchases have been at prices that seem well above market price, and in some cases the ensuing sales of the land have come at considerable losses.[35] UPMC has a long history of dealings with Oxford Development, even while its co-owner and board chairman Anne Lewis was on the UPMC board.[36]

The UPMC board does not differ that greatly from the boards selected by the Wall Street owners of the private health insurers. For example, Cigna's twelve member board

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35 http://www.post-gazette.com/stories/local/neighborhoods-city/upmc-land-purchases-may-be-legal-but-experts-say-more-oversight-needed-654530/

36 Hhttp://hcrenewal.blogspot.com/2010/05/at-upmc-dealings-with-board-members.htmlH reported that Oxford Development received $4.84 million from UPMC, according to 2009 tax returns. Hhttp://www.post-gazette.com/stories/business/news/upmc-easts-land-deals-provoke-questions-654707/H mentions the role of Oxford Real Estate in the acquisition of land for UPMC's Monroeville hospital in 2007. Hhttp://www2.sharonherald.com/localnews/recentnews/0008/ln082000a.htmlH reports that UPMC hired Oxford Development to find a site for

contains, in addition to the president of the company, one doctor, one real estate professional, two people from financial institutions, two private investors, three people from industrial firms, and two from other commercial ventures.

In contrast to Highmark and Independence Blue Cross, UPMC is not just an insurance company but also a hospital company. Hospitals certainly require more land than insurance companies. However, it does not necessarily follow that it should have more people in the real estate industry on its board than the other health insurance non-profits. If anything, the overrepresentation of real estate interests on the board creates greater opportunity for conflicts of interest to arise. As mentioned, Anne V. Lewis is the part-owner and board chairman of the real estate firm Oxford Development Company, which received $4.84 million in business from UPMC during FY2009. This potential for conflicts of interest goes beyond the real estate industry. These self-selected boards do not have shareholders looking over their shoulders to guard against the companies being used as cash cows by board members.

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its $50 million facility north of Cranberry in 2000.

Of course, the idea of shareholders imposing fiscal discipline on health insurance companies only goes so far. It does not seem to apply to executive salaries. The average annual pay of the CEOs of the ten major for-profit health insurance companies during the first decade of the Twenty-first Century was $9.44mn, not counting the exercise of stock options, which would add at least another $8.43mn to average CEO compensation. By contrast, the average compensation of Highmark CEO Kenneth Melani during the five-year period between 2004-2008 was a mere $2.90mn, which compares favorably to the annual pay (not including stock options) of three of the smaller "big ten" for-profit firms (Health Net, Amerigroup, and Universal American Group). The 2009 annual sales of Health Net ($15.7 billion), Amerigroup ($5.2 billion) and Universal American ($5 billion) compare with Highmark's annual sales of $13.4 billion.[37] The annual sales of UPMC during 2009 were $8.05 billion ($3.04 billion coming from insurance premiums), while Jeffrey Romoff, president and CEO of UPMC, received $6.07 million in salary in 2012,

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http://www.suite101.com/content/largest-us-health-insurance-companies-a235788

following $5.98 million in 2011. Romoff top deputy, executive vice president Elizabeth Concordia, received $2.5 million in 2012, while Diane Holder, president and CEO of UPMC Health Plan (the insurance subsidiary of UPMC), made $1.91 million in 2012.[38]

3. Government Insurance Programs

a) Medicare

The Center for Medicare and Medicaid Services (CMS), which oversees administration of Medicare, Medicaid, and the Childrens Health Insurance Program (CHIP), has approximately 4,100 employees, of which 2,700 are located at its headquarters in Maryland. The remaining employees are located in the Hubert H. Humphrey Building in Washington, D.C., 10 regional offices, and in various field offices located throughout the United States. The Social Security Administration determines eligibility for Medicare, and other government agencies and private contractors are also involved in the administration of Medicare, Medicaid, and CHIP. Marilyn

[38] Twedt, Steve: "UPMC paid 26 employees over $1 million last year" Pittsburgh Post-Gazette, May 17, 2013 (http://www.post-gazette.com/stories/business/news/upmc-paid-26-emp

Tavenner is the Acting Administrator for CMS.[39] Together these programs serve some one in three Americans. CMS is in turn a part of the Department of Health and Human Services (HHS). HHS Secretary Katheleen Sebilius earns $199,700 as a cabinet official, while Tavenner can make no more than $179,700 as a sub-cabinet level official.[40] Medicare has 45 million enrollees. Total Medicare spending in 2011 was $524 billion, representing some 15% of all federal outlays and 23% of the $2.19 trillion in national personal health expenditures.[41]

Despite the many challenges it faces, Medicare is certainly the most effective part of the health insurance industry, based both on its low administrative overhead (high medical loss ratio) and its ability to negotiate lower rates from healthcare providers. Medicare is divided into four parts. Part A covers inpatient hospital services, skilled nursing facility, home health, and hospice care. Part A is

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loyees-over-1-million-last-year-688004/)

[39] Hhttp://www.hhs.gov/open/contacts/cms.html

[40] Office of Personnel Management, "Salary Table No. 2012-Ex: Rates Of Basic Pay For The Executive Schedule (Ex), Effective January 2012" (http://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/2012/executive-senior-level/ex.pdf).

[41] Hhttp://www.medpac.gov/documents/Jun12DataBookEntireReport.pdf

funded primarily by a dedicated payroll tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each). An estimated 44.5 million people were enrolled in Part A in 2008. Part A costs up to $441 per month (2013 price) in premiums, although the vast majority of enrollees pay no premiums due to having paid payroll taxes or some other circumstance. Part B helps pay for physician, outpatient, home health, and preventive services. Some 74% of Part B expenses are funded by general revenues (income and corporate taxes, etc.), with the remainder mostly coming from beneficiary premiums. There is a $104.90 monthly premium in 2013 for most people, although higher income people may pay as much as $335.70 per month. There is also a $147 deductable associated with Part B. Part D is a prescription drug benefit and is also funded by general revenues and a monthly premium of about $30 per month. Part C, also known as Medicare Advantage, allows beneficiaries to enroll in a private plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. These plans receive payments from Medicare to provide Medicare-covered benefits,

including hospital and physician services, and in most cases, prescription drug benefits. Part C is not separately financed and draws on the same pool of funds as Part A and Part B, and accounted for 21 percent of Medicare benefit spending in 2008. As of October 2008, 10.2 million beneficiaries were enrolled in Medicare Advantage plans.[42]

Medicare insures people ages 65 and over, as well as nonelderly people with disabilities. It is no surprise that the elderly and disabled require more medical care than the rest of the population. Some 38 percent of all Medicare beneficiaries have three or more chronic conditions, with hypertension and arthritis being the most common. Medicare beneficiaries also tend to have lower incomes, with fully 46 percent of them below 200 percent of the Federal Poverty Level (FPL).[43] This population segment, with its large medical requirements and limited income is not an attractive one for insurance companies. Medicare is made affordable to older Americans by financing vehicles that are not as readily available to insurance companies, namely mandatory payroll deductions for workers not yet

[42] Hhttp://www.kff.org/medicare/upload/7615-02.pdfH Medicare: A Primer (2009) p.9

[43] Hhttp://www.kff.org/medicare/upload/7615-02.pdfH, Medicare: A

eligible for Medicare, and subsidies from the federal budget's general account (although as we shall see in the next chapter, federal payments to private insurers are one of the cornerstones of PPACA). As mentioned, Medicare has been extremely efficient in terms of administration, with only about 2% of the Medicare budget going towards administration. Thus, its medical loss ratio is perennially around 97-98%.[44] Moreover, Medicare has done a better job of containing health care costs than private or non-profit insurance companies.

The vast majority of physicians (97% according to CMS) accept Medicare, either as a participating provider or a non-participating provider. However, an American Medical Association survey finds that 17% restrict the number of Medicare patients they see.[45] Participating providers have participating provider agreements, and will

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Primer (2009) pp. 3-4

[44] Mainstreet Allience: "National Minimum Medical Loss RatioWould Save Tens of Billions of Dollars For Businesses, Individuals, December 2009" p.3 (http://mainstreetalliance.org/wordpress/wp-content/uploads/Ensuring-Value-for-Premiums.pdf).

[45] USATODAY.com: "Doctors Limit New Medicare Patients," June 21, 2010 (http://usatoday30.usatoday.com/news/washington/2010-06-20-medicare_N.htm)

"take assignment," or accept Medicare's approved fee schedule amount (which is the 80 percent that Medicare pays plus the 20 percent the patient pays) as payment in full for all covered services. These physicians must accept assignment on all Medicare claims for their patients, although they do not have to accept every Medicare patient who seeks treatment from them. Doctors who accept medicare but do not have participating provider agreements have two options. They can take assignment and accept a slight discount (5%) in both Medicare's payment and the patient co-pay, or they can not take assignment and charge the patient and any supplemental insurance the patient may have up to 9.25% above the Medicare fee schedule. In these cases, Medicare will reimburse the patient 76% (i.e., the 80% that Medicare typically pays minus the 5% discount off of that 80%). A small minority of doctors refuse to accept Medicare payments altogether.[46]

So how are the payments to physicians who provide services to Medicare patients set? The first step in the process is for a panel of doctors associated with the

[46] American Medical Association, "Medicare Participation Options for Physicians," 2010 (http://www.ama-assn.org/ama1/pub/upload/mm/399/medicarepayment

American Medical Association to calculate the amount of resources required for a particular service, including the time it takes to perform the service, the technical skill and physical effort, and the required mental effort and judgment. The end result is an index in the form of a raw number, not a dollar amount. The process is open to input from the public and from insurance companies. Next, geographic practice costs are factored into the number so as to take into consideration the varying cost of doing businesses in different parts of the country. Finally, the number is multiplied by a monetary conversion factor set by the CMS.[47]

b) Medicaid

Medicaid is a program established by the Federal government that assists low-income and disabled people in obtaining health care. In 2012, some 57 million people

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[47] "The Medicare Physician Payment Schedule," American Medical Association (http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-medicare-physician-payment-schedule.page) and "How Are Medicare Rates Established?" Think Progress Health (http://thinkprogress.org/health/2009/08/13/170906/robertz-medicare/?mobile=nc)

received health care coverage through Medicaid. States run their own Medicaid programs within a framework of guidelines established by the Federal Government. The Feds pick up some 58 percent of state Medicaid expenditures, which in FY2013 are expected to cost the Federal Government $283 billion. Children make up just over 50 percent of Medicaid beneficiaries but account for only 20% of expenditures. By contrast, the disabled and elderly make up 27 percent of beneficiaries (18% and 9% respectively), but they account for 66 percent of expenditures (45% and 21%, respectively). This of course is in addition to the expenditures made by Medicare, which is specifically for certain disabled people and the elderly.[48]

Medicaid is funded by the general budgets of the federal and state governments. The share of expenses paid by the Federal Government to the various states varies depending on the per capita income of that state. If the per capita income of the state is the same as the per capita income of the United States as a whole, then the Federal Government will pay 55 percent of mandated program

[48] "Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans," Department of Health and Human Services (http://www.hhs.gov/budget/budget-brief-fy2013.pdf)

costs. For less affluent states, the feds will pay proportionally more, while for more affluent states they will pay less, although never less that 50 percent. The total cost of Medicaid in 2009 was $380.6 billion, with the Federal Government paying 66 percent of the total and the states picking up the balance. Even so, Medicaid expenditures rival education costs as the largest item in state budgets.[49]

To be eligible for Medicaid one must meet income and asset requirements or have certain disabilities. States are free to have less stringent and more inclusive income requirements, particularly for those with special medical needs. Starting in 2014, PPACA will extend Medicaid eligibility to those with family incomes up to 133 percent of the Federal Poverty Level, although some states, including Pennsylvania, have elected to opt out, thus leaving this segment of the population to the health insurance exchanges, which will be discussed later. The Federal Government requires states to cover certain services, and states may offer additional benefits.

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[49] "The Basics: Medicaid Financing," National Health Policy Forum, February 4, 2011 (http://www.nhpf.org/library/the-basics/Basics_MedicaidFinancing_02-

c) Children's Health Insurance Program (CHIP)

The other notable insurance program under CMS is the Children's Health Insurance Program (CHIP), which subsidizes health insurance for lower income children. CHIP is generally intended for children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance, although a small number of adults, such as pregnant women, may also qualify. The CHIP program is administered by the states and the program specifics can vary. States receive federal matching funds ranging from 65 to 85 percent of total costs for child health care services and program administration. Some states implement CHIP by expanding Medicaid, while others create a separate program or utilize a combination of Medicaid and a separate program. Some 8.7 million individuals were enrolled in CHIP at some point during 2011, an increase of 3.5 percent over FY 2010 enrollment. Enrollment has been steadily increasing since the inception of the program in 1997.[50]

04-11.pdf)

[50] Fiscal Year 2013 Budget in Brief: Strengthening Health and Opportunity for All Americans," Department of Health and Human

In Pennsylvania, CHIP is provided by private health insurance companies that are licensed and regulated by the PID. In Southwest Pennsylvania, those companies are Keystone Health Plan West (Highmark), UnitedHealthCare of Pennsylvania, Inc., and UPMC for Kids. In other regions Aetna, Capital BlueCross, First Priority Health (BCNEPA), Geisinger Health Plan, Highmark Blue Shield (Central PA), Keystone Health Plan East (IBC), and KidzPartners offer CHIP plans. For many families, coverage is free: a family making $46,100 or less per year would qualify for free CHIP. Families with incomes above the free CHIP limits can enroll, although they pay monthly premiums and co-pays for some services. In most cases, children from higher income families have to go without insurance for six months before becoming eligible for CHIP.[51]

d) VA system and Tricare

The other main component of the public sector of the health insurance industry is the VA health care system run by the Veterans Health Administration, which is the

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Services p.71 (http://www.hhs.gov/budget/budget-brief-fy2013.pdf)

[51] What is CHIP?, PA Insurance Department Website (http://www.chipcoverspakids.com/about-chip/what-is-chip/)

main component of the Department of Veterans Affairs. Unlike Medicare, this is not a single payer system with the government acting as the single payer for services supplied by private providers. It is not administered on a state-by-state basis like Medicaid, and it is certainly not outsourced to private firms the way CHIP is in Pennsylvania. Rather, it is a government run system where not just the payments but also the services are provided by the government in government-owned facilities. The Federal Government started providing medical services to veterans 200 years ago at the Naval Home in Philadelphia. Veterans' health care needs increased exponentially after the Civil War. In response, the Federal Government started offering room and board to disabled veterans. Following World War I, these veterans' homes came to resemble hospitals. The Veterans Administration was created in 1930 under President Hoover and then elevated to full-cabinet status as the Department of Veterans Affairs under President Reagan.

Not all veterans qualify for VA health care benefits. Those with service-related injuries or condition receive priority, as well as those in financial need. In 2011 the

government spent $48.1 billion on VA medical services. The VA health care system had nearly 7.9 million veterans who were enrolled as of October 2008.[52]

TRICARE is the health care program of the Department of Defense that provides civilian health benefits for current and retired members of the Armed Forces and their family members. It offers health maintanense organization (HMO), preferred provider organization (PPO), and fee for service options. The TRICARE program contracts out administrative and claims work to private insurance companies, including Health Net, Humana, and BlueCross BlueShield of South Carolina. Its budget for FY2013 is $16.5 billion.[53] In 2010 9.7 million people were eligible for TRICARE.[54]

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[52] Department of Veterans Affairs: “Facts about the Department of Veterans Affairs, January 2009” (http://www.va.gov/opa/publications/factsheets/fs_department_of_veterans_affairs.pdf)

[53] U.S. Government Budget for Fiscal Year 2013 (http://www.whitehouse.gov/sites/default/files/omb/budget/fy2013/assets/mil.pdf)

[54] Gregerson, Brittany: "Curing military health care" Armed Forces Journal (May, 2012) http://www.armedforcesjournal.com/2012/05/10122465/

4. Summation

It is obvious that the three different health insurance sectors behave differently. First of all, the for-profit sector has overhead ranging from 15-25%, including keeping almost 5% of its revenues in the form of profits, as is evidenced by the tables earlier in this chapter. This is part of the reason for their low medical loss ratios, which among the major companies are just over 80%[55] (meaning that only 80% of premium dollars are being spent on health care services). Besides profits, what else are those premiums that are not used for health care services going towards? The five largest private health insurers collectively spent $366.8 million on advertising in 2011, up 51.6% from 2010.[56] Those "feel good" ads don't do anything to benefit patient health. However, the advertizing budgets at these five firms only amounted to 0.14% of their premium revenue, so they were not a major contributor to

[55] HCAN Analysis Shows Health Insurers Pocketed Huge Profits in 2010 Despite Weak Economy (http://healthcareforamericanow.org/wp-content/uploads/2012/02/HCAN-Analysis-Shows-Health-Insurers-Pocketed-Huge-Profits-in-2010-Despite-Weak-Economy.pdf)

[56] AIS Health "Insurers Increased Advertising Budgets in 2011, but Are Keeping a Close Eye on MLR" (Hhttp://aishealth.com/archive/nhpw050712-03H)

low medical loss ratios. Likewise, as outrageous as CEO compensation at these same companies can be, the $10-20 million that the major private insurers were paying to their CEOs in 2011 had even less impact on medical loss ratios than advertising budgets.[57] (Of course, there are some years where a particular CEO has a disgustingly huge severance or bonus package, and the CEO is not the only overpaid executive at the company, so executive pay should be an issue. Still it only goes so far in explaining low medical loss ratios at private insurers, or non-profits, for that matter.)

A great deal of the low medical loss ratio is due to the massive administrative redundancies that are part and parcel of the way that for-profit and non-profit companies do their business. As was stated in the first sentence of this chapter, "the economic role of insurance companies is to spread risk." The wider that risk is spread (i.e. the more policy holders in the insurance pool), the less impact any given individual's bad luck will impact on the group as a whole. However, rather than spreading risk across as wide

[57] American Medical Association, "How much did Health Plan Executives Make?" http://www.ama-assn.org/amednews/2012/images/gbisf0531a.pdf

a pool as possible, insurance companies slice and dice the population into countless numbers of mini and micro pools. Each of the multitude of companies offer a myriad of different products, which have the effect of dividing up the population. As we will see in the next chapter, all companies operating in Pennsylvania in the individual market, and non-profits operating in the group market, must file with the PID each time they raise rates or alter forms (i.e., policy terms). The filings can be dozens or even hundreds of pages long, but may only impact less than 100 policy holders. This represents a massive amount of redundant administration. Moreover, policies are offered to groups with as few as two members. Obviously, the per capita cost of administering such small groups (calculating rates, collecting premiums, etc.) is going to be higher.

So what is the economic logic behind such a system? It must be said that there is no macroeconomic logic, but there is a microeconomic logic. Here is how it works. If insurance company A offered a single policy to the entire population at a single premium, it would minimize per capita administrative costs and could, on average, provide the population with the lowest possible

premiums due to efficiencies of scale. However, insurance company B, knowing that older people tend to use more medical services than younger people, could offer a single nation-wide policy with graduated premiums that are less expensive for younger people and more expensive for older people. There would be some additional administrative costs in setting the premium scales and verifying peoples' ages, but company B would be able to pull away Company A's younger customers with more attractive rates. Company A would have to raise premiums on its remaining, mainly older customers in order to maintain profit margins. Company C could come along and add regional health care costs to the age-based model that Company B developed. Although assessing regional costs would add administrative overhead to Company C, people in regions where health care is less expensive would flock to the lower premiums offered by Company C, and Companies A and B would have to raise rates on their remaining customers to offset the loss of customers from the more profitable regions. Another company could come along and add a dimension known as relative risk of industry, charging employers in relatively safe and healthy industries lower group rates.

Again, there would be more per capita administrative costs, but a relatively profitable risk pool would be gained. Another company could add a layer of personal health history or family background. And so on.

Each time the population is sliced and diced in order to obtain a profitable pool, overall administrative costs are increased and these are passed on to the consumer. Moreover, the consumers in the pools left behind are faced with rate hikes in order to make up for the loss of the more profitable pools. For the company slicing off a profitable risk pool, it makes perfect sense. For the population as a whole, it is pure madness.

In the United States, the for-profit companies have sliced off the most attractive, least expensive to insure segment of the population for themselves. They typically outright refuse to insure people who they feel constitute too much of a risk. The non-profits also engage in slicing and dicing, but usually are obligated to offer insurance to anyone via guaranteed issue policies, albeit at an extremely high price. The government provides insurance to the riskiest and most expensive segments of society: the elderly, the disabled, some veterans, and those with very low

incomes. And as we know too well, a growing share of Americans that do not qualify for the reasonably-priced sliced and diced private medically underwritten pools, cannot afford guaranteed issue policies, and are not eligible for government insurance, have little or no choice other than to forego health insurance altogether.

In the next section, we will examine the massive undertaking that the Pennsylvania Insurance Department assumes in reviewing and regulating the countless plans offered to the public in the Commonwealth.

Section C – Pennsylvania Insurance Department Operation

1. Introduction

We all have heard reports on how health care costs are rising fast. Consumer price data from the Bureau of Labor Statistics indicates that while overall consumer prices rose by 28% between January 2000 and January 2010, the medical component of the consumer price index rose by 49%.[58] Not only have health care costs been rising faster than overall inflation, but indeed faster than any other major expense faced by families with the exception of college tuitions.

Premiums for health insurance in Pennsylvania are no exception. According to the Bureau of Labor Statistics, wages in the Mid-Atlantic region that includes Pennsylvania averaged 2.15% annual growth during the years 2007-2012. Meanwhile, the Consumer Price Index (CPI) has risen by an average of 2.20% per year, slightly

[58] U.S. Department Of Labor, Bureau of Labor Statistics: Consumer Price Index (All Urban Consumers - CPI-U), U.S. city average. (Hftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txtH)

outpacing wages.[59] However, premiums for many insurance policies sold in the Commonwealth are increasing at a much faster clip. For instance, a subscriber to the Guaranteed Issue PreferredBlue PPO offered by Highmark in Western Pennsylvania would have seen his or her premium increase by an average of 6.99% per year during the same period. Not only is this three times as fast as wages or the overall CPI, but it is almost twice the two components of the CPI that measure health care costs. The medical care commodities index (which looks at prescription drugs, medical equipment, etc.) increased by an average of 3.57% per year. Meanwhile, the medical care services index (which looks at doctor fees, hospital charges, and insurance premiums) rose by 3.87% per year.[60] As we will see, this particular policy is typical of what is available to Pennsylvania consumers. So when you consider that health insurance is a major expense for anyone who has to purchase an individual policy, there is no question that

[59] U.S. Department Of Labor, Bureau of Labor Statistics: "Consumer Price Index, All Urban Consumers - (CPI-U)," ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt

[60] U.S. Department Of Labor, Bureau of Labor Statistics, Medical component of CPI: "U.S. Medical Care, (1982-84=100 - CUUR0000SAM), U.S. Medical Care Services, (1982-84=100 - CUUR0000SAM2))" http://data.bls.gov/cgi-bin/surveymost?cu

many Pennsylvanians are seeing their budgets squeezed by rising health insurance premiums.[61]

The question then arises, why does the Pennsylvania Insurance Department allow these regulated premiums to rise so fast? PID actuaries will approve premium hikes if insurance companies can demonstrate that their expenses are increasing enough to warrant such hikes. In fact, the data that they provide to the PID in their rate filings indicates that total claims paid on behalf of policy holders are actually rising even faster than premiums. Moreover, Highmark says that it is now LOSING money on the Guaranteed Issue PreferredBlue PPO plan despite the premium hikes, having gone from a gain of $638,000 in 2007 to a loss of $8.31 million in 2011, and a projected loss of $13.24 million in 2013. The costs are going up, Highmark says, because of "increased health care costs in the programs due to higher hospital pricing and increased

[61] According to the U.S. Census Bureau's "QuickFacts" page on Pennsylvania (http://quickfacts.census.gov/qfd/states/42000.html), median household income in the 2007-2011 period was $51,651, with an average household size of 2.47. Meanwhile, the annual premium for a Highmark Direct Pay policy with a $250 deductable for a healthy couple whose older member was 45-49 years of age would be $6916, or 13.4% of their income. It could easily be more than double that if one of them had a pre-existing condition.

member utilization of health care services."[62] Remember from above that the part of the CPI that measures doctor fees, hospital charges, and insurance premiums rose by 3.87% per year. (We will talk about the causes of medical inflation later in the paper.) If Highmark's claim is correct, it would mean that member utilization is increasing at more than 3% per year.

Sometimes new enrollment in a medically underwritten plan (one that rejects people with certain health conditions) is ended. When this happens, the existing plan members tend to age, and some of them develop conditions that would have led to their rejection if those conditions were pre-existing at the time of enrollment. Thus, it is certainly plausible that a medically underwritten plan with closed enrollment could see a steady increase in the usage of services.

However, PreferredBlue PPO is a guaranteed issue plan, and its enrollment remains open. It is not at all obvious why service utilization should increase so rapidly. Even so, on July 25, 2012 Highmark requested an increase

[62] Pittsburgh Post-Gazaette "Highmark set to raise low-income plan rates"(http://www.post-gazette.com/stories/business/news/highmark-set-to-raise-low-income-plan-rates-307137/)

in the premiums for this policy averaging 9.5%.[63]

The correspondences between Highmark and the PID reveal that Highmark claimed a "trend factor" (increase in the cost of providing benefits) of 15.6%. In an objection letter submitted on August 21, 2012, the PID stated that the Highmark filing

> "failed to support the proposed trend of 15.6%. Please provide the data and your detailed analylsis and assumptions that support these trends and the considerations used in your actuarial judgment."

The objection letter goes on to request that

> "[t]o the extent that provider contracting has contributed to the requested trend please show all data and analysis used by Highmark to quantify the contracting adjustment. This data must at least include calendar years 2009, 2010 and 2011 data, by hospital: total dollars paid to the facility, total days utilized and negotiated percentage increase. Also include the negotiated percentage increase for 2012 and the expected 2013 percentage increase; and the effective period of the contract. To maintain anonymity, you may use numbers to identify each hospital. Please use consistent hospital numbering

[63] Page 43 of the filing requesting a January 1, 2013 rate increase for the Highmark Guaranteed Issue PreferredBlue PPO, which can be found at (http://www.insurance.state.pa.us/serff_filings/HGHM-128557959.pdf)

> for each year. This information will be kept confidential as provided for by Section 9 of Act 159 of 1996."[64]

In the end, Highmark wound up revising downwards its high rate request to 8.9%, which was approved by the PID.[65] The PID did request key information on the breakdown of payments by year and by hospital as well as days utilized and negotiated prices, although there does not seem to be any breakdown by type of service. Highmark was allowed to keep the identity of hospitals anonymous and the public was denied access to the information due to section 9 of Act 159 of 1996. This lack of transparency makes it almost impossible for an independent watch dog to assess whether the PID was diligent in fulfilling its mission to "safeguard consumer rights."

Still, even if we assume that the PID is diligent, then we are faced with a situation in which there is a large and unexplained increase in utilization of health care services. Such an increase would appear to be unsustainable, yet what can we do to rectify it if we are

[64] Ob cit p.7
[65] Ob cit, p.19

denied access to the basic data regarding what services might be being over-utilized and by whom? The logic in keeping this information confidential is that its release may allow competitors to gain some sort of advantage. Yet this begs the question: In Pennsylvania, where both health insurance and the health care delivery are dominated by non-profits, what benefit does the public derive from this kind of "competition" between ostensibly charitable organizations with similar missions? It certainly would be hard to argue that this competition is holding down prices. The rivaly between Highmark and UPMC, for instance, has become legendary. The two companies have reached the point of attacking each other in paid commercial messages.[66] In fact, in a February 2013 position paper, Highmark contends that UPMC "desperately wishes to destroy" the West Penn Allegheny Health System. [67]

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[66] Two examples include: "New Highmark Ad Goes After UPMC" *CBS Pittsburgh.* April 12, 2013 (Hhttp://pittsburgh.cbslocal.com/2013/04/12/new-highmark-ad-goes-after-upmc/H) and "UPMC asks judge to dismiss Highmark advertising claims" TribLive February 23, 2012 (Hhttp://triblive.com/x/pittsburghtrib/news/s_783163.html#axzz2WmI1rfx6H), (both accessed on Web. 20 June 2013).

[67] "A Competitive and Affordable Healthcare Marketplace For Western Pennsylvania," Highmark Position Paper, February 25, 2013 (Hhttps://www.highmark.com/hmk2/newsroom/pressreleases/2013/pdf/

With greater transparency, the public could see for itself whether the premium hikes are justified and if so, what could be done to reverse the utilization trends that make them necessary. These benefits would far outweigh any damage to the competitive position of tax exempt non-profits.

One of the huge problems with our current health insurance system is uncertainty. That is to say, people often have little idea what to expect when they use their insurance, or alternatively their expectations are erroneous. So often people go to a provider and present their insurance card on the day they receive services, and then some weeks later when the various bills start arriving they discover to their horror that a particular procedure is not covered or the provider was not part of the network or there was a pre-existing exclusion or any one of a number of pitfalls that one can stumble into. With policy contracts being so long and technically worded, for many people the only way to learn the ins and outs of the policy is through bitter experience.

Of course, the whole purpose of insurance is to

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healthcaremarketplace.pdfH), p.5

manage uncertainty. We buy insurance because we never know when we will be sick or injured. However, there are so many aspects of health insurance that are complicated or non-transparent that even routine medical visits are full of the risk of non-payment. A dentist office could check with an insurer and provide a patient with a price for a filling. However, if the dentist winds up drilling on three faces of the tooth instead of the two assumed by the quote, the insurance may not cover the procedure and the patient could be on the hook for the full price. Alternatively, when a doctor's office checks with an insurance company to see if an MRI is covered under a patient's policy, the company may reply that the procedure is covered without bothering to check if the patient is subject to a pre-existing clause. When insurance companies "authorize" such procedures, the authorizations typically state that there is no guarantee of payment.

Another source of uncertainty has to do with provider networks. Health insurance companies negotiate discounts with providers in their networks for goods and services. These discounts are obtained by insurance companies through their market power, though the value of

the discount to the policy holder is diminished by the amount kept by the insurance company. Insurance companies also typically require policy holders to shoulder only half as much of the coinsurance for in-network services as they do for out-of-network services. For example, an insurance policy may cover in-network procedures at 90% and out of network procedures at 80%. However, this is not to say that the patient is going to wind up paying double for out of network. The actual difference in cost to the patient can be several times as much. This is because in-network prices are subject to meaningful negotiations, whereas out-of-network prices can be completely arbitrary and divorced from the cost of actually providing the service. Market forces cannot play a role because prices are typically not disclosed until long after the service was provided. Furthermore, out-of-network services are often subject to a separate deductable that can be twice as high, so it is quite likely that the patient will be paying full price for out-of-network services, as if he or she had no insurance at all.

As mentioned at the start of this chapter, between January 2000 and January 2010, the medical component of

the consumer price index rose by 49%, as compared to an overall inflation rate of 28% for the same period. However, many Pennsylvanians are seeing even faster growth in premiums. For instance, Highmark Blue Shield (Central Region) hiked the rates for its Direct Pay Medically Underwritten PPO Plans by 9.0% in October 2007, 14.3% in October 2008, by another 10% a year later, and a further 9.9% in November of 2010.[68] These rate hikes impact some 8900 policy holders in Pennsylvania. When you compound the four increases that PID granted in 2007-2010 you wind up with a 54% increase -- not spread over a decade but in just four years. So not only is the medical component of the CPI rising considerably faster than the overall CPI but many Pennsylvania customers of Highmark are seeing their health insurance bills rise even faster. And there are plenty of other indications that health insurance consumers across Pennsylvania are seeing their insurance bills rise faster than the medical component of the CPI would indicate.

In its western region, Highmark hiked the rates for its CompleteCare Program by 9% on October 1, 2007, by

[68] SERFF filings PAAH-126621620 (on PA website as http://www.portal.state.pa.us/portal/server.pt/document/904969/paah-126621620_pdf), PAAH-125639414, PAAH-12612961, and

13% a year later, and by 7.9% in 2009, resulting in a 32.9% increase over just three years.[69] These hikes impact over 25,000 policy holders for this product.

Another 8,200 Pennsylvania contract holders are being impacted by the successive rate hikes being sought by Keystone Health Plan West for its Individual HMO Plan. After a 9.0% hike in 2007, a 2.2% hike in 2008, and a 10% hike in 2009 (when they actually requested a 20.2% hike), the company sought an 8.5% hike in 2010, eventually receiving a 6.0% hike.[70] That represents a 31.5% increase over four years. Again, this is greater than a whole decade's worth of increases for the overall CPI.

These are typical of the rate filings that are disclosed via the System for Electronic Rates and Form Filings (SERFF) database available on the Pennsylvania Insurance Department's website. To continue with Highmark, SERFF listed some 20 Medicare supplemental insurance plans (such as Medigap Blue) with about 120,000 subscribers that had all been approved by the Insurance

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PAAH-126753336

[69] SERFF filings PAAH-125639371, PAAH-126753327 and PAAH-126129604

[70] SERFF filings PAAH-125639355, PAAH-126621585 and PAAH-126129601

Department for rate hikes of 9.9%. Even so, in almost all these cases Highmark had requested rate hikes significantly higher that 9.9%, sometimes double or even triple that figure. According to then-Commissioner Ario, the PID felt that in the midst of the financial crisis, rate increases had to be held to single digits. [71] Still, for these 120,000 Pennsylvania seniors, whose Social Security is linked to the CPI and who in many cases had just taken a major hit on their 401(k)s, the 9.9% increase was quite unwelcome; especially since Highmark had just hiked its rates for most of these products around 8% the year before.

Also, it is not only the Blues who are hiking their rates. Aetna's Individual Advantage HMO plans, which are subscribed to by more than 20,000 Pennsylvanians, saw an average 9.7% rate hike in October 2009.[72] Conseco Senior Health Insurance Company has had back-to-back 20% rate hikes approved for its Long-term care insurance products.[73] Also, RiverSource Life Insurance Company received a 15%

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[71] "Testimony before the Pennsylvania House Appropriations Committee," Presented by:Joel Ario, Insurance Commissioner, February 24, 2010, p.7 (www.pema.state.pa.us/portal/server.pt/document/768382/house_appropriations_022410_pdf)

[72] SERFF filing PAAH-125683224 and AETN-126145485

[73] SERFF filing CNLT-125814501

rate hike in 2008 for its long-term care products subscribed to by over 5000 Pennsylvanians and then another 10% increase in 2009.[74] This list is far from exclusive.

This is not to say that the PID simply rubberstamps rate filings. As we shall see, most rate filings are either initially disapproved before being approved in a modified form, or notice is published in the PA Bulletin, which slows down the review process and starts a different set of procedures that often lead to rates being modified before being approved. Pennsylvania requires that insurers maintain a minimum 60% medical loss ratio, although PID actuaries try to see to it that the policies under PID authority maintain higher ratios. Moreover, skyrocketing health care costs are not solely due to insurance companies taking ever larger cuts of the pie. The hospitals, doctors, malpractice lawyers, pharmaceutical companies, and medical equipment manufacturers all play a role in driving up costs that wind up being covered by insurance, and in some cases there are justifiable reasons for the increased costs. Furthermore, the PID only has limited regulatory authority over rate hikes. It does have authority over

[74] SERFF filing PAAH-125634624 and AERS-125943590

individual policies and many small group policies, but does not have any authority over the underlying health care costs.

2. PID Statutory Authority

Note: This section gives an overview of the statutory authority of the Pennsylvania Insurance Department regarding health insurance. For a more detailed discussion, refer to Appendix B.

The Pennsylvania Insurance Department (PID) is responsible for administering the laws regulating the insurance industry within the Commonwealth. Although the PID was established in the 19th century and the current foundational statutes are from the 1920s, regulation of health insurance did not occur until after the introduction of health insurance in the 1930s with most of the significant statutes enacted from the 1970s through today. The current authority of the PID to regulate health insurance is composed of dozens of statutes and amendments to statutes which are located in both Title 40 of the Unconsolidated Pennsylvania Statutes and Title 40 of the Consolidated Pennsylvania Statutes. These statutes have been used as the

basis for the PID's regulations, which are located in Title 31 of the Pennsylvania Code.

The role of the PID in regulating health insurance is only part of the overall regulatory scheme. The federal government, beginning with the establishment of Medicare and Medicaid in 1965, has become increasingly involved in health insurance regulation. The impact of federal regulations on the PID's authority is significant because federal regulations related to insurance take precedence over state regulations. Therefore, the actual authority of the PID is based upon the relevant Pennsylvania statues that have not been superseded by federal laws. For example, the Employee Retirement Income Security Act (ERISA), a federal law, regulates large group coverage and employers that choose to self-insure their employees. Pennsylvania is effectively barred from regulating the large group market and companies that choose to self-insure in many respects. For that reason, the rest of this section will focus on the small group and individual policy markets.

The federal government and states regulate health insurance in a number of ways, many of which could arguably be considered consumer protection measures.

Initially, the basis of state regulation of insurance companies was primarily to make sure they had enough assets in order to pay insured's claims. As the role of health insurance changed over time, the number of consumer protection measures has expanded rapidly. Today, there are regulations regarding the rates charged by insurance companies, their financial health, their marketing practices, consumer access to insurance, the terms of health insurance policies, and the business practices of insurance companies regarding enrolled customers. This section will outline the PID's statutory authority regarding rate review and regulating the financial health of insurers. A more detailed discussion of regulations is included in Appendix B.

a. Rate Regulation

One of the most important functions of the PID is their process for approving or disapproving proposed base rates, which is the initial rating formula filed with the PID, and rate increases for small group and individual policies. The statutory authority of the PID to review rates is based upon the Accident and Health Filing Reform Act (Act 159 of 1996) and Act 134 of 2011. All individual rates must be filed with the PID, and unless disapproved within 45 days

are deemed approved.[75] For small group rate filings, all base rates and rate changes must be filed with the PID.[76] *If the rate change is less than 10%, the PID will not review the filing and it may be used 45 days after submittal*.[77] If the proposed rate change is 10% or more, the filing will be reviewed. However, unless the PID disapproves the filing within 45 days or extends the review period, it will be deemed approved.[78]

Additionally, rates must meet certain medical loss ratios. Pennsylvania regulations require that any initial rate filing have a medical loss ratio of not less than 50% and any rate change must have a medical loss ratio of 60%.[79] However, these requirements have been superseded by the Public Health Services Act (PHSA), which requires a medical loss ratio of 80% for the small group and individual markets.[80]

b. Financial Health of Insurance Companies

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[75] 40 P.S. § 3801.303(c); 40 P.S. § 3801.304(a)(1); 40 P.S. § 3801.503(c); 40 P.S. § 3801.504(a)

[76] 40 P.S. § 3801.303(e)

[77] 40 P.S. § 3801.303(e)(3)

[78] 40 P.S. § 3801.303(e)(2)

[79] 31 Pa. Code 89.93(b)(1); 31 Pa. Code (c)(1)

[80] PHSA 2718(b)(1)(A)(ii). Note that these percentages may be adjusted by the HHS Secretary under Section 2718(d).

A fundamental legislative concern regarding the insurance industry is that insurance companies have enough money in reserve to pay all claims that arise under the issued policies. Under the Insurance Department Act of 1921 as amended by Act 177 of 1992, both non-profit and for-profit insurers can be subject to financial examinations.[81] The PID may determine if an insurer meets minimum reserve standards.[82] However, another concern in the case of non-profit insurers is whether they have too much money in reserve in contravention of the public interest. The Health Plan Corporations Act of 1972 allows the PID to investigate the level of reserves and surpluses for non-profit insurers as well as request material to aid in the investigation.[83] Reserves, or loss reserves, are the funds held in order to pay estimated claims. A surplus is the amount of net assets a plan has after deducting all liabilities. In examining the proper levels of surplus, the PID has looked at the risk based capital (RBC) ratio which is the ratio between a plan's net worth to the assets that the plan is required to hold to pay estimated claims. In 2005, the

[81] 40 P.S. § 323.1-323.8
[82] 31 Pa. Code §§ 84a.1-84a.8
[83] 40 C.S.A. §§6601(e); 6124(a),(b); 6329(a),(b)

PID determined that the proper RBC ratio for Highmark and Independence Blue Cross was between 550 and 750%, while a proper ratio for Capital Blue Cross and Blue Cross of Northeastern Pennsylvania was between 750% and 900%.[84] Although the question of whether these levels of reserves are correct is a contentious issue, it is clear that the PID has broad authority over the surpluses and reserves of non-profit health insurers.

3. Data

The National Association of Insurance Commissioners (NAIC) runs an electronic filing system known as the System for Electronic Rate and Form Filings, or SERFF. It allows insurance companies, for a fee, to submit rate, form, and other filings electronically, thus reducing labor and expenses. Pennsylvania went on the SERFF system in January 2008. Until that time, insurance companies submitted paper filings which were not scanned and made available over the internet.

SERFF allows for a great deal of information to be entered into on-line forms, including Company Name,

[84] *In Re: Application of Capital BlueCross*, Misc. Docket No.

Product Name, Reviewer Names, and Type of Insurance. *There is a field for overall rate impact, but unfortunately this is usually left blank.* If information on rate impact, number of users, and the additional premium revenues generated by the rate increases were always included, it would be easy to get a very accurate reading on inflation in the health insurance industry. A variety of other information can also be submitted to SERFF, such as correspondences between insurance departments and companies and supporting documentation like rate experience tables. This information is made available to the public over the PID website. However, one comes across documents within those filings that are not public. This is generally because companies have requested to keep the documents confidential so their competitors cannot see them and gain commercial advantage. Filings that are finally disapproved are also not available on the PID website. In addition, the PID does not publish compiled data that it uses internally or provides to the General Assembly when requested.

During the period between January 2008 and April

MS05-02-006, Determination and Order, 2/9/2005, pg. 37.

2010 there were 3548 filings listed on the Pennsylvania Insurance Department website. The PID interface is only for filings that were ultimately approved. Filings that received final rejections are not included. According to most of the actuaries at PID *final rejections are few and far between*. As for the PA Bulletin, the PID posted 629 announcements during this period, 246 of which pertained to rate filings. The PID announcements included some information that was not always available from the SERFF text-based data, such as the number of contract holders who would be impacted and the total monetary value of the rate increase.

Again, in Pennsylvania, all individual policies are regulated. Small groups are subject to rate regulation for increases above 10%. All Medicare supplement policies are subject to annual rate approval, whether they are group or individual. The PID's rate reviewers are supposed to make sure that proposed rate changes are "not excessive, inadequate, or unfairly discriminatory." However, "unfairly discriminatory" has not been defined. Pennsylvania rules stipulate that proposed changes to an approved base rate of

individual policies are subject to PID review.[85] (The acknowledgement process is used for minor changes, typically in such cases where the insurer was under no obligation to file. It is simply PID acknowledging that a filing was made.) There is a variety of methodologies used by the PID for review rate filings, such as past experience and actuarial data. There is a mechanism for automatic approval of filings that are not reviewed within 45 days of filing, but this rarely happens.

Of the 3548 filings approved during the 28-month period of January 2008 through April 2010, 1579 were rate filings. These totals include basic, major medical, and comprehensive health insurance as well as other policies such as long-term care, dental, and policies covering specific disease. There were a very small handful of filings that were ultimately disapproved. Disapproved rate filings are not required to be made available to the public over the PID website. However, it is very common for rate filings to be initially disapproved and then approved following modification. There were 664 disapprovals of this kind, representing 42.1% of all rate filings. In addition, there

[85] Act 159 of 1996. Section 303(c) and Section 303(e)(2).

were the 246 rate filings that were posted in the Pennsylvania Bulletin (PA Bulletin) mentioned previously. Only eleven of these received initial disapproval, but that is because the process of posting a filing in the PA Bulletin puts an alternative process into play for modifying rates. The substantial majority of PA Bulletin filings were granted increases for less than what was initially requested.[86ii] The PA Bulletin is for high profile filings, in particular for the Blues and for HMOs. The PID does not publish filings in the PA Bulletin if the rate increase is below 10% and the number of members affected is not large. [87]

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[86] There were 644 rate filings whose SERFF data specified rate impacts -- 346 below 10% and 298 at or above 10%. Of these 644 filings, only 12 were "acknowledged" as opposed to “approved” -- four for less than 10% and eight for more than 10%. However, at least two of these were for individual HMO products that should be under PID's approval authority, and three others impacted enough people that they were advertised in the PA Bulletin.

[87] From the PID's Project Narative that was part of an application to the U.S. Department of Health and Human Services grant. (http://www.portal.state.pa.us/portal/server.pt/document/1224501/project_narrative_cycle_i_pdf&ei=amTDUeH-LbjJ4AOMwoGoBA&usg=AFQjCNFTqV63WURWJLxi0SqvPOge9TRvNA&bvm=bv.48175248,d.dmg). The grant application was for the following: Department of Health and Human Services - Grants to States for Health Insurance Premium Review-Cycle I, Initial Announcement: Invitation to Apply for FY 2010
(CFDA: 93.511,

Each time a filing is listed in the PA Bulletin, there is a public comment period of 30 days and then the PID must reach a decision within 45 days after that. Moreover, it usually takes a couple of weeks before a filing is posted in the PA Bulletin. This slows down the review process and allows for considerable correspondence between PID actuaries and insurance companies over the justifications for the requested rate increase.

There is also a procedure for holding public hearings on rate filings, but is not considered cost effective and almost never happens. Also, the Commissioner may exempt rate filings from review under his or her discretionary power from Act 159, Section 3, but this has not happened in recent history. Notices of filings are also listed in the newspaper on an ad hoc basis.

4. Summary and Recommendations

At a Pennsylvania House of Representatives Insurance Committee hearing on July 20, 2010, Insurance Commissioner Joel Ario commented that following the

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http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/Downloads/final_premium_review_grant_solicitation_with_disclosure_statement.pdf

financial crisis of the autumn of 2008, his department tried to rein in premium hikes to less than 10%. (Before the crisis, insurance companies tended to make annual rate applications that often requested increases well in excess of 10%.) This prompted House Committee Chairman DeLuca to ask "why 10%, why not 5%?"[88] With so many people suffering from the economic downturn, the notion that the PID felt that it was keeping rates in check by holding increases to below 10% seemed odd given that underlying inflation during the past decade has been less than a quarter of that rate. As mentioned above, it is entirely likely that medical providers share a large portion of the blame for spiraling health care costs. To the extent that insurers can demonstrate to regulators that their costs are going up, they will likely be granted rate hikes. However, the experience data that is submitted with many rate filings shows that the administrative costs and sales commissions for many policy products is considerable. Additionally, the publicly available financial records for the insurance companies confirm that insurance companies are a big part of the

[88] July 20, 2010 hearing before the PA House Insurance Committee and House Democratic Policy Committee, William E. Anderson Library of Penn Hills

problem.

Improvements are necessary in both the quality of the information available to consumers and the outside review of rate increases. In order for this information to be impactful, outside interests representing consumers must be able to participate in the process. We recommend the following:

- All approved, disapproved, and ongoing filings should be available on the PID website's Rate and Form Filing Search Page in order for consumers to have an accurate picture of the PID's rate review process.
- Filings should be accompanied by the rate review formulas used by the PID and any criteria used in the PID's decision.
- All correspondence between the PID and the insurer should be in the public record.
- There should be annual reporting requirements whereby the PID would release aggregate data on filings and other relevant information.
- An Office of Consumer Advocate for Health Insurance should be established.
- Approved rate increases (as opposed to requested increase) should be made available in a more readily accessible format than an image file. The NAIC should

> add an “approved rate” field to the SERFF system so that people would not have to peruse through dozens of pages of document images in order to find the approved rate for a given filing.

As mentioned earlier in this paper, there are a multitude of reasons for our health care crisis, such as the massive waste and inefficiency of the private insurance industry, the failure by hospitals and doctors to contain costs, profiteering among suppliers of pharmaceuticals and medical equipment, and increased utilization (for both justifiable and unjustifiable reasons) of more expensive procedures. As we shall see later, excessive malpractice claims also play a role. While the PID’s regulatory authority can be aimed at only a small corner of the problem, it could be used more effectively.

It does not seem from the data that the PID is in the pocket of the insurance industry. The PID routinely uses its review and approval process to pare down the premium increases submitted to it by insurance companies. The PID’s actuaries diligently examine experience data and actuarial forecasts to make sure that the premium hikes are

justified by rising past and/or expected payments by the companies. However, the PID cannot look into whether the rising health care costs themselves are justified. Stated in other words, the paradigm that they are operating in is one in which insurers can pass on all their higher costs to consumers. And this is the problem.

What is needed is for the PID to emphasize their mission of public interest over assuring the financial well-being of insurance companies. Obviously, insurers need reasonable reserves in order to carry out their contractual obligations, but the massive reserves of Pennsylvania's Blues ($4 billion for Highmark[89] and almost as much for Independence Blue Cross) and the substantial profits of the investor-owned insurers demonstrate that inadequate reserves is hardly a pressing problem. The PID cannot regulate the prices that hospitals charge for procedures or pharmaceutical companies charge

[89] Fábregas, Luis: "Cash isn't cure-all for Highmark" TribLIVE News (Monday, March 18, 2013)
Hhttp://triblive.com/investigative/luisf%C3%A1bregas/3240824-74/highmark-health-pay#axzz2YDBGhe1d
Also Davis, Steve: "Will Record Surpluses Among Not-for-Profit Blues Plans Trigger Price Wars in 2011? (with Table: Not-for-Profit Blues Plans Hold $27 Billion in Excess Capital)" Health Plan Week, (December 20, 2010, Volume 20, Issue 45)
http://aishealth.com/archive/nhpw122010-01

for drugs. However, companies such as Highmark and Aetna could use their massive purchasing power to hold costs down if that was needed in order to protect their bottom lines. The PID needs to look beyond simple premium and payment data for narrow insurance products. The PID should do the following:

(1) Scrutinize administrative costs more thoroughly before approving any rate hikes, as the logic of increases for healthcare costs does not apply to administration, which if anything should have become more efficient with the introduction of technology. The decline in medical loss ratios seen over the past two decades indicates that administration is actually becoming less efficient.

(2) Should seek authority to reject premium increases as long as companies are paying executives bloated salaries, saturating airwaves with commercials that are of no use to existing policy holders, and reaping large company-wide profits. As long as insurance companies know they can always get higher premiums, they will have no incentive to pressure providers and suppliers to hold down prices,

which is absolutely necessary.

(3) Increase the transparency of insurance company rate case filings. The PID has already gone a long way towards this goal by making SERFF filings available over the internet on its homepage. This massive amount of data is indispensable to anyone wanting to monitor the insurance industry. However, some changes need to be made in order to make the data more useful to self-appointed watchdogs, including the recommendations listed in Appendix C. (For a more detailed list of recommendations as to how the PID can improve its data systems, please see Appendix C.)

Some necessary changes are beyond the powers of the PID, and will require action by the PA General Assembly. Specifically, the regulatory authority of the PID also needs to be expanded to cover the small group market even for rate cases below 10%. In fact, the PA General Assembly should transform the PID into something akin to the Public Utility Commission so that any premium hikes will have to go through a transparent public hearing process. Policy holders should be given notice of requested rate hikes, and public hearings should be held if certain criteria

are met.

We have reached a situation in which insurance companies are contending that they need ever-rising premiums in order to cover medical expenses and overhead, yet consumers are increasingly finding it impossible to pay for insurance and out-of-pocked medical expenses. In this clash of interests between insurance companies and consumers, something has to give. If health insurance companies are unable to serve the needs of PA residents then it is time to think about alternative means of providing health insurance to consumers. Part of the PID's review criteria is to consider what rates are adequate or inadequate to maintain the financial health of the insurance companies, and judging by the profits and surpluses enjoyed by the companies and the rapid premium increases endured by consumers, it seems that this is emphasized over the PID's role of protecting consumer interests. This must change. If the PID reviewers are unable, either by legislative constraints or by organizational disposition, to regulate in such a way as to maintain the financial health of insurance consumers, then this should be remedied, and the Pennsylvania General Assembly must be ready to make

that happen. In an environment where the rolls of the uninsured are growing year after year, it is safe to say that with each rate increase consumers are losing health care. Too many people are at risk right now to sit around and wait to see if the PPACA "reforms" will actually help anything when they start to kick in after 2014.

Section D – The Patient Protection and Affordable Care Act and its Implications

1. Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act was signed into law by President Obama with much fanfare. The bill is 906 pages long[90], and there are widespread expectations for considerable change in how health insurance operates once most of the bill's provisions go into effect in 2014. Just whether those changes will be beneficial or detrimental is a matter of some debate. Regardless, the main purpose of this section is to identify just what changes can actually be expected and what the Pennsylvania Insurance Department should do to prepare itself.

Despite charges of this being the start of "socialized medicine," private and nonprofit health insurance companies, such as the Blues, will continue to insure the bulk of the American population and will likely pick up

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(Hhttp://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdfH or http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf)

millions of new customers due to individual mandates (or “personal responsibility requirements”) for purchasing insurance, subsidies for small businesses to provide health insurance benefits, and penalties against large companies that fail to insure their employees. The failure to create any "public option" means that the number of Americans covered by some sort of government-run system (Medicare, Medicaid, VA, etc.) will not experience the same growth, although Medicaid will be expanded and the VA system should continue to pick up more patients as a result of continuing wars. Proponents of the bill tout the following improvements to the health care system:

- Millions of people will gain health care coverage due to individual mandates, with tax credits and subsidies available to help lower income people afford premiums and out of pocket expenses.
- Pre-existing condition exclusions have been eliminated in non-grandfathered policies for children under 19 in 2010, and then expanded to all ages starting in 2014.

- Medical underwriting (the practice of using medical health history to determine whether to offer coverage and premiums amounts) will be ended.
- After June of 2010, temporary mechanisms were established to provide coverage to individuals with pre-existing conditions and for non-Medicare eligible retirees over 55.
- Rescissions for unintentional mistakes in applications have been banned.
- Lifetime benefit limits on policies issued after September 23, 2010, have been eliminated. Annual benefit limits are being phased out and will be eliminated by 2014 for all plans except grandfathered individual plans.
- Dependent children are allowed to stay on parents insurance until age 26.
- Plan members may designate any available participating primary care physician as their provider.
- Insurers will no longer be able to charge higher copayments and coinsurance for emergency services out of network.

- Blue Cross Blue Shield insurers are required to maintain a medical loss ratio (the proportion of premium dollars that an insurer spends on health care) of 85% or higher to take advantage of IRS non-profit tax benefits.[91]
- PPACA will extend eligibility for Medicaid to all individuals earning up to 133% of the Federal Poverty Level ($29,326 for a family of four in 2010), unless the state opts out of expanded Medicaid.

Critics of PPACA make a number of charges. Some of these charges (such as "government death panels") have little basis in fact and are basically political scare tactics, thus we will not deal with them. Other criticisms have some merit. These come in two broad categories. The first type contends that the touted improvements are not as good as they are billed to be. The second type claims that the costs of PPACA are not sustainable.

The first type of criticism includes several examples.

[91]PPACA SEC. 9016 (a) (5) [page 754], which refers to Subsection (c) of section 833 of the Internal
Revenue Code of 1986.

For one, the temporary coverage for individuals with pre-existing conditions is insufficant. Adults with pre-existing conditions applying for coverage through the temporary high-risk pool prior to 2014 have had to go without coverage for six months before becoming eligible, and then the insurance has co-insurance rates (the portion of medical bills that must be paid by the policy holder) as high as 35%, and out of pocket costs as high as $11,900, not including premiums for a family. Regarding rescissions, it will still be up to the insurance companies to determine whether a mistake on the form was intentional or not. It might seem that the ending of medical underwriting should remove the incentive for applicants to withhold information, or even for companies to ask questions about health history on their enrollment forms. Moreover, tobacco is the one health factor that can be considered in setting premiums, and PPACA specifically states rescissions will not be allowed in the event that tobacco usage is misstated on enrollment forms.

However, as we will demonstrate below, there is a potential loophole in the form of “wellness programs.” It remains to be seen whether this loophole will be exploited

to continue some form of medical underwriting, and if so whether companies will try to rescind policies based on intentional misrepresentations on enrollment forms that include wellness program discounts.

The ban on lifetime and annual limits is only for "essential health benefits" as defined by the Department of Health and Human Services.[92] Also, medical loss ratios can be manipulated by recategorizing some administrative expenses as medical.[93]

The second category of criticism attacks the costs of the law. Opponents on the “left” complain that the law does

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[92] Essential Health Benefite are:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance abuse disorder services;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care.

From “HHS defines 'essential health benefits' under PPACA,” By Edward I. Leeds and Jean C. Hemphill, Employee Benefit News (http://ebn.benefitnews.com/news/hhs-defines-essential-health-benefits-ppaca-2729494-1.html).

[93] http://www.pnhp.org/news/2010/june/questions-and-answers-about-benefits-under-the-patient-protection-and-affordable-care

little to contain runaway costs and leaves for-profit health insurers in an even stronger position. Opponents on the "right" say that the subsidies incorporated into the law will put too much strain on the budget. Questions about the constitutionality of the requirement to purchase insurance from a private company were resolved by the Supreme Court in 2012, which found that Congress could impose an individual manadate under its Constitutional power to levy taxes.

2. PPACA Issues

a) Medical Loss Ratio

PPACA requires that health plans report their medical loss ratios starting with plan year 2010, and then starting in 2011 maintain minimum medical loss ratios of 85% for plans in the large group market and 80% in the small group and individual market. If these minimums are not met then the difference will be refunded to policy holders.

The imposition of a minimum for medical loss ratios is intended to ensure that a high percentage of premiums paid go towards medical expenses and not

excessive profits, administrative overhead, sales commissions, executive pay, and advertising. It would seem to be a positive step towards limiting runaway premium hikes. However, the move could be insufficient or even backfire for one of two reasons. First of all, insurers could reclassify some of their administrative expenditures as health care spending. The wording of the bill is vague, and it is conceivable that all sorts of expenses currently categorized as administrative could be claimed as "improving health care quality." [94] For example, Highmark's Vice President Michael Warfel in September 2010 stated in a public forum that perhaps wellness programs should be counted as medical services. [95] Wellness programs no doubt can conceivably be "activities that improve health care quality" as stipulated in the PPACA text, but as discussed below there are concerns that they also might be used to do an end-run around the ban on medical underwriting. Moreover, others have proposed

[94] Paragraph (2) of the relevant section refers to "activities that improve health care quality." See the Medical Loss Ratio section of the PPACA Appendix.

[95] PCNTV, September 9, 2010. He was speaking before the Pennsylvania Business Council Education Found

counting fraud prevention towards the medical loss ratio.[96] Fraud prevention expenses would likely go towards identifying grounds for rescinding policies.

However, there is second way that insurers could maintain high administrative spending and profits without running afoul of medical loss ratio requirements. This would be to collude with providers like pharmaceutical companies and hospitals to hike overall costs. A demonstration that underlying cost trends are rising is usually sufficient to get a premium hike approved by the Pennsylvania Insurance Department. Therefore, higher health care costs lead to higher premiums, which result in greater unrestricted funds being available after applying the minimum 80-85% of premium revenue to medical services. Until now, insurers have had at least some interest in negotiating lower prices with providers, because the less money they spend the more money they keep. However, with 80-85% of premium dollars having to go towards medical services, the opposite becomes true. Seeing as they

[96] America's Health Insurance Plans, the health insurance industry lobby group, laments that PPACA "turns-back-the-clock on efforts to improve quality and root out fraud and abuse by only allowing recoveries from fraud programs to be counted towards the MLR (while capping expenses to prevent or deter fraud)."

can only keep 15-20% of premium dollars for administration and profits, most of the money they save by negotiating lower prices with providers could just wind up being passed on to policy holders. In fact, there is an incentive created to shift administrative expenses from the insurance companies to affiliated health providers where they can be recategorized as "activities that improve health care quality." Additionally, the use of a medical loss ratio as a metric may lead to more insurer/health provider mergers. While one might hope that competition will limit such premium hikes, it has been the experience of the past few decades that premiums are on a constant upward spiral despite the current level of competition. Increased cross ownership between provider and insurer entities and the resultant increase in market concentration and market power can only lead to higher premiums.

At present, the requirements for minimum loss ratios in Pennsylvania are among the lowest in the nation.[97]

(http://ahip.org/Issues/Medical-Loss-Ratio.aspx)

[97] America's Health Insurance Plans "State Mandatory Medical Loss Ratio (MLR) Requirements for Comprehensive, Major Medical Coverage: Summary of State Laws and Regulations (as of April 15, 2010)," (http://www.naic.org/documents/committees_e_hrsi_comdoc_ahip_chart_mlr.pdf)

A new plan in the individual market can gain approval with an initial medical loss ratio of 50% over the lifetime of the plan, although subsequent rate hikes require a 60% medical loss ratio. Medical loss ratios are typically not scrutinized in rate cases in Pennsylvania.[98] To the extent they are considered, the PID does not necessarily seek high ratios that would be beneficial to consumers. The following passage in a reply from the PID to a request from UPMC to establish a new product shows that the PID can be more concerned about the financial health of the company:

> "Pursuant to Title 31 Pa. Code sec. 89.83(b)(1) the minimum loss ratio for individual accident and health filings is initially 50% (lifetime) and for rate increases 60%. With this in mind, UPMC has priced its products using loss ratios, depending on the product, ranging from 79.7% to 80.8%. Given the statutory loss ratio requirements, does UPMC believe its pricing strategy can be sustained over the long term?"[99]

It is noteworthy that the medical loss ratios proposed by UPMC that raised the concern of the PID

[98] A computer search for the term "loss ratio" showed that it appeared in 1028 out of 4238 rate filings submitted between January 2008 and July 2010, or 24.3% of rate filings.

[99] http://www.insurance.state.pa.us/serff_filings/PAAH-125781816.pdf,

barely, if at all, met the level that will be legally required under PPACA. On the other hand, none of the SERFF filings from 2008 or the first half of 2009 made any reference to the "public interest." Since July 2009 there have been 28 objections from PID actuaries to rate hike increases based on their not being in the public interest (out of 1241 approved rate filings during the period). That comes to just over 2%. Prior to July 2009, such objections were even more infrequent. In 2009 PID implemented a general policy of not approving rate increases over 10%.

b) Actuarial Value

Comparing one policy to another can be extremely difficult. One measure, of course, is price. However, health insurance policies, with their 100-page "agreements,' do not lend themselves to easy apples-to-apples comparisons. They may have different deductibles, different coinsurance levels, and different out-of-pocket maximums. If they rely on networks of providers, then the scope and quality of the network and the in-network discount matter. And of course, just what procedures and medications are covered by the

policy impact its value. Furthermore, when a policy holder files a claim, the quality of customer support is a factor in the value of a policy. PPACA tries to make it easier to compare policies. The first way is to define "essential health benefits" that all policies sold in the Exchange must include. Of course, some policies will include "non-essential" benefits, and this will blur comparisons to a degree. The second way is by utilizing actuarial values of policies.

The actuarial value is the proportion of medical payments incurred by the average person in a standard population (not just the group or market that the plan is sold to) that the plan would pay for. The Actuarial Value Calculator developed by the U.S. Department of Health and Human Services is based on claims data from the Health Intelligence Company, LLC (HIC) database for calendar year 2010. This commercial database includes detailed enrollment and claims information for individuals who are members of several regional insurers and covers over 54 million individuals enrolled in individual and group health plans.[100]

[100] Department of Health and Human Services: *Patient Protection and*

So actuarial value is simply the proportion of medical expenses shouldered by the plan. Plans with the same actuarial value can have very different combinations of deductibles, co-insurance rates, and out-of-pocket maximums. Plans can achieve a given actuarial value with very little or no deductable by having a high out-of-pocket maximum or low co-insurance rate. This is better for people who are so deterred by having to pay full price for the first dollars of health care that they will avoid going to the doctor altogether, even for routine or preventative care. Alternatively, plans with a high deductable can still meet the same actuarial value standard by lowering the out of pocket maximum and raising the coinsurance rate. These plans are better for people who are willing to set aside some funds to pay for the first dollars of health care and are more interested in limiting their exposure should they face a serious health issue.

A consumer can get a low deductable, a low out of pocket maximum, and high co-insurance rate by getting a policy with a high actuarial value, such Highmark's

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Affordable Care Act; Actuarial Value Calculator Methodology (http://www.cms.gov/CCIIO/Resources/Files/Downloads/av-calculator-methodology.pdf).

DirectBlue. Of course, this policy will come with a higher monthly premium. A consumer can generally save money on monthly premiums by purchasing a policy with a lower actuarial value, but will pay much more out of pocket when they seek healthcare. However, the link between actuarial value and premium can be loose. As noted in the chart below, Assurant Major Medical "CoreMed" Plan with a $2000 deductable is considerably more expensive than Highmark's AdvancedBlue and SimplyBlue plans, despite a much lower actuarial value.

The actuarial value is primarily based on deductibles, co-insurance rates, and out-of-pocket maximums. It does not consider the quality or size of any network, nor does it look at the level of discounts negotiated with providers. After all, each insurer negotiates its own in-network deal with providers, and the discounts can vary. A policy from an insurer with a very large in-network discount from its providers could conceivably cost the policy holder less in out-of-pocket costs than would a higher actuarial value policy from an insurer with a worse in-network deal. It would be of great value to consumers if the Insurance Department could see to it that

information on provider networks, including in-network discounts, was made available to the public.

Sample medically underwritten policies currently available in Western Pennsylvania (February, 2013)

	Highmark Direct-Blue	UPMC Individual Advanage EPO	Highmark Single Advanced-Blue	Highmark Simply-Blue	Assurant Major Medical CoreMed Plan	Assurant One-Deductible PPO	Assurant Major Medical CoreMed Plan
Deductable	$250	$500	$1200	$500	$2000	$5000	$3500
Coinsurance	90%	80%	90%	80%	80%	100%	50%
OOP Max	$1500	$1500	$3200	$4500	$5500	$5000	$5500
Actuarial Value	88.90%	86.20%	81.30%	81.00%	68.80%	63.00%	62.10%
Premium (female 50-54), current	$380.4	$321.66	$245.75	$218.75	$275.61	$211.97	$219.49

(Actuarial rations calculated using the Department of Health and Human Services Actuarial Value Calculator, released in November 2012[124]

[124] CCIIO posts actuarial value calculator: LifeHealthPro (http://www.lifehealthpro.com/2012/11/27/cciio-posts-actuarial-value-calculator) The actual calculator can be found at the following URL: http://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsm.

c) Pre-existing conditions and Medical Underwriting

One of the most potentially beneficial aspects of the PPACA is the ban on using pre-existing conditions to deny insurance coverage or to set discriminatory premium rates. Insurers are not allowed to impose any preexisting condition exclusion and companies are limited from considering anything in setting premiums in the individual or small group market other than the number and structure of family members, the geographic rating area, age (up to a 3:1 differential), and tobacco use (up to a 1.5:1 differential) unless the plan is grandfathered. (See Appendix A).

This appears to limit the use of health status or pre-existing conditions in the setting of premiums. However, there is a potential loophole: wellness programs. (Wellness programs are health promotion programs, activities, or policies implemented by insurance companies or employers to support healthy behavior and improve health outcomes.) While the law states that rewards in the form of premium discounts under a wellness program shall not be based on health status, it does provide an exception if the reward is no more than 30% of the cost of coverage.

(For instance, if the monthly premium was $100, the discount for participants in the wellness program could be no more than $30.) This could be increased to 50% should the Secretaries of Labor, Health and Human Services, and the Treasury determine the increase to be appropriate. Wellness programs come in many forms, and could include attending presentations about healthy lifestyles or participation in a work-out routine at a gym. There are further stipulations that the program must not be a subterfuge for discriminating based on a health status factor or highly suspect in its method, but insurance companies may very well push the envelope on these vague prohibitions.[101] Moreover, there is a grandfather clause covering wellness programs (although no such exception for pre-existing conditions), so more blatantly

[101] PPACA, pp.38-40.
According to California State Senator Bill Monning, "employees of CVS, a national drug chain, were told they had to undergo medical screenings and disclose their personal health information to CVS's insurance company or pay a monthly penalty of $50. CVS calls this a "health screening and wellness review....Another problematic scenario would occur if an employer were to levy varying premium rates based on an employee's ability to achieve a specific weight loss goal, a decrease in blood pressure or an improved body mass index."
Bill Monning: "Sen. Bill Monning: Employer health programs can backfire on employees" *The Mercury News*, April 29, 2013 (http://www.mercurynews.com/opinion/ci_23134392/sen-bill-monning

discriminatory wellness programs that were already in operation on the date that PPACA was enacted may remain in effect permanently.

A 30% wellness program discount combined with the lower premiums for non-smokers means that two people the same age and in the same location could pay substantially different premiums, with the smoker who does not get the wellness program discount paying 114% more than the non-smoker who qualified for the discount. A 50% wellness program discount increases that differential to 200%. For reference, at present a Tier 7 (highest-risk tier) policy holder with Highmark's Direct Pay PPO Blue pays about 90% more in premiums than a Tier 1 (lowest risk) policy holder of the same approximate age.[102] Keep in mind that a Tier 7 policy is still considered medically underwritten, and about one in five people applying for Direct Pay are rejected without even being offered a Tier 7

-employer-health-programs-can-backfire)

[102] Some medically underwritten policies accept applicants with certain pre-existing health conditions or medical histories, but at a higher rate. Tier one refers to people with no medical problems targeted by insurance companies. In the case of Highmark's Direct Pay PPO Blue, there are currently seven tiers, with Tier 7 considered the highest risk and paying the highest premiums.

policy.[103] Highmark's guaranteed issue policy has a set premium that is NOT based on age or gender, and it is currently $695 per month. This is LESS than a person over the age of 55 would pay for the Tier 7 Direct Pay PPO Blue with the same $500 deductable, although more than three times as much as someone under the age of 30 would pay for a Tier 7 policy.[104] The bottom line is that even after PPACA goes into effect, there will still be wildly divergent premium rates based on medical status (i.e. smoker or wellness program participant. For lower income people this will be mitigated by government subsidies, but not for middle income people.

Also, while PPACA banned pre-existing condition exclusions for children starting in September 2010, the ban is not extended to adults until 2014. In the meantime there is a mechanism for providing coverage to adults with pre-existing conditions. (See Appendix A). However, as mentioned earlier, to be eligible one must go without coverage for six months. Also, the actuarial values of the policies can be as low as 65%, with the out of pocket

[103] SERFF filing HGHM-128122104
[104] SERFF filing HGHM-128557959 (http://www.insurance.state.pa.us/serff_filings/HGHM-128557959.pdf)

maximum as high as the annual limit for Health Savings Account donations ($5950 for an individual and $11,900 for a family in 2010), not including premiums.[105] Even after 2014, companies will be able to deny recommended treatment for a condition and insist on a cheaper treatment, and thus avoid withholding "coverage."[106] Moreover, grandfathered plans, while they will have to accept applications from people with pre-existing conditions, will not have to offer them the essential benefits coverage required of plans offered through the Exchanges. In other words, **people with pre-existing conditions will still face discrimination in that they may not be able to buy policies that actually cover their needs**.[107]

The "wellness program" potential loophole notwithstanding, the combination of the prohibition on considering medical conditions when pricing policies and the end of pre-existing exclusions for adults in 2014 mean

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105 http://www.pnhp.org/news/2010/june/questions-and-answers-about-benefits-under-the-patient-protection-and-affordable-care#2

106 http://www.pnhp.org/news/2010/june/questions-and-answers-about-benefits-under-the-patient-protection-and-affordable-care#2

107 http://www.pnhp.org/news/2010/june/questions-and-answers-about-benefits-under-the-patient-protection-and-affordable-care#7

that, at least formally, medical underwriting will be a thing of the past. (Medical underwriting is the process whereby an individual's health information is used in deciding whether to offer or deny coverage; and then what premium rate to set for the policy should coverage be offered.) Only family structure, geographic location, age, and tobacco use can be considered in setting premiums. This is a good thing from the point of view of ending discrimination against people based on medical factors. On the other hand, the healthy people whom the insurance industry has cherry picked for relatively low-priced medically underwritten policies will likely have to start paying considerably higher premiums for what will in effect be guaranteed-issue policies.[108] One would hope that the infusion of healthy people into the guaranteed-issue pool (which is full of higher-risk people that for-profit companies have left to the Blues) would bring down premiums for this type of insurance. However, insurance companies will likely claim

[108] PPACA. p.38, SEC 2735(a) states: "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage." Non-profit blues like Highmark already do this, but they are able to turn people down for less expensive medically underwritten policies provided they offer them guaranteed issues policies, which are considerably more expensive

that the end of pre-existing condition exclusions means that they have to pay for treatment that they previously did not have to cover (because new policy holders were excluded for a certain period of time from coverage for pre-existing conditions), thus driving up their costs. They can also argue that many people will opt to pay the tax penalty for not carrying coverage until they get sick, and then will apply for policies that insurers will be forced to issue them, including coverage of their newly acquired conditions. The PID should monitor changes in the risk pool and push for premium decreases when warranted.

d) Rescission

Rescission is the practice of canceling a policy (usually during the first two years after being issued) based on misrepresentations made by the policy holder on application forms. PPACA includes a much heralded ban on rescissions for all policies, including grandfathered ones, but the actual wording of the ban refers only to unintentional mistakes.[109] It will still be up to insurance

[109] PPACA, p.13. "A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is

companies to determine whether a mistake on an application form was intentional or not. When faced with potentially high benefits payments, a company can still comb through an enrollee's application to search for errors that they could claim as intentional. **However, cancelling coverage in order to simply avoid paying benefits is already illegal, but according to Physicians for a National Health Program, it is just that state regulators have not always strictly enforced the prohibition**.[110] Part of the problem is determining the motivation for cancelling coverage. Insurance companies claim to be motivated by the desire to "prevent fraud." Still, as we show below, some companies launch investigations of all people who are diagnosed with certain expensive to treat conditions, such as breast cancer. And there is evidence of cases where insignificant and unrelated misrepresentations were used as

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covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage." See also Hhttp://edocket.access.gpo.gov/2010/pdf/2010-15278.pdfH, p.7 for grandfather issue.

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http://www.pnhp.org/news/2010/june/questions-and-answers-about-benefits-under-the-patient-protection-and-affordable-care#5

the basis for rescissions.[111]

From a Monty Python sketch

Vicar: It's about this letter you sent me regarding my insurance claim.
Insurance agent: Oh, yeah, yeah - well, you see, it's just that we're not, as yet, totally satisfied with the grounds of your claim.
Vicar: But it says something about filling my mouth in with cement.
Insurance agent: Oh well, that's just insurance jargon, you know.
Vicar: But my car was hit by a lorry while standing in the garage and you refuse to pay my claim.
Insurance agent: Oh well, Reverend Morrison, in your policy it states quite clearly that no claim you make will be paid.
Vicar: Oh dear.
Insurance agent: You see, you unfortunately plumped for our 'Neverpay' policy, which, you know, if you never claim is very worthwhile, but you had to claim, and, well, there it is.[112]

Unfortunately, this bit of absurdity all too often has reflected a reality of the American health insurance

[111] CNN.com: "Cancer patient tells of rips in health insurance safety net" June 16, 2009 (http://edition.cnn.com/2009/POLITICS/06/16/health.care.hearing/).
[112] Monty Python Scripts: Motor Insurance Sketch (http://montypython.50webs.com/scripts/Series_2/21.htm)

industry: rescission. It then becomes as if the policy never existed. No claims are paid, and premiums are refunded. The amount of the refunded premiums, of course, can be dwarfed by the size of the medical bills of the person making a claim. Some companies such as Wellpoint and Assurant have been found to launch investigations seeking withheld information automatically upon claims being made for certain expensive-to-treat conditions, such as breast cancer and HIV.[113] Although the industry contends that this is a rare occurrence affecting only about 1% of policy holders, claims for expensive-to-treat ailments are also rather rare during the first two years of a policy. Policy holders who need expensive treatment within the first two years of a policy (the period during which recissions are generally allowed) are quite likely to have their applications reviewed, and in such cases rescissions are not

[113] Reuters: "Insurer targeted HIV patients to drop coverage," http://www.reuters.com/article/2010/03/17/us-insurers-idUSTRE62G2DO20100317.
Reuters: "WellPoint routinely targets breast cancer patients," http://www.reuters.com/article/2010/04/23/us-wellpoint-breastcancer-idUSTRE63M5D420100423.
Los Angeles Times, "Blue Cross praised employees who dropped sick policyholders, lawmaker says", (http://articles.latimes.com/2009/jun/17/business/fi-rescind17.

at all uncommon.[114]

It has been pointed out that the "misrepresentations" that formed the basis for rescissions were often unintentional, such as lack of familiarity with medical jargon. Moreover, many forms used for the sake of medical underwriting lump unrelated ailments into a single category and then require applicants to check either "yes" or "no." For instance, the Aetna Advantage Plans for Individuals and Families application form includes acne and skin cancer in a single category called "Skin Conditions/Disorders." Participation in a counseling or support group is lumped together with schizophrenia. Furthermore, there is a blanket category titled "Other Conditions," which requires the applicant to check a box "yes" if he or she has consulted with a doctor about any condition or symptom not listed on the form.[115] While the form does offer space at the bottom of the application to explain the boxes checked "yes," no doubt some insurance

[114] Walter Updegrave and Kate Ashford, "The neutron bomb of health insurance" Money Magazine, February 13 2007 (http://money.cnn.com/2007/02/12/magazines/moneymag/insurance_rescission.moneymag/)

[115] Aetna Advantage Plans for Individuals and Families - HMO* and PPO** - PA (http://www.aetna.com/producer/data/iqbs/paenrollment.pdf)

applicants with acne may not want to check the Skin Conditions/Disorders box for fear of erroneously raising a red flag about skin cancer, or perhaps do not want to take time to search for the address and phone number of the dermatologist they saw five years ago about acne. Yet failure to disclose acne treatments has been used as grounds to rescind a policy, according to testimony before Congress from a Texas nurse who lost her coverage after she was diagnosed with aggressive breast cancer.[116] (According to Jeff Isaacs, the chief assistant Los Angeles City Attorney, there are "two things that really scare them [insurance companies] and they are breast cancer and pregnancy. Breast cancer can really be a costly thing for them."[117]

One problem is that a patient undergoing a physical may be tempted to ask about any condition or symptom, real or imagined, while he or she has the doctor's ear. However, if the doctor then makes note of these questions in the patient's records, the patient would then be obligated

[116] Los Angeles Times, "Blue Cross praised employees who dropped sick policyholders, lawmaker says", (http://articles.latimes.com/2009/jun/17/business/fi-rescind17.

[117] Rurray Waas (Reuters) Fri Apr 23, 2010 7:28pm EDT "WellPoint routinely targets breast cancer patients" (http://www.reuters.com/article/2010/04/23/us-wellpoint-breastcancer-idUSTRE63M5D420100423)

to state on an insurance application that s/he sought medical advice for the ailment even if no treatment was advised. Failure to reveal this when filling out the insurance form could still be grounds for rescission.[118]

Moreover, **rules issued since PPACA was passed clarify that rescissions only refer to retroactive cancellations.**[119] **Cancellations effective immediately (or "prospectively") would not be considered a rescission**, so there is still the risk of people losing coverage once they get sick, notwithstanding the fact that the insurer remains on the hook for the medical bills prior to the cancellation.[120] Will the Federal Government be effective in stopping recissions, and if they do not address it, will state insurance departments, which were not able to keep insurance companies from abusing rescissions prior to PPACA, be able to prevent a rash of prospective cancellations under PPACA?

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[118] The above mentioned Aetna application, for example, has the applicant authorize the company to access all medical records.

[119] UnitedHealthcare PPACA – Interim Final Regulations – Rescission (http://www.uhc.com/live/uhc_com/Assets/Documents/IFR_Rescission.pdf)

[120] "A cancellation or discontinuance of coverage is not a rescission if (i) The cancellation or discontinuance of coverage has only a prospective effect…"
Hhttp://edocket.access.gpo.gov/2010/pdf/2010-15278.pdfH, p.35

Even leaving aside the issue of prospective cancellations, there remain two problems. First, who is to say if an omission is intentional or unintentional? Ultimately, the courts would have the final say, but how many cases would go that far? Second, forms often ask for information that an applicant may reasonably feel is irrelevant, embarrassing, or none of the company's business. The Aetna form asks if the applicant has *ever* used any illegal substance, such as marijuana. An applicant may not want to admit in writing participation in an illegal activity, especially if it occurred decades ago. (Interestingly, the form only inquires about tobacco use in the past two years, despite the fact that tobacco use has and will continue to routinely factor into premium calculations.) Blood banks routinely ask potential donors about past homosexual activity or sex with prostitutes. If an insurance company asked similarly embarrassing questions, it is easily conceivable that an applicant, in the presence of a spouse, could feel no alternative than to conceal this information. However, such concealment would certainly constitute intentional misrepresentation and leave the applicant vulnerable to rescission, even after the PPACA

changes go into effect. Application forms for health insurance can not only be unnecessarily intrusive, but can be extremely laborious to complete, especially if one has to search for documentation of doctors' appointments from years ago. Hopefully the ending of medical underwriting will simplify the application process and make such questions irrelevant, but such lines of inquiry could find new homes in wellness program forms. The Insurance Department, which reviews new forms that insurers want to use, will have to be diligent in order to prevent insurance companies from utilizing this potential loophole.

One thing that is certain is that questions about tobacco use will remain on the form, and with potentially 50% higher premiums for smokers, there is huge potential for tobacco-based rescissions. Moreover, if medical underwriting continues under the guise of wellness programs, the possibility of rescissions based on intentional misrepresentation remains. However, the final rules issued by the Federal agencies with jurisdiction over recissions have clarified that a policy cannot be rescinded based on misrepresentation of tobacco use, and that the maximum sanction against someone who lies about their usage is that

they will have to pay the higher tobacco user rate retroactively to the start of the plan year.[121]

e) Lifetime and annual limits

PPACA prohibits group or individual health care plans that are required to provide "essential health benefits" (EHBs) from establishing a lifetime limit on EHBs for plan years beginning on or after September 23, 2010.[122]

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[121] "The remedy of recouping the tobacco premium surcharge that should have been paid since the beginning of the plan or policy year is provided under PHS Act section 2701 and its implementing regulations. As stated in the preamble to those regulations, it is the view of the Departments (which share interpretive jurisdiction over section 2712 of the PHS Act) that this remedy of recoupment renders any misrepresentation with regard to tobacco use no longer a material' fact for purposes of rescission under PHS Act section 2712 and its implementing regulations."
from: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services: "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans," Final rule, Footnote #26 (http://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinalrule.pdf)

[122] PPACA, p.13. More precise wording can be found on pp.765-766:
"A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish—
''(A) lifetime limits on the dollar value of benefits for any participant or beneficiary; or
''(B) except [prior to 2014 for essential health benefits], annual limits on the dollar value of benefits for any participant or beneficiary.
(PPACA, p.765)
''(b) PER BENEFICIARY LIMITS.—Subsection (a) shall not be construed to prevent a group health plan or health insurance coverage

Furthermore, it bans annual limits after 2014, but allows the Secretary of HHS to set limits until 2014.[123] In the case that the policy covers a family, then each member of the family has his or her own limit, regardless of whether any other member of the family has maxed out their benefits.[124]

Grandfathered individual plans do not have to eliminate annual limits.[125] Even non-grandfathered plans only have to ban lifetime and annual limits for EHBs. Moreover, grandfathered individual and group plans do not

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from placing annual or lifetime per beneficiary limits on specific covered benefits that are not essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, to the extent that such limits are otherwise permitted under Federal or State law.'' (PPACA, p.766)

[123] The Secretary subsequently set the following permissible annual limits in the group market (whether or not the plan is grandfathered) or the individual market (but not for grandfathered policies) for the three years in question:
2011 $750,000
2012 $1,250,000
2013 $2,000,000
Federal Register /Vol. 75, No. 123 /Monday, June 28, 2010 /Rules and Regulations 37192 (Hhttp://edocket.access.gpo.gov/2010/pdf/2010-15278.pdfH). Also http://odnss.com/publications/index.cfm?Fuseaction=PubDetail&publicationid=1286

[124] Federal Register /Vol. 75, No. 123 /Monday, June 28, 2010 /Rules and Regulations p.37191 (http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf)

[125] Hhttp://edocket.access.gpo.gov/2010/pdf/2010-15278.pdfH, Kaiser Family, p.6

have to include all EHBs.[126] Because 98-99% of policies already have lifetime limits set at $1,000,000 or above,[127] and seeing as the percentage of patients reaching this level is so small, the removal of the limits has only a minor impact on premiums.

Again, the restriction on lifetime limits only applies to EHBs, which were finally defined by the Secretary of Health and Human Services on February 20, 2013.[128] Plans

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http://www.pnhp.org/news/2010/june/questions-and-answers-about-benefits-under-the-patient-protection-and-affordable-care#4

127 Federal Register Volume 75, Number 123 (Monday, June 28, 2010) (http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/html/2010-15278.htm).

128 The full rule is here: DEPARTMENT OF HEALTH AND HUMAN SERVICES: "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,"
Hhttp://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf
Under the statute, Essential Health Benefits must include items and services within at least the following 10 categories:
(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.
U.S. Department of Health & Human Services: "Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage,"

may still enforce lifetime limits on specific covered benefits that are not EHBs. While the law prohibits lifetime limits on the dollar amount of benefits, nothing appears to prohibit the use of lifetime visit limits or other treatment limits, according to the private health insurance company UnitedHealthcare.[129] Although this is only one view, it is troubling that a major insurer would have an interpretation which would essentially render the elimination of lifetime and annual limits moot. In other words, while the dollar amount spent on an expensive treatment cannot be limited, the number of times the treatment is administered may be, and this would be an alternative means of a company limiting its financial exposure. Moreover, an exclusion of all benefits for a particular condition is not considered to be an annual or lifetime dollar limit. [130] The PID will need to see what, if any, means it has to stop this potential loophole from being abused.

f) Exchanges

(Hhttp://cciio.cms.gov/resources/factsheets/ehb-2-20-2013.htmlH)

[129] (http://www.uhc.com/united_for_reform_resource_center/health_reform_provisions/lifetime_limits.htm)

[130] Hhttp://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf, p.5

States must have at least one health insurance Exchange (formally known as American Health Benefit Exchanges) in place by Jan 1, 2014. If the state elects not to set up an Exchange, the Federal Government will set one up instead. Policies will be divided into four categories depending on their actuarial values: Bronze (covering 60% of medical expenses), Silver (70%), Gold (80%), or Platinum (90%). The actuarial value of a plan shall be determined on the basis of "essential health benefits" provided to a standard population, regardless of whether the population is the one the plan may actually provide benefits to. These values can be achieved through different mixes of deductibles, coinsurance, and out-of-pocket maximums. However, because PPACA limits out-of-pocket expenses to the maximum annual contribution set for a Health Savings account, silver and (especially) bronze policies pretty much have to have high deductables and are likely to have low coinsurance rates in order to fit within the lower actuarial value brackets, as is demonstrated in the chart below.

Hypothetical policies offered through the Exchange

Plat.	**Plat.**	**Gold**	**Gold**	**Silv.**	**Silv.**	**Bron.**	**Bron.**

Deduct-able	$100	$500	$500	$1200	$1700	$1200	$3650	$3700
Coinsur-ance	90%	90%	80%	90%	80%	70%	60%	40%
OOP Max	$6500	$950	$5200	$3200	$6500	$6100	$6500	$6000
Actuarial Ratio	90%	90%	80%	80%	70%	70%	60%	60%

(Actuarial rations calculated using the Department of Health and Human Services Actuarial Value Calculator, released in November 2012[131]

Premium tax credits will be based on the second lowest priced silver plan available in the Exchange. The tax credits are advanceable and available at the time of purchase of a policy in the Exchange to be used directly to pay for the policy. A person can purchase a higher value plan, but will have to pay the difference.[132] Bronze plans will not be eligible for premium tax credits at the Exchanges for individuals. The only plans that will be eligible for cost sharing subsidies (i.e., government help with the patient's share of provider costs such as deductibles and co-pays) will be individual silver plans

[131] CCIIO posts actuarial value calculator: LifeHealthPro (Hhttp://www.lifehealthpro.com/2012/11/27/cciio-posts-actuarial-value-calculatorH) The actual calculator can be found at the following URL: Hhttp://cciio.cms.gov/resources/EHBBenchmark/av-calculator-final-locked-11-20-2012.xlsmH.

[132] PPACA SEC. 1401(b)(3)(D)

enrolled in via the Exchange.[133] (Seeing as cost sharing subsidies raise the actuarial value of the silver plans at no extra cost to the policy holder, there is little point in the policy holder shelling out for a gold or platinum plan.)

PPACA does not grant the states the authority to set the premiums for plans offered through the Exchanges, although it does require that insurance companies justify any rate increases and prices to the state regulators. If the state regulators are not satisfied with an insurer's justification, the regulators may exclude the company from participating in the Exchange.[134] Furthermore, the 80-85% minimum requirement for medical loss ratio, as well as the actuarial requirements for the four metallic policy levels establishes some effective price parameters for policies.

In order to qualify for enrolling in a plan through a state's Exchange, a person must reside in the state, must not be incarcerated, and must be a U.S. citizen or legal alien.

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[133] (PPACA Sec. 1402(b)(1); IRC sec. 36B), Peterson, Chris L. and Bernadette Fernandez: "PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange" (Congressional Research Service, June 1, 2010) p.9 (http://web.archive.org/web/20120302200944/http://www.nahu.org/legislative/resources/CRS_PPACA%20Requirements%20for%20Offering%20Health%20Ins%20Inside%20V%20Outside%20Exchanges_June%2010.pdf)

[134] PPACA p.21

The state will have to be able to verify the legal residence status of anyone seeking health coverage through the Exchange. Someone offered a qualified health plan via his place of employment may not be able to shop in the Exchange for individuals, although the Exchanges will also operate a Small Business Health Options Program – or SHOP – that offers small businesses (50 or fewer employees) and their employees a variety of Qualified Health Plans.

g) Temporary high-risk pool

PPACA established temporary mechanisms to provide coverage to individuals with pre-existing conditions. Applicants must prove that they are U.S. citizens or legal aliens. They must have gone without insurance for the previous six months when they apply. They also must demonstrate that they have or likely would be excluded from purchasing private insurance that would cover their pre-existing condition. Over 10,000 individuals have enrolled in the program in Pennsylvania since its inception (in October 2010). Still, this only covered a

portion of Pennsylvanians with pre-existing conditions.[135]

The program has put an additional administrative burden on the Pennsylvania Insurance Department, which administers the program and has to determine whether an individual is a citizen or legal alien, has gone without coverage for at least six months, has a pre-existing condition, and meets other requirements.

h) Grandfathered plans

While campaigning on behalf of PPACA, President Obama repeatedly stated that “if you like your current plan, you can keep it.” This is done via the grandfathering of plans that were in existence on March 23, 2010. There is already a certain amount of confusion about what will be considered "grandfathered." Of course, the corollary to “being able to keep you plan if you like it” is being stuck with it even though you don’t like it. This could happen when the fact that a person is offered coverage at his or her place of employment disqualifies that person from being

[135] Centers for Medicare and Medicaid Services, The Center for Consumer Information & Insurance Oversight: “Covering People With Pre-Existing Conditions: Report On The Implementation And Operation Of The Pre-Existing Condition Insurance Plan Program” (http://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip_annual_

eligible for the tax credits and subsidies that can make plans offered through the Exchange affordable.

Grandfathered plans are exempted from some key PPACA provisions. They are not required to cover certain preventative care without cost sharing and without out-of-pocket maximum limits. (See Appendix A for further information.) Grandfathered plans are also not required to cover EHBs, provide for an internal and external appeals process for contesting coverage decisions, or allow direct access to an OB/GYN without referral.[136] Moreover, grandfathered plans are not eligible for premium tax credits or cost sharing subsidies, which are reserved for the qualified health plans available through the Exchanges.

i) Individual mandate

PPACA includes a "personal responsibility requirement," which mandates that most people will be required to purchase health insurance or face a tax penalty. The size of the tax penalty will be the greater of $95 ($285 for a family) or 1% of taxable income in 2014, $325 ($975

report_01312013.pdf)

[136] Focus on Health Reform, January 2012, The Henry J. Kaiser Family Fund: "EXPLAINING HEALTH CARE REFORM"

for a family) or 2% of taxable income in 2015, and $695 ($2085 for a family) or 2.5% of income in 2016. After 2016 the penalty will be indexed to increases in the cost of living.[137] However, there are exceptions to the mandate for certain groups of people, including members of Indian tribes, people with religious objections, and people undergoing economic hardship.

PPACA also stipulates that the inability to purchase the lowest-priced qualified plan (a bronze plan with a 60% actuarial value) for no more than 8% of household income exempts someone from the personal responsibility requirement.[138] Because the cost of the bronze plan is reduced by the amount of the premium credits (which are paid directly to the insurer by the Federal Government) that a person is eligible for if his or her income is less than 400% of the Federal Poverty Limit (FPL, $11,490 for a single person in 2013), it is likely that, in most areas at least,

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http://www.kff.org/healthreform/upload/8275.pdf

[137] PPACA pp.126-7, Hhttp://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdfH p.1032

[138] PPACA p.129. Actuarial values show the percentage of expenses each plan would pay if identical populations were enrolled in all plans. http://www.chcf.org/~/media/Files/PDF/H/HealthPlanActuarialValue.pdf

few people will be exempted from the personal mandate due to economic hardship.[139] (For examples of what the calculations would look like for people of selected ages and incomes, please see Appendix A). Complicating things, however, is the fact that cost sharing subsidies can only be used with the more expensive silver plans. This means a person might have to choose between paying the full price for a bronze plan that is less than 8% of income when premium credits are applied but which would be ineligible for cost sharing subsidies, or shelling out for a silver plan that would be eligible for the subsidies but could be over 8% of income for anyone with an income of 250% of the FPL or over.

For people with incomes greater than 400% FPL ($45,960 in 2013 for an individual), the premium credits do not come into play, so the only relevant issue is the mandate threshold. The older among these people, especially those that smoke, could still be unable to find a bronze plan for less than 8% of income ($3,677 per year, or $306.40 per month in the case of someone making just over 400% FPL) as their premiums can be as much as four and a

[139] PPACA p.129 SEC. 5000A(e)(1).

half times higher than a young non-smoker. For a person in their late fifties or early sixties, who is likely to be saving for retirement or paying for their children's college, and who can look forward to Medicare starting at age 65, the option of going without coverage and saving perhaps several thousand dollars a year might be an attractive one. It is certainly one that many middle-age people who currently go without insurance are already choosing.

One other situation that could result in large numbers of people being exempt from the personal mandate is the possibility of the FPL being manipulated downward. Adjustments to FPL are based on changes in the urban Consumer Price Index (CPI-U). An administration wanting to hold down expenditures on the health care subsidies set up by PPACA could simply lowball the CPI-U, and this would reduce the number of people eligible for premium credits and cost-sharing subsidies and would reduce their size for people still eligible for them. The CPI can be manipulated by changing the mix of the basket of goods and services tracked to compute it. For many people, this would effectively raise the cost of acquiring a bronze plan, putting it above the 8% threshold and qualifying them

for an exemption. Similar results would be produced by efforts to mask inflation for political purposes not directly related to health care policy.

Finally, it may prove that many people subject to the mandate choose not to purchase insurance and simply pay the tax penalty (or not pay the tax penalty and hope they don't get caught). With the elimination of medical underwriting and the reduction of price differentials based on age, premiums for young people are bound to rise[140], causing some to conclude that health insurance is not worth the cost.

j) Premium credits

One of the major provisions of PPACA designed to extend health care to people currently uninsured, is the "premium credits" system. "Refundable, advanceable" tax credits (which are available regardless of whether the person has any tax liability and may be available up front instead of when taxes are filed) will subsidize the purchase

[140] For instance, premiums effective October 1, 2009 for Highmark's CompleteCare (Western Region) $500 deductable policy had a 20-year old male paying $94.20 and a 60-year old male paying $535.65, a differential of more than 5:1. Such differential will have to narrow to no more than 3:1 in 2014. (PAAH-126753327)

of private health insurance policies by low-income people (those between 100% and 400% of the FPL). The formula for determining the size of the credit is based on the cost of the second-lowest priced "silver plan" in the taxpayer's region and the person's income. The credit is designed to cap the amount that the taxpayer must bear, with the lowest income people getting the biggest breaks.[141] For instance, if the second-lowest price silver plan costs $4000 per year, a person making $40,000 will pay $3800 and would benefit from a premium credit of $200. A person making $23,000 a year would pay $1450 for the same policy with the premium credit covering the remaining $2550. For people whose incomes are between 100% and 133% of the FPL, the cap is 2% of income, bringing the amount these people would pay annually to just a few hundred dollars, with Uncle Sam picking up the rest. (PPACA expands Medicaid so that most people in this income bracket become eligible for Medicaid, but Pennsylvania is among the states that are unlikely to implement the Medicaid expansion in 2014). People with incomes above 400% are not eligible for premium credits. For those in between, there is a formula

[141] PPACA p.96 -- Sec. 1401.(a), Internal Revenue Code of 1986, Sec.

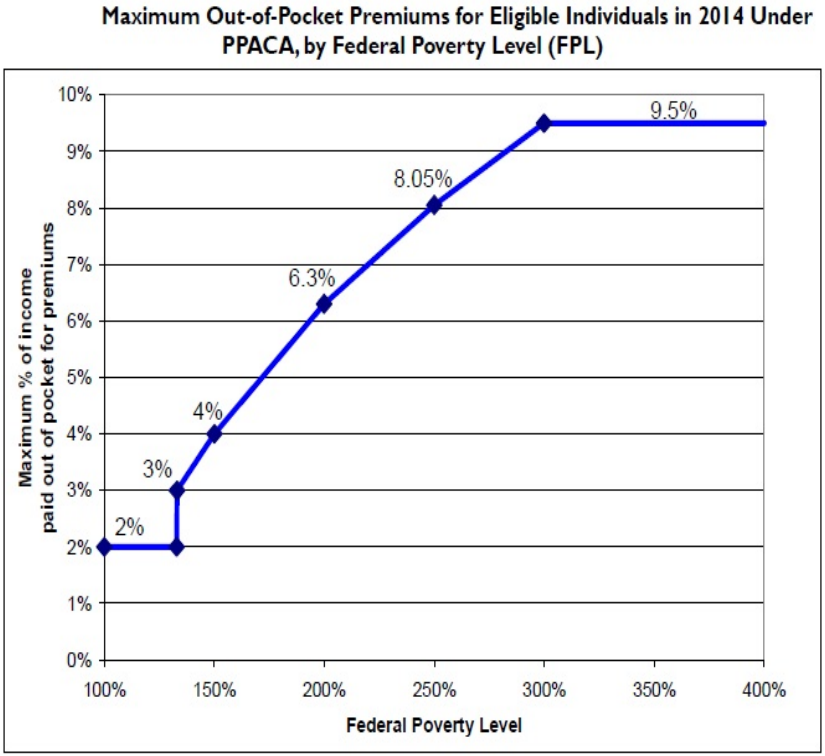
that slides from 3% up to 9.5%.[142] The federal government pays the health insurer the balance of the premium, so the individual never actually handles the "credit."

The premium credit qualification brackets will be indexed to the gap between health insurance inflation and income growth. This will keep down the cost of the program for the government by passing higher premium costs on to consumers.[143]

36B.(3)(B)

[142] Reconciliation bill, p.1031, also . (PPACA, p.96 or Subtitle E, Part I, Subpart A, Section 1401).

[143] SEC. 1401. SEC. 36B.(b)(3)(A)(iii)INDEXING.—In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.



One effect of the linking of premium and other subsidies to the Federal Poverty Level is a substantial marriage penalty in some cases. A married couple would be subject to the FPL for two people ($15,510, 2013 FPL) based on their combined incomes, whereas two unmarried people living together would each be subject to the FPL for single people ($11,490 times two). If an unmarried couple living together with both partners receiving premium tax

credits were to get married, they would see a significant reduction or elimination of their subsidies.[144] For a couple where both people are working full time at $7.80 per hour, they would pay 6.3% of income on premiums if they get married but only 3% of income on premiums if they remain unmarried. [145]

k) Cliff Effect

With the premium credits and cost-sharing subsidies (explained below) ending abruptly at 400% of FPL instead of being phased out, a "cliff effect" will appear in high-premium markets whereby a rise in income from marginally below 400% FPL to marginally above it will result in a massive increase in health insurance premiums. In some cases this could make it detrimental for spouses to earn more money and could result in situations in which employers and employees try to find alternatives to wage

[144] ''(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year." PPACA p.96 **SEC. 1401. SEC. 36B(b)(3)(B)**

[145] For a single person $7.80/hour x 40 hours/week x 50weeks = $15,600, or 135.8% FPL. For a couple with each person making this same amount, $31,200 comes to 201.1% FPL.

increases. This “cliff” effect will be felt in particular by older people who smoke.

Aside from producing a disincentive to work for certain income brackets, the people on the wrong side of the "cliff" will likely resent the very generous subsidies provided to those lower down on the income scale. It would be natural for some people who had to drop a policy they can no longer afford due to sharp premium hikes to feel that their health care was taken from them by the government and given to a lower income person who qualifies for subsidies. Moreover, the silver plans purchased by lower income people will come with cost-sharing subsidies, making them more valuable policies than the full-priced, unsubsidized policies that middle-income people who do not qualify for subsidies will be offered.

The Pennsylvania Insurance Department, which has been less than successful at holding the line on premium hikes in recent years, will have to consider the emergence of such a cliff when reviewing premium hike applications. It is quite possible that the new incentive structure being created by PPACA (generous subsidies for lower income

people in the individual market combined with a relatively weak employer mandate) will push more and more people out of group policies and into the individual market. However, it is clear that employees at varying income levels will be impacted quite differently should their company cease to offer coverage.

l) Cost-sharing reduction and out-of-pocket limits

In addition to the premium tax credits, the other main means by which the government will subsidize health care for lower income people in the individual market is through cost-sharing subsidies. Eligible individuals and families will receive cost-sharing credits to reduce the cost sharing (out-of-pocket) amounts. Annual cost-sharing limits will be established. These are to have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:

100-150% FPL: 94%
150-200% FPL: 87%
200-250% FPL: 73%

250-400% FPL: 70%[146]

The main forms of out-of-pocket expenses are deductibles, coinsurance, and co-pays. Annual out-of-pocket limits cap these expenses. However, many policies also require payment of "access fees" or "facility charges", which are similar to co-pays but can be much more expensive and do not enter into calculations about deductibles or out-of-pocket maximums.[147] (PPACA's language on cost-sharing refers to "deductibles, coinsurance, copayments, or *similar charges*," so it is possible but not certain that access fees and facility charges will be eligible for cost-sharing subsidies.)[148]

The actuarial value of a policy could be raised by decreasing the deductable, the coinsurance, the co-pays, or

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146 Hhttp://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdfH, pp.1031-32

147 Access fee is subtracted from covered charge before applying any deductables, coinsurance, or other out of pocket limit.

148 "(3) COST-SHARING.—In this title—
(A) IN GENERAL.—The term ''cost-sharing'' includes—
(i) deductibles, coinsurance, copayments, or similar charges; and
(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan." -- PPACA p.48

the out-of-pocket maximum. For very low-income working people, who typically live paycheck to paycheck and are unable to maintain health savings accounts, the initial full-price visits to the doctor prior to the deductible being met (the so-called "first dollars") can be a prohibitive deterrent to seeking medical services. Of all the ways of raising the actuarial value of the policy, the elimination of the deductible would be the best for low-income people as it would remove the obstacle of the initial full-price visits for particular complaints. Similarly, the least effective means would be to lower the out-of-pocket maximum, although the lower out-of-pocket maximums called for by the PPACA almost necessitate deductibles. The reduction of co-pays and coinsurance would fall somewhere in between in the impact on low-income consumers.

While PPACA does limit deductibles on small group plans, PPACA also stipulates that the reduction in cost-sharing "shall first be achieved by reducing the applicable out-of pocket limit." Out-of-pocket limits in general will be capped at the limit on annual contributions to Health Savings Accounts ($5950 for an individual and $11,900 for a family when the bill was written, increased to

$6,250 for individual coverage and $12,500 for family coverage in 2013),[149] but these limits will be further reduced for lower income people as follows:[150]

Out of pocket limits:
– 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);
– 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);
– 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family).

The Pennsylvania Insurance Department must be able to confirm that these reductions in deductibles, coinsurance, and co-pays actually do increase the actuarial values to the levels specified for each income group as described in the section on cost-sharing reduction. When the income brackets for out-of-pocket limits are combined with out-of-pocket subsidy income guidelines, each silver

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Hhttp://ebn.benefitnews.com/news/hhs-defines-essential-health-benefits-ppaca-2729494-1.htmlH. Also deductibles will be subject to a separate limit that, in 2014, will be $2,000 for self-only coverage and $4,000 for other tiers.

plan offered in the Exchange will have five different mixes of government subsidies, deductibles, co-pays, coinsurance, and out-of-pocket limits associated with the five different income levels. Still, in all cases the plan will pay for 70% of covered expenses. (For more details, see Appendix A). This will complicate the oversight task in seeing to it that the plans actually are offering the required actuarial value and cannot help but increase the regulatory burden on the PID.

m) Single risk pool requirements

PPACA requires that members of all health plans (other than grandfathered plans) offered by a given company in the individual market, including those enrollees who do not enroll through the Exchange, must be members of a single risk pool. There is a similar stipulation for small group plans.[151] The single risk pool requirement is very important because it means that riskier people are going to be mixed in with healthy people. Insurance companies have traditionally tried their best to separate the healthy from the risky, at least in the market for individuals. Even though

[150] PPACA, p.103

risk is best spread out over a large population, because private insurance companies are not obligated to take on higher risk people at all, they are motivated to completely exclude risky people in order to compete for healthy people based on premiums. Non-profit insurers, who are typically not able to exclude higher risk people, still need to compete with the for-profit companies, so they offer separate policies based on separate risk pools that divide healthy people from risky people. For-profit companies try to avoid risky people, leaving them largely to the non-profits and to state-sponsored programs like AdultBasic. Moreover, when the number of people in a given pool is small, the financial benefit to the plan of excluding a person with a pre-existing condition or rescinding someone's coverage can be significant – enough to impact the premiums charged and thus affect the plan's competitiveness. Of course, if the entire population was in one big risk pool, as would be the case in a single payer system, there would be no such motivation to exclude people or rescind coverage.

Another manifestation of the chopped up risk pool is that when an existing medically underwritten pool starts

[151] PPACA SEC. 1312(c)

to see its members age and become less healthy, an insurer can close enrollment in the plan (like Highmark's CompleteCare) and then go to the PID and file for premium hikes based on costs, while at the same time start a new plan with a new risk pool that it cherry picked and offer low premiums. The slice and dice risk pools reduce the insurance function (the spreading of risk), while at the same time creating huge administrative redundancies and driving up costs. The single risk pool requirement helps avoid these inefficiencies.

n) Fees for employers not offering coverage

Large employers (those with 50 or more employees) that do not offer coverage but have at least one full-time employee receiving a premium tax credit will pay a non-deductible excise tax of $2000 per full time employee, excluding the first 30 employees.

o) Credits for small employers for health insurance purchases

Starting in 2014, eligible small employers (no more than 50 employees) receive credits worth up to 50% of their

premium contributions to employee health insurance coverage. This credit gradually decreases as the number of employees in a small business approaches 25 and as the average taxable wages paid to employees exceeds $25,000.[152] The credits are only available for two years after 2014, although similar but smaller credits were made available during 2011-13. The purpose of the credits is to reduce the financial burden on a small company of offering health insurance, thereby keeping their employees out of the individual Exchange. However, the premium credits and cost-sharing subsidies available to individuals in the Exchange are generous enough in many instances that employees might be better off if their employers DO NOT offer insurance and thus qualify their employees to shop in

[152] For nonprofit (tax-exempt) organizations, the credit will be in the form of a reduction in income and Medicare tax the employer is required to withhold from employees' wages and the employer share of Medicare tax on employees' wages (with the credit thus limited by these amounts). For all other qualifying employers, it will be in the form of a general business credit. This type of credit is not refundable, but is limited by the for-profit employer's actual tax liability. In other words, if a for-profit company had a year in which it ended up paying no taxes (i.e., it had no taxable income, after accounting for all its other deductions and credits), then the small business tax credit could not be used for that year as there would be no income tax for this credit to reduce. However, as a general business credit, an unused credit amount can generally be carried back for one year and carried forward up to 20 years. (Quoted from

the Exchange. Companies with fewer than 50 employees are not penalized for failing to offer coverage, and if they can save money while at the same time making their employees eligible for a better deal at the Exchange, many may cease offering coverage.

Much more about PPACA group policies and employer regulations is in Appendix A.

Summation and Recommendations

PPACA had the opportunity to repair many of the problems that have led to the current health insurance crisis we have in this country. The Exchanges and the implementation of actuarial value-based levels of insurance along with the requirement of essential benefits will make it easier for people to compare policies in a meaningful way. The ending of medical underwriting, pre-existing conditions exclusions, and annual and lifetime limits on benefits will help people who have been sick or are in need of large amounts of care find insurance, although at the cost of raising prices for healthier people. Lower income people,

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http://bingaman.senate.gov/policy/crs_privhins.pdf)

especially the older among them, will benefit from the premium credits and subsidies. Those with incomes less than 200% FLP will be able to purchase insurance with the government paying the bulk of the premiums and most of the out-of-pocket expenses as well. These subsidies, of course, come at the expense of the taxpayer. Also, the duel requirement that individual plans offered through the Exchange by a single company must be based on a single risk pool (and likewise for small group plans) will hold down administrative costs, which are bloated in part by the current practice by health insurance companies of slicing and dicing policy holders into numerous small risk pools in order to always be able to market a low-price product with a healthy risk pool to new, healthy customers.

On the other hand, PPACA has some glaring defects. First among them is the failure to seriously address runaway costs. Rather than reining in costs, PPACA provides subsidies which will strain the federal budget while only providing a temporary fix. Without reining in costs, the reduction of the number of uninsured people cannot possibly be sustained due to the way the personal mandate exemption and the premium tax credits are

indexed. President Obama declared that he wanted to base the reforms on what we already have rather than "starting from scratch", but unfortunately chose to build on the private and non-profit sectors of the health insurance industry rather than on Medicare, which does by far the best job of holding down costs. Also, there are many potential loopholes that could undermine some of the positive aspects of the law, such as the ban on medical underwriting and rescissions.

The improved ability of people to shop meaningfully for policies may prove to be one of the bigger benefits. Competition and consumer choice are nothing more than buzzwords if consumers lack the knowledge and information to make rational decisions. While some complain that there is not enough choice in some parts of Pennsylvania, an uninformed consumer can be worse off when faced with too many choices. Many people nowadays are finding that they are spending more on health insurance than on any other part of their budget, including food, transportation, or even housing. With so much at stake, consumers need to be able to make informed decisions, but insurance policies can differ in so many aspects such as

deductibles, coinsurance, co-pays, out-of-pocket maximums, covered services, provider networks, and in-network discounts that apples to apples comparisons are extremely difficult. The same can be said for food, cars, or housing, but the fundamental difference is that people experience the various aspects of these other necessities in their daily lives. When somebody is shopping for a car, they know from their own experience whether they are likely to need seven seats or two, how often they need to accelerate rapidly to merge onto a highway, and how gas mileage will impact their wallets. This is simply not the case with health insurance. Insurance is by its very nature focused on *unlikely* events. Also, so many of the terms of an insurance policy tend to be very intangible, and proficiency in probability and statistics, which very few people have, is required to really understand how policies work. This once again points to the need for a single-payer system. However, if the US is going to continue with the private health insurance paradigm, there is a need for strong government regulation.

Even so, actuarial value-based insurance policy grades (bronze, silver, gold, platinum) and standardized

essential benefits are still not enough to make a true apples-to-apples comparison. Policies with identical actuarial values and identical benefits packages may be of very different value if they have different discounts with their provider networks. For instance, a gold policy is supposed to have, on average, an 80-20 split between the insurer and the policy holder for covered medical expenses. However, if the insurer has poor network discounts with hospital and other providers, the share that the policy holder is supposed to bear will be 20% of a much larger pie. At present it is very difficult to get information on the network discounts agreements between providers and insurers. This information is vital to consumers, and the PID should find a way to make this available to people looking for insurance.

Another major problem with PPACA is the almost haphazard way that the various subsidies fall on different groups of people. In many cases low income people will be subjected to a harsh marriage penalty should they get married. This, of course, comes at a time when about 40% of births in the United States are out of wedlock, with lower income groups being even more likely to have babies

outside of marriage.[153] Pregnancy and childbirth require expensive healthcare and are the reason for traditionally much higher premiums for women in their child-bearing years compared to men of the same age. The structure of PPACA's subsidies strongly discourages low-income pregnant women from marrying.

Many middle income people, meanwhile, will be subject to the "cliff effect," having to bear the brunt of higher premiums due to the elimination of medical underwriting and the expansion of required benefits without the assistance of any government subsidies. Even with the subsidies working as intended, they provide benefits to people in the 133%-200% FLP level to an extent that may wind up being resented by those in higher yet still modest income brackets who will have to pay high premiums for insurance that could turn out to be too costly to use. People who pay federal income taxes will be saddled with increased government expenditures to extend coverage to lower income people while also subsidizing a grossly inefficient insurance industry.

[153]Department of Health and Human Services, Centers for Disease Control Prevention, National Center Statistics: "Births: Final Data for 2010" (Volume 61, Number 1 August 28, 2012) p.44

Moreover, PPACA assumes ever-rising costs and premiums. The wording of the price level indexes written into the bill does not take into consideration the possibility of deflation. Traditionally the PID has allowed for rate hikes if the companies can demonstrate that their own costs are rising. If companies feel safe in the knowledge that they can get rate hikes approved provided they are seeing rising costs, and if their profits are confined by medical loss ratios, then they have an incentive in allowing for provider prices to continue to rise as they are getting a percentage of a larger total. Higher provider prices allow insurers to go to state regulators and justify the need for a premium hike. This indeed is the tendency in the electric utility industry, but profit margins for distribution companies are regulated because of the natural inclination to seek increased energy consumption. Similar regulation of the insurance industry is warranted, with greater transparency and public input in the rate making process. The status and authority of the Pennsylvania Insurance Department should be increased to the point where it is on a par with the Pennsylvania Public Utilities Commission in order to make sure that health

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Hhttp://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf#table16H.

insurance, a necessity of modern life, is available to all people without exploitative business practices or profiteering. Finally, an insurance division should be established in the Pennsylvania Office of Consumer Advocate so that consumers have a statutory representative advocating on their behalf at PID proceedings.

Section E -- Conclusion

The reforms we recommend are not intended to be "part of a solution" or "a step in the right direction." The condition of the health care system in this country is such that a fundamental transformation is required. Our recommendations are intended, therefore, to help keep people insured (and alive) until the day that such a transformation takes place. As we have already seen, 5% of premiums paid to investor-owned insurance companies go back to the investors in the form of profits. All insurance companies, even the so-called "non-profits," pay many times higher salaries to their upper management than do public-sector insurance programs. Huge advertising budgets may be necessary for the companies to compete against each other, but they do nothing to improve the quality of healthcare. There is a massive amount of redundancy in so many of the functions carried out by insurance companies, such as billing and administration. And perhaps most importantly, compared to Medicare, the companies do a poor and piecemeal job of amalgamating consumer purchasing power and using it to negotiate lower costs for the consumer. All these factors clearly indicate the

need for a real solution to America's health care delivery crisis. That solution is a national single-payer insurance system.

A national insurance system using Medicare as a starting point would be the most direct path to the goal of a national single-payer system. In the interim, the PID and the General Assembly should prepare for an alternative route, if necessary, by looking into creating a state-wide public insurance system. Such a system should replace the redundancy and waste of our multitude of companies that cherry-pick healthy customer and exclude those most in need with a public system in which everyone not already part of a Federal program would be in, and then use the public's purchasing power to hold down costs. While some might be philosophically opposed to such a plan due to its expansion of a government function at the expense of the market, it is important to emphasize that our current system does not have some of the most basic elements of a functioning market.

First of all, there is extremely unequal information between the seller and the buyer. For instance, very few buyers, even personnel professionals making decisions at

companies purchasing group policies, have access to information on the in-network discounts that impact so greatly on out-of-pocket costs faced by consumers. Also, health insurance products are impossible for most consumers to compare. Any meaningful comparison requires a very advanced mathematical calculation taking into consideration deductables, co-pays, coininsurance rates, out-of-pocket maximums, and the probability of incurring various levels of medical expenses. This then has to be considered against the premium, the covered procedures, the provider network, the network discount, and the reliability of the insurer.

Some may counter that consumers routinely operate in markets for expensive and complex products, such as automobiles. However, people have a tangible sense of the variables they need to compare when shopping for cars. We know from our life experiences what fuel efficiency, cabin space, acceleration, and other factors are and what they are worth to us. This is a very different state of affairs from health insurance.

The system that we are proposing would preferably be planned in conjunction with other like-minded states.

The state-wide public insurance system should be set up with an eye towards integrating it into a national single-payer system as soon as that becomes feasible, without undermining national programs like Medicare that would likely form the foundation of the national single-payer system.

At present there are potential legal obstacles to the implementation of such a system, but that should not stop Pennsylvania from getting one ready. The response to events such as the financial crisis in the autumn of 2008 and the 9/11 attacks in 2001 demonstrate that lawmakers can be pressured into undertaking far-reaching initiatives with little time for deliberation or consideration of unintended consequences. Our health care system is stretched to its financial breaking point, and a crisis could be triggered at any time. Rather than allowing the crisis to be hijacked by vested interests or allowing masses of people to lose access to medical care, a plan for a state system should be ready to go.

PPACA includes some needed and welcome reforms, but it does not address the massive waste and inefficiency spelled out above. It is this waste that makes

the Amercian healthcare system cost more than twice as much per capita than most other advanced economies while producing inferior results. PPACA injects massive taxpayer-financed subsidies to redistribute the costs of our system, but the fundamental problem with our system is not one of maldistribution of costs, but rather massive waste and inefficiency.

The function of insurance is supposed to be to spread out the risk of unexpected losses over time (i.e. taking the unaffordable cost of an illness or injury and spreading it out over regular monthly payments) and over a population (spreading the cost of unusual catastrophic afflictions that would bankrupt a family over so many families that it becomes affordable to each family participating in the insurance). Events that would have in the past put a huge dent in a monthly budget, like a broken bone, still put a huge dent in the budget via co-payments, co-insurance, and facilities fees for each of the multiple institutions that may be involved in the treatment. Moreover, budgets are already strained by monthly insurance premiums that can be as much as the actual costs of the one-time events that they are designed to protect

against.

Socializing the costs of injury and illness by spreading it out over the whole of society is done very poorly by our current system, which only spreads costs over small risk pools. Over 15% of society is not involved in this socialization process, but even the remainder that are involved are sliced and diced into so many tiny risk pools that a given pool can be very tangibly impacted by an event that befalls an individual member. And the administrative costs of managing the almost infinite number of pools are astronomical. This is much of the reason why Medicare's medical loss ratio is so much better than that of insurance companies.

In fact, it is really more accurate to think of the U.S. health insurance system as a protection racket. Health care providers routinely bill far more for their services than they actually cost, and routinely accept far less than they bill from insurance companies as complete payment. It is not just the absence of "one price for all," indeed the price discrepancies are so huge that without insurance a relatively minor trip to the doctor's office or hospital can put a typical family of modest means in dire financial

straits, while the more affluent could face the loss of all they have worked for should a family member have a more severe problem.

However, someone who does not have insurance – i.e. who is not paying protection money – is expected to pay "full cost" (read ridiculously inflated cost) for these same services. What is worse, even those people who do pay protection money still too often have to pay full cost because their insurance company finds a reason to refuse to pay for a given procedure. When an individual without health insurance is faced with one of these ridiculously inflated bills, they may be able to negotiate a lower price or they may simply not pay. Either way, the provider, many of which are non-profits, can call the unpaid balance "uncompensated care," which they can count as the charitable contribution that they are required to make to society in order to receive the huge perks associated with being a non-profit, such as not paying taxes on their vast land holdings. [154] This is another aspect of the racket.

[154] Under IRS regulations that apply to all nonprofit health care providers, "uncompensated care" is defined as "care for those without means to pay and shortfalls in payments for those covered by government programs for low-income households at cost." (http://www.bizjournals.com/pittsburgh/print-edition/2013/02/22/upmc

One almost wishes that there was "insurance insurance" that would cover expenses that health insurance companies are currently shirking! Again, Medicare does the best job in holding down provider costs through its system of participating provider agreements, whereby physicians accept prices offered by Medicare that are based mainly on the calculations by a panel of doctors (associated with the American Medical Association) of the amount of resources required for a particular service. Most doctors accept Medicare patients based on these payments, and as we know most doctors are doing pretty well financially.

The current situation of our health care system is unsustainable. Medical bankruptcies already account for half of personal bankruptcies in this country.[155] With unemployment at its highest level in decades and so many people under water in their mortgages, there is no longer any cushion in the household finances of many Pennsylvanians. Each additional rate hike can only result in an increase in the already record number of uninsured

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-never-misleading-charity-care.html) The issue is shortfall in payments compared to what? If the comparison is with a price that is several times higher than what is accepted as full payment from an in-network insurer, should it really be considered charity?

[155]MSNBC.com: "Medical bills make up half of bankruptcies"

people. While the Patient Protection and Affordable Care Act is being touted as landmark legislation that will dramatically reduce the rolls of the uninsured, this prediction is premised on people being able to afford to purchase insurance, albeit with government subsidies, from existing companies in Exchanges regulated by the states. However, the current state of affairs in which the PID is unable to rein in premium hikes to a manageable level does not bode well for this prediction, as PPACA's indexing mechanisms pass on incremental increases in premiums to consumers and not to the government, which will already be fiscally strained from the PPACA subsidies.

The passage of PPACA imposes new responsibilities on the PID at a time when health insurers are likely to take advantage of the changes and confusion to push for higher rates. Because Governor Corbett decided against Pennsylvania setting up Exchanges in the Commonwealth, the Federal Government will run the insurance Exchange through which the various subsidies and tax credits established by PPACA will be made available. Even so, PID will retain its regulatory authority

(http://www.msnbc.msn.com/id/6895896).

and will continue to handle rate cases, and thus will have to be equipped to monitor the companies that participate in the Exchange to make sure they are meeting requirements for medical loss ratios and providing policies that actually meet the actuarial values prescribed by PPACA.[156] While PPACA should, at least initially, allow many of the working poor who are currently uninsured to purchase insurance via subsidies and tax credits, it will create a new "doughnut hole" of uninsured people whose incomes are too high for the subsidies but whose budgets are too tight for high premiums; who are too young for Medicare yet are in the oldest and most expensive premium bracket. This doughnut hole will grow as premiums inevitably rise. Moreover, the costs to the federal government of PPACA will expand a budget deficit already at historic levels thanks to wars, banker bail outs, and the yoke of interest payments on old debts.

Pennsylvanian's access to health care is at more risk now than it has been for decades. Almost 16% remain without health insurance, and the bulk of those with health

[156] SEC. 1321. (d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY.— "Nothing in this title shall be construed to preempt any State law that does not prevent the

insurance get it through their employment.[157] Insurance premiums have been rising fast and are predicted (even by the authors of PPACA) to continue to rise faster than wages or inflation. Regardless of one's prediction for the economy, it would be foolhardy to say that there is no risk of an increase in unemployment, and that would translate directly to people losing healthcare. COBRA is at best an 18-month stop-gap, and unaffordable for many. PPACA will not change the temporary and unaffordable nature of COBRA. Moreover, companies that stay in business and retain their workers will be under pressure from the forces of market competition to join the trend of downgrading their health insurance packages, passing on more costs to workers or providing fewer benefits.

There are a multitude of reasons for our health care crisis, but the PID could be better utilized to help protect Pennsylvanians from the fallout from this crisis. The PID needs the regulatory authority to rein in rate hikes in all segments of the health insurance market. As mentioned in a

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application of the provisions of this title."

[157] Susan R. Todd and Benjamin D. Sommers: "Overview of the Uninsured in the United States: A Summary of the 2012 Current Population Survey Report," U.S. Department of Health & Human Services, September 12, 2012

previous section of this paper, the mission of the PID is to "*safeguard consumer rights and ensure access to health and other vital insurance products."* To accomplish this mission, the Department (among other things) monitors the financial solvency of insurance companies.[158] In the current environment, in which most people have no government option for health insurance yet health insurance is a necessity, it makes sense that the PID would want to make sure that insurance companies are financially solvent. Even non-profit insurers like the Blues cannot operate indefinitely at a loss. People cannot get insurance if there is no one to sell it. However, if insurance becomes so unaffordable that people cannot buy it, then the end result is the same. Precisely because health insurance is a necessity, the PID needs also to consider the financial solvency of consumers. To this end, when considering requests for rate hikes from insurance companies, the PID should examine not only company data on claims experience and medical loss ratios, but also must consider

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(http://aspe.hhs.gov/health/reports/2012/uninsuredintheus/ib.shtml)

[158] Pennsylvania Insurance Department Website, "About" page. Accessed June 17, 2010. (http://web.archive.org/web/20100617022804/http://www.insurance.pa.gov/portal/server.pt/community/about/5230)

data on the finances of the public, including growth in wages and inflation.

By the PID giving equal consideration to consumer solvency, health insurance companies would be faced with having to put more pressure on providers and pharmaceutical companies rather than simply passing on all increased costs to premium-paying policy holders. The purchasing power that large insurers possess gives them the ability to put this kind of pressure on providers. In the field of retailing, Walmart has used its purchasing power to demand lower prices of its suppliers. It has such power that it can often force changes on suppliers, for better or worse, in order to get a lower price, including introducing new technologies and moving production locations. Walmart's suppliers need Walmart's sales outlets in order to remain competitive, and thus comply. Other major retailers need to demand similar price concessions from their suppliers in order to compete with Walmart.

In the field of health insurance, the Federal Government via Medicare, Medicaid, and the VA system has similar purchasing power to Walmart, and it uses that power in setting physician fees. However, because the

private insurance companies are for the most part not in competition with the Federal Government, but rather have a relatively healthy and affluent segment cornered for themselves, the government's deals with Medicare providers, for instance, do not lead to lower premiums for the policy holders of private insurers.

Of course, insurance companies are not the sole cause of our health care crisis. The prices that hospitals and doctors charge to patients are based on a "Chargemaster," a comprehensive listing of hospital services, medical procedures, drugs, supplies, and diagnostic evaluations billable to a hospital patient or a patient's health insurance provider. Chargemasters are used to generate patient bills, and every hospital system maintains its own Chargemaster. However, the Chargemaster price is hardly ever the price paid by patients and, in fact, is typically a rather arbitrary and ridiculously high starting point to which discounts are applied. An insurer that has a close relationship with the provider, such as UPMC Healthplans has with UPMC, or that covers a very large segment of the patients in the community, such as Highmark in western Pennsylvania, can negotiate very significant discounts off the

Chargemaster price. By contrast, an uninsured patient may simply be offered a token 15% off the Chargemaster price.

Thus, far from having one price for all customers, doctors and hospitals may bill out-of-network or uninsured patients at ten times the price as in-network patients without batting an eye. They can get away with this because prices are almost never discussed prior to a service being provided. Granted, not all merchants charge set prices for their goods and services, but nobody would tolerate a situation in which the buyer of a new car didn't know whether the dealer was charging $10,000 or $100,000 for the purchase until weeks later. But that is exactly what hospitals do.

In addition, there are other causes of the crazy prices faced by consumers. Pharmaceutical and medical equipment companies are often able to overprice their products because the decisions about whether or not to use them are typically made by doctors, who are not the people paying for them. Especially for non-Medicare patients, a doctor is likely to know little or nothing about a patient's insurance policy, let alone the insurance company's arrangements with suppliers or the prices of items. To the

extent that the patient might be involved in the decision, he or she is likely to be no better informed. Insurance companies are involved in deciding what treatments will be covered and thus can effect a doctor's decision in this regard, but may not be contacted until after the procedure, by which time it is too late to seek alternatives to treatment that put unnecessary expenses on the patient.

Markets cannot be expected to function without price information. Consumers lack the most fundamental information. Many of the basic laws of economics cease to apply. The law of one price, whereby the cost difference between the locations cannot be greater than cost of shipping, taxes, and other distribution costs obviously does not apply to a situation in which the price is not known at the time and point of transaction.[159]

PPACA attempts to improve the functionality of the market for health insurance by creating Exchanges where multiple companies can offer their policies, actuarial value-based categories for policies, and minimum requirements for covered services. But the Act's provisions for bringing down the cost of health care (Sec. 2718) are

[159] http://en.wikipedia.org/wiki/Price

meager at best. The main provision is an 80% minimum for medical loss ratios for small group and individual policies and an 85% minimum for large group policies. As mentioned previously, this does nothing to hold down the prices charged by providers. Moreover, the charges that insurance plans pay to providers are health care payments that get included in the numerator of the equation, so the higher those charges are the higher the medical loss ratio will be.

The other provision for keeping down the cost of health care is a requirement that all hospitals make public the list of their standard charges for items and services (i.e. their Chargemaster). In February 2013, Time Magazine published a major article exposing the problems with the Chargemaster system,[160] and nothing came of it, so there is little reason to believe that publication of the Chargemaster in the absence of any mechanism for reviewing or regulating those charges will help rein in costs. Furthermore, PPACA does not include any provision for disclosing in-network discounts or pricing arrangements between insurers and suppliers, so in no way addresses the

[160] Brill, Steven. "Bitter Pill: Why Medical Bills Are Killing Us." *Time*.

problems raised by the previous paragraphs.

Rather than taking on the issue of reining in prices, PPACA simply mobilizes additional fiscal resources in order to subsidize patient payments both to insurance companies and to health care providers, and even then in an unsustainable way. Based on an assumption that medical inflation will continue unabated, PPACA includes mechanisms that pass most of the burden of future inflation on to patients and limits increases in subsidies.[161] After a number of years, it is quite conceivable that the percentage of Americans who cannot afford health insurance premiums or out-of-pocket expenses will return to pre-PPACA levels even with the subsidies. While evaluation of in-network discounts is not a part of the review process for rate cases, it would be of great service to the public if the PID were able to make such pricing information available.

(Mar. 04, 2013)

[161] SEC. 1401. (a) ammends the Internal Revenue Code of 1986 by inserting the following as SEC. 36B.(b)(3)(A)(ii): "In the case of taxable years beginning in any calendar year after 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate subsection."

Malpractice lawsuits are also raised as a source of run-away costs. In addition to the considerable cost of medical malpractice insurance, the threat of a lawsuit has led to a rise in "defensive medicine," whereby a doctor conducts tests or prescribes treatments based not on medical necessity but on reducing the chances of being sued. A 2003 survey of 824 Pennsylvania physicians from specialties at a high risk of malpractice suits (emergency medicine, general surgery, orthopedic surgery, neurosurgery, obstetrics/gynecology, and radiology) showed that 93% reported practicing defensive medicine. Some 92% reported "assurance behavior" such as ordering tests, performing diagnostic procedures, and referring patients for consultation. The study states that "[a]mong practitioners of defensive medicine who detailed their most recent defensive act, 43% reported using imaging technology in clinically unnecessary circumstances."[162] As we well know, MRIs and other imaging technologies are

[162] David M. Studdert, LLB, ScD, MPH; Michelle M. Mello, JD, PhD, MPhil; William M. Sage, MD, JD; Catherine M. DesRoches, DrPH; Jordon Peugh, MA; Kinga Zapert, PhD; Troyen A. Brennan, MD, JD, MPH: "Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment" The Journal of the American Medical Association (June 1, 2005, Vol 293, No. 21) (http://jama.jamanetwork.com/article.aspx?articleid=200994)

not cheap. Furthermore, defensive medicine need not only be unnecessary tests and procedures, but also can be avoidance of necessary procedures that expose the practitioner to elevated risks of liability.[163] While there is significant resistance to the idea of capping the monetary value of judgments in malpractice cases, a limit on lawyers' contingency fees would likely eliminate those cases with the least merit from being filed in the first place.

Insurance companies are go-betweens for consumers, and they should act as agents for consumers vis-à-vis providers, pharmaceutical companies, and even (if indirectly) medical equipment manufacturers. They need to use their purchasing power on their behalf seeing as individual consumers do not have the information at the point of transaction to make rational decisions in the way posited by mainstream economic theory. However, there are other obstacles to a properly functioning market for healthcare. As mentioned before, consumers have no information on in-network discounts and arrangements, so would have no way of judging between insurers even if insurance companies acted as honest agents for consumers.

[163] Michael, Fouad B.: In the Guts of Health Care (Bloomington, In,

What is even more problematic is the trend towards vertical integration of insurer and provider, especially in western Pennsylvania. How can UPMC Healthplans act as the consumer's agent if it is owned by the provider UPMC. Likewise, if Highmark owns a financially struggling West Penn Allegheny hospital system, how aggressively can it be expected to represent the policy holder's interest?

Pennsylvania's elected officials need to provide the Insurance Department with the authority and resources to take on the well-financed actuarial divisions of the multitude of health insurance companies that submit filings in Pennsylvania each year. Pennsylvania's political leadership must do the following:

(1) Reorient PID's emphasis away from maintaining the fiscal health of the insurance companies and towards protecting the public interest.

(2) Make sure that insurance companies become motivated to hold down provider costs rather than padding their bottom line to the detriment of consumers via premium

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Author House, 2004) p.41

hikes and coverage denials.

(3) Crack down on the massive excesses on the part of these insurers, whether it is in the form of executive compensation or advertizing oversaturation in markets where their corporate names are already well known.

(4) Revamp the criteria used by the PID when assessing rate increase filings. While PID actuaries seem to diligently follow the policies and procedures set by the PID, given the low medical loss ratios of the various plans and the excessive surpluses and profits of the health insurance corporations, the upward spiral in premiums is hard to justify.

(5) Step up transparency and disclosure of information, starting with the SERFF system. Openness in government is crucial to democracy, and any citizen should be able to appoint him or herself as a watchdog.

(6) Establish more stringent loss ratio standards than those set by the federal government. PPACA allows states to do

this, and isont would be in the interest of Pennsylvanians for the state to do so and provide the Insurance Department with the regulatory resources, the legislative authority, and the political direction to see to it that insurance companies not be allowed to game the system to the detriment of policy holders. Even if PPACA proves to be insufficient to keep Americans from sinking in a rising tide of health insurance rate hikes, the General Assembly can take action to throw Pennsylvania consumers a life raft until such a time when Congress rectifies the mistakes it made in the recent health care battle.

(7) Increase the status and authority of the Pennsylvania Insurance Department to the point where it is on a par with the Pennsylvania Public Utilities Commission in order to make sure that health insurance, a necessity of modern life, is available to all people without exploitative business practices or profiteering.

(8) Establish an insurance division within the Pennsylvania Office of Consumer Advocate so that consumers have a statutory representative advocating on their behalf at PID

proceedings.

(9) Take steps to keep people healthy and solvent under the current system, while at the same time lay the groundwork for a possible introduction of its own public health insurance system that would resemble a single-payer system as soon as it can legally do so.

Although a national single-payer system is the ultimate solution to the US healthcare financing debacle, some national systems had their origins in regional or local systems. Also, Pennsylvania is large enough and has the health care infrastructure to make a state-wide insurance system work. But it must be designed to protect Medicare.

It is also important to recognize that the problems of the healthcare system are not entirely due to the greed or profit motives of insurance companies, doctors, hospitals, malpractice lawyers, pharmaceutical companies, and medical equipment manufacturers. Our society is undergoing numerous changes that impact the cost and quality of our health care system. There are demographic changes, most notably that society is aging, and as older

people tend to have greater health care requirements it stands to reason that overall costs will rise. There are changes in usage patterns. These changes have a variety of causes, but one obvious one is advertizing by drug makers advising the public to "ask your doctor" about this or that syndrome that wasn't even identified a decade or two ago. There are health changes. The well-reported "obesity epidemic" puts more demands on the system as it is linked with rises in certain costly conditions like diabetes. And there are certainly technological changes. New drugs, equipment, and procedures are constantly being innovated, and in many cases lead to better results, but at a cost.

Some of these changes can be addressed, such as the increase in obesity, but others are unavoidable and must be accepted. The certainty of higher costs due to demographics and technology, however, make it that much more critical that we pursue savings and efficiency in areas where they are possible. One tried and proven approach would be the single-payer model.

The single-payer system has the advantage of a very large pool that is truly representative of the state of health of the population and thus able to apportion costs in a

sustainable way based on lifetime actuarial requirements. This is in contrast to the current system, in which the population is divided into a myriad of pools based on short-term health risk factors, with each pool requiring extra revenue to cover the statistically higher financial risk associated with small pools. There is also massive administrative redundancy in managing so many small pools. One obvious example of this administrative waste is the tens, hundreds, or even thousands of pages that must be produced every year or two for each filing that an insurance company has to send to the various state regulators for each insurance pool. This is part of the reason that the private and non-profit health insurance firms can come nowhere near the Medicare system in terms of administrative efficiency reflected in high medical loss ratios.

The Insurance Department must use whatever authority it has to clamp down on premium hikes. It must make sure that the Exchange established under PPACA functions and that consumers can take full advantage of its subsidies and tax credits. It must prioritize programs like CHIPS, AdultCare, Medicaid, and PAFairCare within the state budget, making sure that these programs receive

adequate funding. It must go above and beyond PPACA to make sure consumers have information on in-network discounts.

Finally, at the very least, this paper makes it abundantly clear that the US health insurance system is insanely complex and unsustainable. Indeed, for many Americans, as measured by the 50 million uninsured and the 45,000 people who die each year due to going untreated, the system is unacceptably dysfunctional.[164] It cries out for a real solution. As we have emphasized, we are convinced that a national single-payer system along the lines of an expanded and improved Medicare for all Americans is the only real solution to a health care crisis that threatens the entire US economy. There is already such a proposal before the U.S. Congress in the form of HR 676.

It remains to be seen if leaders at the state and national level will rise to the occasion.

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[164] Andrew P. Wilper, MD, MPH, Steffie Woolhandler, MD, MPH, Karen E. Lasser, MD, MPH, Danny McCormick, MD: "Health Insurance and Mortality in US Adults," American Journal of Public Health (December 2009, Vol 99, No. 12 http://www.pnhp.org/excessdeaths/health-insurance-and-mortality-in-US-adults.pdf)

Appendix A – PPACA Details

Medical Loss Ratio

The actual wording of the bill is as follows:

"A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expends—

''(1) on reimbursement for clinical services provided to enrollees under such coverage;

''(2) for activities that improve health care quality; and

''(3) on all other non-claims costs, including an explanation of the nature of such costs, and excluding Federal and State taxes and licensing or regulatory fees."

The law then stipulates that both expenses associated with

both (1) and (2) would count towards the minimum medical loss ratio.[165] Moreover, for policies in the small group and individual market, the Secretary of Health and Human Services, at her discretion, may decrease the minimum medical loss ratio "if the Secretary determines that the application of such 80 percent may destabilize the individual market" in a given state. At the same time, states may increase the minimum ratio in the large group market by regulation.

Along with actuarial value, the medical loss ratio is an important measure of the finances of a health insurance plan. Whereas the actuarial value measures how much of covered benefits are paid for by the plan and how much are out of pocket regardless of premium levels, the medical loss ratio is a measure of how much of premiums go towards covered benefits and how much go towards administration, regardless of out-of-pocket payments.

Pre-Existing Conditions

Section 2704 of the law clearly states that "A group health plan and a health insurance issuer offering group or

[165] PPACA pp. 767-768

individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage." The law goes on to stipulate that the only factors that can be taken into effect in setting premiums in the individual or small group market is whether the plan covers an individual or family, the rating area, age (up to a 3:1 differential), and tobacco use (up to a 1.5:1 differential).[166] Rules for eligibility (including continued eligibility) may not include:

"(1) Health status.

"(2) Medical condition (including both physical and mental illnesses).

"(3) Claims experience.

"(4) Receipt of health care.

"(5) Medical history.

"(6) Genetic information.

"(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

"(8) Disability.

"(9) Any other health status-related factor determined

[166] PPACA, p.36-37

appropriate by the Secretary.[167]

Setting Of Premiums

PPACA states that:

"IN GENERAL.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

"(A) such rate shall vary with respect to the particular plan or coverage involved only by—

"(i) whether such plan or coverage covers an individual or family;

"(ii) rating area, as established in accordance with paragraph (2);

"(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 2707(c)); and

"(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

"(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A)."[168]

[167] PPACA, p.38, SEC 2705

Temporary high-risk pool

PPACA established temporary mechanisms to provide coverage to individuals with pre-existing conditions and (in some states but not Pennsylvania) for non-Medicare eligible retirees over 55 after June 23, 2010. Starting in June 2010 and running until January 1, 2014, the Secretary of HHS will establish a temporary high-risk pool for adults with pre-existing conditions. States or non-profit insurers will issue coverage to such people unless the states elect to have the federal government administer the program.[169]

The premiums must be based on a standard population and age bands must not differ by a ratio of more than 4:1. The plan must have an actuarial value of at least 65% and it must have the same $5,950 for an individual and $11,900 for a family out-of-pocket limits as other plans.[170]

In Pennsylvania the system that has been created to meet this requirement is known as PA Fair Care. The premium for PA Fair Care is $283.20 per month, regardless

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[168] PPACA, p.37, SEC. 2701(a)(1)
[169] PPACA, p.23

of age. The coinsurance rate is 20% for in-network services and 50% for out-of-network. Some co-pays also apply. The deductible is $1000 in network and $10,000 out of network, while the out-of-pocket maximum is $5000 in network and $20,000 out of network. The program is to run through 2013 and Pennsylvania was slated to receive a total of $160mn from the federal government to administer it though 2013.

While many states elected to allow the federal government to run their high-risk pools, Pennsylvania's "PA Fair Care" is being administered statewide through a contract with Highmark Blue Shield, which is legally a non-profit. It received initial funding to serve approximately 3,500 individuals, and as of January 2013, 6,779 individuals are enrolled in the program. Eligible applicants were enrolled on a first-come, first-served basis, and enrollment in the program ended on March 2, 2013.[171]

Deductable limitation

Non-grandfathered small group market deductibles are limited to $2000 for individuals and $4000 for families

[170] PPACA p.46-47

unless contributions are offered that offset deductible amounts. [172] Grandfathered plans can continue with higher deductibles providing they were already in place on the grandfather date, although there is a 15% plus medical inflation limit to how much they could raise these deductibles while maintaining their grandfathered status. Individual and large-group non-grandfathered plans are not impacted by the deductable limitation. These figures will be indexed upward according to the percentage per capita increase in health insurance premiums in the United States for the preceding calendar year. Certain preventative services are to be exempt from deductibles (as well as from coinsurance and co-pays) for non-grandfathered plans. These deductible limits are to be applied in such a way as not to alter the actuarial value of insurance policies. This means that if a high deductible policy had to reduce its deductible in order to stay in accordance with the new rule, it could increase coinsurance or co-pays.

Exchanges

States must have at least one health insurance

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[171] Hhttp://www.pafaircare.com/H, accessed March 1, 2013.

Exchange by Jan 1, 2014. The Exchange can be a regional one shared with other states, or a state can set up more than one Exchange within its boundaries to serve geographically distinct areas. Also, small business policies and individual policies can be sold in the same Exchange or in functionally divided Exchanges. The small business Exchanges will be known as the Small Business Health Options (SHOP) Exchanges, and the individual ones will be known as the American Health Benefit Exchanges. If a state decides not to establish an Exchange or if the Secretary of Health and Human Services determines that the state has not made enough progress by January 1, 2010, then HHS will set up the Exchange in the state.

Insurance companies will not be required to offer policies via the Exchanges and there will be no penalties for purchasing policies in the market outside the Exchanges. However, policies offered in the Exchanges will have to meet certain guidelines in terms of what they cover, which will be known as "essential health benefits." Policies will be divided into four categories depending on their actuarial values: Bronze (covering 60% of medical expenses), Silver

[172] Kaiser Family p.7, PPACA p.48

(70%), Gold (80%), or Platinum (90%). The actuarial value of a plan shall be determined on the basis of "essential health benefits" provided to a standard population, regardless of whether the population is the one the plan may actually provide benefits to. (The Secretary will develop guidelines for variations in differences in actuarial estimates.) In order to participate in the Exchange, a health insurer must offer at least one silver plan and one gold plan.[173] The only plans that will be eligible for premium tax credits and cost sharing subsidies will be individual silver plans enrolled in via the Exchange.[174]

Employers must inform each employee about the Exchange. If the employer plan's share of total allowed costs of benefits is less than 60%, then the employee may be eligible for a premium tax credit and cost-sharing subsidies (described below). If the employee purchases a qualified health plan through the Exchange, he or she will lose any employer contribution to any health benefits plan

[173] PPACA p.44-45 (PPACA § 1301(a)(1)(C)(ii))

[174] (PPACA sec. 1401; IRC sec. 36B), Hhttp://www.nahu.org/legislative/resources/CRS_PPACA%20Requirements%20for%20Offering%20Health%20Ins%20Inside%20V%20Outside%20Exchanges_June%2010.pdfH p.2

offered by the employer.[175]

Grandfathered plans cannot be offered through the Exchange.[176]

Grandfathered plans

Simply put, a grandfathered health plan is a fully-insured or a self-insured plan that was in existence on March 23, 2010. Grandfathered health plans may be individual or group health plans. The plan does not lose its grandfathered status because some or all of the individuals enrolled in the plan on the grandfather date cease to be covered, as long as the plan has continuously covered someone since the grandfather date, and new or existing employees can continue to enroll.[177]

Grandfathered plans may hike their premiums, but in order to maintain the grandfathered status of a plan, its administrators must avoid doing the following:

- Entering into a new policy, certificate, or contract of

[175] PPACA p.134

[176] http://www.nahu.org/legislative/resources/CRS_PPACA%20Requirements%20for%20Offering%20Health%20Ins%20Inside%20V%20Outside%20Exchanges_June%2010.pdf

[177] http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/252468f1-136b-4fcd-a4a6-d086eaf51cae.cfm

insurance with the plan's insurance issuer.

- Changing the insurance issuer of a group health plan. Changing a self-insured plan's third-party administrator would not cause a plan to lose grandfathered status.
- Eliminating benefits needed to diagnose or treat a particular condition.
- Increasing coinsurance.
- Increasing a deductible or out-of-pocket limit more than the increase in the overall medical care component of the Consumer Price Index for All Urban Consumers [CPI-U] plus 15 percentage points.
- Increasing a copayment by more than the greater of $5 or the sum of medical inflation plus 15 percentage points.
- Decreasing the employer contribution rate by more than 5 percentage points. (It is unclear whether a plan could add new tiers of coverage -- e.g., adding a new "employee plus two dependents" category to help defray the added cost of covering adult dependents -- without losing grandfathered status.)
- Decreasing or imposing a new annual limit on the

dollar value of benefits, unless the plan already had a lifetime limit that is greater than the plan's new annual limit.[178]

Grandfathered plans are exempted from some key PPACA provisions. These include:

(Effective September 23, 2010)

• IRC Section 105(h) nondiscrimination rules.

• Providing certain preventative care with no cost sharing.

• Out-of-pocket maximum limits.

• Complying with doctor selection and referral requirements.

• Providing access to emergency care in accordance with certain new requirements.

• Providing specified appeal procedures.

• Applying new benefit standards.

(Effective January 1, 2014)

• Covering clinical trials and related costs and services.

• Discriminating against providers.

178

http://www.mwe.com/index.cfm/fuseaction/publications.nldetail/object_id/252468f1-136b-4fcd-a4a6-d086eaf51cae.cfm

Moreover, grandfathered plans have delayed deadlines for others requirements:

• Covering adult children until age 26 by the September 23, 2010 deadline, except if they are eligible for other employer-sponsored coverage.[179] (Grandfathered Plans must provide dependent coverage for adult children until age 26 by January 1, 2014. Nothing in PPACA prohibits charging extra for this expanded dependent coverage. Most employers will build the extra cost into the contributions they require employees to pay for employee-plus-family or employee-plus children coverage, but an employer could charge an extra premium for each PPACA-eligible child if it wanted to limit the cost of extended coverage for adult children to participants who take advantage of it.)

• Grandfathered group plans have until January 2014 (instead of September 23, 2010) to eliminate lifetime limits on coverage, and beginning in 2014, eliminate annual limits on coverage. Prior to 2014, grandfathered group plans may only impose annual limits as determined by the Secretary.

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179 http://www.proskauer.com/publications/client-alerts/health-care-reform-has-arrived-grandfathered-plans/

As mentioned above, grandfathered plans cannot be offered through the Exchange.[180]

FOR INDIVIDUALS

Individual mandate (Personal Responsibility Requirement)

Geisinger's lowest price policy that would likely qualify as bronze would cost $575 per month for the family of a 45-49 year old male. This would be less than 8% of his income. For the 50-54 year old man the price of $655 for the same policy would exceed 8%, but because he is eligible for a $114.75 premium credit and this is applied to the price of the bronze plan for purposes of testing his eligibility for the exemption, he too would be subject to the mandate. Because premiums are rising faster than incomes, one would expect that over time more and more people would be exempt from the personal mandate as the cost of the lowest cost bronze plan exceeded their income. However, because the 8% level is also not set in stone and rather is indexed to the rate of premium increases over the

[180]http://www.nahu.org/legislative/resources/CRS_PPACA%20Requirements%20for%20Offering%20Health%20Ins%20Inside%20V%20Outside%20Exchanges_June%2010.pdf

rate of income growth, that 8% figure will push higher towards nine and ten percent as premium growth continues to outstrip income growth.

For people who have incomes of about 250% or less of FPL, premium credits prevent the cost of premiums from rising over 8% in the first place, so these people will be subject to the mandate and will be required to purchase insurance. However, at 300-400% of FPL, where the premium credits don't kick in until the price of the silver plan exceeds 9.5% of income, these credits may not be enough so that when applied to the price of a bronze plan its cost will be within 8% of income. This is because the 9.5:8 ratio of premium credits to economic hardship threshold exceeds the 70:60 ratio of the actuarial value of a silver plan to the actuarial value of a bronze plan. Assuming that premiums for the plans in the Exchange are based on the cost of benefits paid by the plans, then the premium for a silver plan should be one sixth (16.7%) more than the price of a bronze plan. If the silver plan cost 9.5% of income, then by this logic a bronze plan should cost 8.1% of income, and the person would be exempt from the mandate. On the other hand, if the silver plan cost 11.2% of

income then the bronze plan should cost 9.6% of income. In this case, the person would be eligible for an off-setting premium credit worth 1.7% of income, bringing the effective cost of the bronze plan down to 7.9%, which would not be higher than the threshold. The point is that it is possible that a segment of middle-income Americans might wind up not qualifying for premium credits but also not being able to find insurance coverage for less than 8% of their income. They would be exempt from the mandate and could go without insurance.

Of course, much depends on how the markets develop within the Exchange structures. It is conceivable that within a given state or region's Exchange, the market for bronze plans will be more competitive than for silver plans, and the price differential for the plans will be greater than the 16.7% posited in the previous paragraph, or that at least one company will offer a bare bones bronze plan that meets only the very minimum coverage requirements and thus can be priced at a relative discount to the silver plans that may offer more extensive coverage in addition to a higher actuarial value. This would subject more people to the mandate due to low prices for bronze plans. However,

at least in the market for individual policies, it is more likely that the silver plans will be more competitive than bronze as only the silver plans allow for cost-sharing subsidies. In the case that the silver plan market is more competitive, premium credits will be smaller and fewer people would be subject to the mandate.

Premium credits

Thus, insurance premiums would be limited to the following:

Up to 133% FPL: 2.0%

133% up to 150% FPL: 3.0% 4.0%

150% up to 200% FPL: 4.0% 6.3%

200% up to 250% FPL: 6.3% 8.05%

250% up to 300% FPL: 8.05% 9.5%

300% up to 400% FPL: 9.5% 9.5%[181]

In 2010, FPL was $10,830 for a single person, $22,050 for a family of four. Four hundred percent of the poverty level obviously reaches well into the middle class at $43,320 for a single person and $88,200 for a family of

[181] Reconciliation Act p.1031

four. If the second lowest priced silver plan in the regional Exchange is priced at no more than $8379 per year ($698.25 per month), then the family of four making $88,200 would not receive any subsidy. So how likely is it that a person would be able to find a silver plan for that price? Well, insurance prices depend on a number of factors, including age, gender, tobacco use, and region. The Geisinger Comprehensive PPO #5 would likely qualify as a silver plan.[182] The "Standard 1" rate for a family headed by a male age 45-49 is currently $714. If this was the second cheapest plan available, then the family would receive a $15.75 per month premium credit. If the family was headed by a male age 50-54, then the premium would be $813 and the premium credit would be $114.75 per month. However, if the family was headed by a male 40-44 then the premium would be $644 and the family would not receive a premium credit.

However, these percentages are not set in stone.

[182] Silver plans must have an actuarial value of at least 70%, meaning that not including premiums the plan pays for at least 70% of medical expenses and the policy holder pays for no more than 30% in the form of deductibles, coinsurance and copays. The Geisinger #5 plan has a $500 deductible, 20% coinsurance, $20-45 co-pays ($150 for ER) and a $3000 out-of-pocket maximum. (http://www.insurance.state.pa.us/serff_filings/PAAH-126533741.pdf)

Between 2014 and 2018 the percentage of income that eligible taxpayers would be expected to pay for health insurance premiums will increase if health insurers hike premiums faster than growth in incomes (which, of course, has been the case for many years). This would contain the costs for the government. Starting in 2019, taxpayer premiums caps will also be raised to reflect any higher rate of inflation for health insurance premiums compared to overall consumer prices (which has been the case for decades), provided that health insurance premium and cost-sharing exceed 0.504% of GDP. So, provided that premiums continue to rise faster than incomes, during the second half of the current decade that same male age 50-54 could expect to pay more and more of his income each year for health insurance.

An individual eligible for an employer-sponsored plan can only receive premium credits and cost-sharing subsidies if the employee's contribution to premiums exceeds 9.5% of household income, or if the plan's actuarial value is less than 60%. The person would not be able to enroll in the employer-sponsored plan but would have to enroll in the Exchange plan instead. An individual

cannot receive premium credits if his employer is paying for part of the premiums.[183]

Cliff Effect

The structure of the premium credits provided by PPACA create a "cliff effect" whereby the size of the subsidies that a given family configuration can receive end abruptly at 400% FPL rather than phasing out. The subsidies are based strictly on income, but the amount that insurance companies can charge for premiums is based on age, geography, and tobacco use, and the effective end of medical underwriting is sure to mean much higher premiums for people currently on such policies. Of course, anyone unable to find a bronze-level policy for 8% of income is exempt from the personal mandate. A 60-year-old couple with an annual income of $58,280 would pay no more than $5536.60 for insurance due to premium credits provided by the government. However, if their income was just one dollar higher they would have to pay the full amount for insurance. Projections by the Kaiser Family Fund foresee premiums for this couple of as high as

[183] Sec. 1401 of PPACA, adding a new Sec. 36B(c)(2)(A)(ii) to the

$18,988 if they live in a high-premium area.[184] That one extra dollar of income would cost them a $13,451.40 subsidy. In fact, assuming that they are a two-income household and one spouse only makes $14,000 per year, they would be better off financially if that spouse quit his or her job.

Cost-sharing reduction and out-of-pocket limits

Annual cost-sharing limits will have the effect of increasing the actuarial value of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:

100-150% FPL: 94%

150-200% FPL: 87%

200-250% FPL: 73%

250-400% FPL: 70%[185]

Internal Revenue Code. Also p.106 of PPACA.

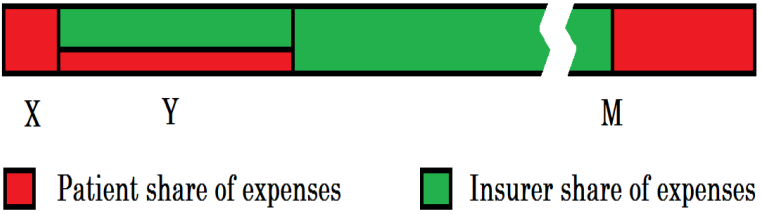
[184] As noted by Chris L. Peterson and Thomas Gabe of the Congressional Research Service, http://liberalarts.iupui.edu/economics/uploads/docs/jeanabrahamcrscredits.pdf. Kaiser projections can be found at http://healthreform.kff.org/SubsidyCalculator.aspx

[185] Hhttp://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdfH, pp.1031-32

The actuarial value of a health plan is determined by the percentage of payments to health care providers paid for by the health insurance plan, or in other words the amount not paid for out of pocket by policy holders. Obviously, an individual policy holder may have none of her health care paid for by the plan if she does not meet the deductable or does not even use any services (insurer paying for 0% of services), or she may use so much provider service due to a catastrophic health condition that the out-of-pocket maximum expenses may only represent a tiny share of payments (insurer paying for close to 100% of services). The actuarial value would be calculated based on the percentage of expected costs for all plan members that will be paid for by the plan.

For a typical policy, the first X number of dollars (i.e., the deductible) in medical expenses (besides certain routine preventative care that a policy may exempt) are paid by the patient, or policy holder. The next Y number of dollars are paid largely by the insurer, with the policy holder paying a share via coinsurance and co-pays. Once X (the deductible) plus the policy holder share of Y (coinsurance and co-pays) reaches the out-of-pocket limit,

the insurance company will pick up the tab for the remaining bills for the rest of the year (not counting facility charges) until the point when the annual or lifetime benefit maximum (M) is reached. (Some policies are structured so that the deductible does not count towards the out-of-pocket limit, and certain other co-pays and coinsurance, such as those relating to prescription drugs, may have to be paid even after the out-of-pocket maximum has been met.)[186]



As can be seen from the figure above, the first services received during the policy year are the most expensive for the policy holder, then after the deductable is met services require much less expense and then eventually

[186] The Washington State Health Care Authority is one such example (http://www.fuzeqna.com/ump/consumer/kbdetail.asp?kbid=565)

become free of out-of-pocket expenses for the remainder of the year.

PPACA stipulates that on plans "offered in the small group market, the deductible under the plan shall not exceed—

(i) $2,000 in the case of a plan covering a single individual; and

(ii) $4,000 in the case of any other plan."[187]

It also stipulates that the reduction in cost-sharing "shall first be achieved by reducing the applicable out-of pocket limit." An out-of-pocket maximum is capped for all policies (except grandfathered policies[188]) at the level of the Health Savings Account (HSA) limit, which is currently $5,950 for an individual and $11,900 for a family.[189]

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[187] PPACA, SEC. 1302(c)(2) (p.48), also Congressional Research Service, "Private Health Insurance Provisions in PPACA (P.L. 111-148), p.14 (Hhttp://assets.opencrs.com/rpts/11-148_20100415.pdfH)

[188] http://www.paulhastings.com/assets/publications/1560.pdf?wt.mc_ID=1560.pdf

[189] Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 stipulates that for a high-deductable plan:
"**(ii)** the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—
(I) $5,000 for self-only coverage, and
(II) twice the dollar amount in subclause (I) for family coverage."

Out of pocket limits

– 100-200% FPL: one-third of the HSA limits ($1,983/individual and $3,967/family);

– 200-300% FPL: one-half of the HSA limits ($2,975/individual and $5,950/family);

– 300-400% FPL: two-thirds of the HSA limits ($3,987/individual and $7,973/family). [190]

Reductions in deductibles, coinsurance, and co-pays can also be utilized to bring up actuarial values, although the bill is not specific as to the formula and each plan will be able to select its own combination. The Department of Health and Human Services will periodically reimburse health insurers for the cost-sharing reductions they provide to low income people.[191] Cost-sharing subsidies will be available only to credit-eligible individuals enrolled in a silver plan.[192]

What is worth noting is that the cost sharing

(Hhttp://www.myhsabenefit.com/Section%20223/Internal%20Revenue%20Code.pdfH). This has since been adjusted for the cost of living.

[190] PPACA, p.103

[191] PPACA, p.104

[192] PPACA §1402(b)(1) according to

subsidies are intended to raise actuarial values, but the out-of-pocket limits are to be applied within the limits of the plan. As was mentioned above, cost sharing subsidies will raise the effective actuarial value of a silver plan to 94% for people with incomes of 100-150% FPL. This means that for a standard population[193] of policy holders with that income level, the plan will pay 70% of covered medical expenses, the policy holder will pay 6%, and the government will pick up the remaining 24%. Even with the out-of-pocket limit lowered by two-thirds, in order to achieve a 94% actuarial value on a silver policy, there will have to be some reductions of deductibles, coinsurance, or co-pays (shouldered by the government).

The same, to a lesser extent, is likely for people with incomes of 150-200% FPL, who will also enjoy a two-thirds reduction in out-of-pocket limit. For them, the plan will pay on average 70% of covered expenses, they will pay 17%, and the government will cover the remaining

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http://assets.opencrs.com/rpts/11-148_20100415.pdf

[193] PPACA makes it clear that actuarial values are based not on the pool of holders of a particular policy, but on a standard population: "[T]he level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to). (PPACA, p.49)

13%.

The next income group is 200-250% of FPL. They qualify for a one-half reduction in out-of-pocket limit and the actuarial value of their silver plans are to be raised only slightly to 73%. This means that on average the plan will pay for 70% of covered expenses, the policy holder 27%, while the Feds will chip in just 3%. In this case, cost-sharing subsidies may not need to include reductions in deductibles, coinsurance, or co-pays.

The next three income groups – 250-300% FPL, 300-400% FPL, and over 400% FPL – will have the same actuarial value of their silver policies: the basic 70%. However, the out-of-pocket maximums for these three groups will vary at ½ HSA, 2/3 HSA, and full HSA respectively. It stands to reason that those policy holders in the lower of these three groups will face *higher* deductibles, coinsurance, and co-pays than the higher-income groups. This is because the mix of out-of-pocket maximum, deductibles, coinsurance, and co-pays produces the actuarial value, and if you lower one element while keeping the actuarial value the same, it means at least one other element must be increased.

EMPLOYERS

Fees for employers not offering coverage

PPACA states that employers with 50 or more employees that do not offer coverage but have at least one full-time employee receiving a premium tax credit will pay a non-deductible excise tax of $2000 per full time employee, excluding the first 30 employees. (e.g., if they have 55 employees they will only pay the fee on 25 of them.) Employers with more than 50 employees that do offer coverage but have at least one full-time employee receiving a premium tax credit (in other words, the coverage is not generous enough – 60% actuarial value with the employer paying 50% of the premium – to keep employees from qualifying for premium tax credits), will be subject to the same $2000 per employee fee (not counting the first 30) OR will pay $3,000 for each employee receiving a premium credit, whichever is less. This was to come into effect on January 1, 2014, but has been postponed by one year.[194] The original bill that passed the Senate called for a $750 fee per employee. The

[194] PPACA pp.135-137, Reconciliation bill p.1033

reconciliation bill changed this by excluding the first 30 employees from the assessment, so that smaller companies with not much more than 50 employees will effectively be paying closer to $750 on average per employee. On the other hand, for very large employers the exemption of the first 30 employees from the assessment will do little to lower the average from $2000 per employee. Thus the reconciliation bill considerably stiffened the penalty against larger employers who do not offer their employees attractive enough health insurance to keep them out of the Exchange, while mitigating most of the additional penalties for smaller businesses. Moreover, the hours worked by part-time employees will be amalgamated each month and divided by 120 to derive a full-time equivalent (30 hours a week being considered full-time for the purposes of this bill).[195] This way, employers should find it an unattractive option to try to skirt the requirement by hiring part-time instead of full-time workers. The fees are indexed the same way as premium credits are in other parts of the law.[196]

[195] Reconciliation bill p.1033

[196] Namely, that the average per capita premium for health insurance coverage in the United States for the preceding calendar year exceeds such average per capita premium for 2013. It is noteworthy that the wording of the indexation language does not take into consideration the

Credits for small employers for health insurance purchases

Starting in 2014, eligible small employers will receive 50% (35% if they are tax-exempt) of the premium contributions they actually made, limited by the average premium for the small group market in their rating area. This credit gradually decreases as the number of employees in a small business approaches 25 and as the average taxable wages paid to employees exceeds $25,000 (with indexing based on the Cost of Living Adjustment (COLA) kicking in starting in 2014).[197] Specifically, the credit will be granted in full for companies up to 10 full-time

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possibility of deflation. PPACA p.49

[197] For nonprofit (tax-exempt) organizations, the credit will be in the form of a reduction in income and Medicare tax the employer is required to withhold from employees' wages and the employer share of Medicare tax on employees' wages (with the credit thus limited by these amounts). For all other qualifying employers, it will be in the form of a general business credit. This type of credit is not refundable, but is limited by the for-profit employer's actual tax liability. In other words, if a for-profit company had a year in which it ended up paying no taxes (i.e., it had no taxable income, after accounting for all its other deductions and credits), then the small business tax credit could not be used for that year as there would be no income tax for this credit to reduce. However, as a general business credit, an unused credit amount can generally be carried back for one year and carried forward up to 20 years. (Quoted from http://bingaman.senate.gov/policy/crs_privhins.pdf)

employee equivalents and then reduced linearly for each additional employee such that it is completely phased out at 25 full-time employee equivalents. Also, the credit will be reduced linearly for small businesses with average taxable wages (rounded to the next lowest $1000) more than $25,000 (adjusted by the COLA starting in 2014) and phases out completely at $50,000. In order to qualify for the credit the company must pay at least 50% of the cost of the premiums for a qualified health plan. The number of employees is determined by adding the total number of employee hours worked and dividing it by 2080 (40 hours times 52 weeks), rounded down to the next lowest whole number. (There are special rules for workers not on an hourly basis. Seasonal workers working 120 days or less are not factored in.) Average annual taxable wages would be aggregate wages paid, divided by the number of employees, and then rounded down to the next lowest multiple of $1000. The credits will be available for two years, starting with the first year that the employer offers one of more qualified health plans through an Exchange.

PHASE OUT 1: E=number of full-time equivalent

employees, (E-10)/15
PHASE OUT 2: W=average taxable wages, B=$25,000 plus COLA, (W-B)/B

During 2011, 2012, and 2013 the maximum tax credit will be 35% of the employer's contribution to the employee's premiums (25% for non-profits). The two-year limitation does not apply during this period. Otherwise, the same phase-outs and rules apply. [198]

In the case of a small retail shop with four female minimum wage workers under the age of 25 ($7.25x2080 hours =$15,080 per year per worker), using the bronze-equivalent Geisinger plan from above, the monthly premium costs per worker would be $110 (or $1320 per year). The employer would qualify for the full credit (35% of his or her costs during 2011-13, and 50% during 2014-15, after which time the credits would expire).[199] Assuming that the employer chips in the minimum 50% of the premium necessary to qualify for the credit (or $660 per worker), the employer's credit would be $231 per worker

[198] PPACA pp.120-4. Original $20K wage base on p.121 amended to $25K on PPACA p.788. Summary on Kaiser Family, p.3.
[199]

during the first three years and $330 for the next two years. This would add 2.8% to labor costs during the first three years and 2.2% after that, the equivalent of a $0.21 or $0.16 per hour raise, respectively. The young womens' share of the premiums would be $55 per month. These women would actually get a better deal if they purchased insurance in the Exchange, which will become possible in 2014. They would qualify for $67.70 in premium credits from the government, bringing their cost down to $42.30. In addition, their low income would also qualify them for cost-sharing subsidies that would bring up the actuarial value of the policy to 94% and an out-of-pocket maximum reduced by 67%. However, these women would not qualify for purchasing insurance in the Exchange because their employer is offering them bronze-level insurance and their share of the premium is less than 9.5% of their income (Thanks, boss!). Moreover, they do not qualify for free-choice vouchers because their contribution to the premium does not exceed 8% of their income.

A small employer like the one in the example above is not bound by mandates to provide health insurance, so it

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http://www.insurance.state.pa.us/serff_filings/PAAH-126533741.pdf

is quite possible that such an employer would decide not to make the necessary contributions in order to provide insurance, even with small business tax credits, that would be less valuable to employees than what they could purchase in the Exchange with government aid. During the last two years, when the credits are in full force, the employee would be paying $55.00 per month towards the premiums, the employer $27.50, and the government $27.50. The insurance company, of course, would receive the full price of $110 per policy. On the other hand, if the employer refused to offer health insurance benefits, he or she would save the $27.50 per month per employee contribution towards their premiums and face no penalties, while the women would become eligible for the Exchange, where they could purchase a more highly rated sliver plan with a maximum contribution of $41.61, with the government chipping in the rest of the premium. On top of that, the women would be eligible for cost-sharing subsidies that would bring the actuarial value of their policy up to 94%. Even the insurance companies would benefit from the employer not offering health benefits as they would be selling a more expensive silver plan, whose

premiums would certainly be more than the $110 per month for the bronze plan. The government, of course, would be paying much more under this scenario.

In the case of a lawyer employing a lone 52-year-old female secretary with a $40,000 per year salary, the premiums for the same Geisinger insurance policy would be $276 per month, or $3312 per year. Her relatively high salary would lead to a much smaller credit for her employer: 14% (or $231.84) in the first two years and 20% (or $331.20), again assuming that the employer is chipping in 50% of the cost of the premium. This would leave the employer's share at $1424.16 during the first three years and $1324.80 for the next two years. The secretary would be playing $138 per month, or $1656 per year. However, in this scenario if the employer decides to save money and cease providing health benefits, the employee upon entering the Exchange would be expected to pay as much as $4085 (albeit for a sliver plan) before any premium assistance from the government would kick in. Clearly, she would hope that the small business tax credits, even while limited, would be enough to keep her employer offering health benefits.

Of course, one can easily imagine a scenario where the four young women and the one older woman were working for the same business. In this case, the financial interests of the younger women would be damaged by the employer offering health benefits, while the older woman would suffer if the employer withdrew the benefits.

Finally, there are rules against employers firing or discriminating against employees who receive premium credits or cost-sharing subsidies. Employees are also protected in the event that they report PPACA violations to their employer, the Federal Government, or the attorney general of a state. [200]

Free Choice Voucher

Employers that offer minimum essential coverage to their employees and pay for a portion of the cost of these plans are required to allow qualified employees to opt for a "free choice voucher" should the contribution of the employee to the employer-sponsored plan exceed 8% of employee household income, but not exceed 9.8% for a given year. If an employer-sponsored plan costs more than

[200] PPACA, p.143

9.8% of income it is considered unaffordable and the employee is free to purchase insurance in the Exchange just like someone without employer coverage and is eligible for the same premium credits and cost-sharing subsidies. After 2014, these percentages will be indexed to the rate of premium growth, just as premium tax credits and mandate exemptions will be. Furthermore, the employee household income must not be greater than 400% FPL in order to qualify for the free choice voucher. The monetary amount of the voucher will be the same as what the employer would have paid for the employer portion of the sponsored plan. These vouchers can then be used in the Exchange towards the purchase of a qualified health plan. If the amount of the voucher exceeds the premium for the plan purchased in the Exchange, the employee keeps the change. The vouchers do not count as income for the employee except in cases where there was change left over after the purchase of a qualified plan in the Exchange. Employers who provide free choice vouchers will not be subject to fines for failing to provide health benefits. Employees receiving free choice vouchers will not be eligible for

premium credits or cost-sharing subsidies.[201]

Large Employer issues

Waiting period penalties

PPACA imposes fines on large employers whose coverage include`s waiting periods. The fine for each employee made to wait for coverage between 30 and 60 days will be $400 and for waiting periods exceeding 60 days the fine will be $600.[202]

Automatic enrollment

A large employer that has more than 200 full-time employees and offers employees enrollment in one or more health benefits plans must automatically enroll new fulltime employees in one of the plans offered.[203]

Real life forecasts

So what would the health insurance landscape look like for a family of four with parents in their late forties with a household income of $75,000? They would be under

[201] PPACA, p.794-796
[202] PPACA, p.135
[203] PPACA, p.134

the 400% FPL limit, so they would qualify for Premium Credits. This tax credit is available in advance and is applied to premiums, so the family does not have to wait to file taxes to take advantage of it. How much would it be? It would be the difference between the second lowest price "Silver Plan" listed on their regional Exchange and their maximum premium contribution as set out by PPACA (in their case, $7350 per year). In other words, if the monthly premium for the second cheapest Silver Plan was more than $612.50 per month, the feds would refund the family the difference. Moreover, because the family is below 400% FPL, there would be a limit on their out of pocket costs of $7973 (or two-thirds of the HSA limit for Exchange plans). A qualified Silver Plan would have to have a full actuarial value of 70% of benefits, a $11,900 out of pocket limit, and deductibles of $2000 for individuals and $4000 for families (this is for small group policies).

Geisinger offers policies that seem to exceed these requirements that cost slightly less than $612.50 per month, and as long as there are two Silver Policies that cost less that this figure then there will be no Premium Credit from

the Federal government. [204]

Now, let's suppose that someone bought a basic silver plan, either with or without a Premium Credit. What kind of insurance would this be? How fast would those out of pocket limits be met?

Certain measures seem to depend on awareness on the part of individuals of details of PPACA provisions. For instance, Free Choice Vouchers depend on the employee share of an employer offered plan being within a narrow 8%-9.8% of *household income* band. Any second income within the household would impact eligibility. Moreover, if that second income is irregular, it will be almost impossible for the individual to know whether he or she qualifies for the voucher. Will this be a "mail-in rebate" situation in which the discount can be advertized but will only be honored if the individual jumps through hoops?

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http://www.insurance.state.pa.us/serff_filings/PAAH-126533741.pdf

Appendix B– Pennsylvania Insurance Department Statutory Authority

1. Introduction

The purpose of this section of the White Paper is to determine the current statutory authority of the Pennsylvania Insurance Department (PID) to support consumer interests regarding health insurance, the regulations used by the PID to exercise this authority, and any possible holes in the regulatory framework when looking at the current combined Pennsylvania and Federal efforts to protect health insurance consumers. However, before the issues of PID regulation are addressed, a little background information regarding health insurance regulation is necessary.

2. Governmental Interest in Health Insurance Regulation

The increased government oversight of the health insurance industry at both the state and federal levels is a result of the greater role health insurance has played in the economy, a recognition that contract law may not

adequately protect consumers, and a desire of the government to promote certain societal goals.

First of all, the amount of spending on healthcare overall and the role of health insurance have increased substantially. In 1960, the per capita national health expenditures were only $147, which represented 5.2% of the gross domestic product. By 2011, spending had increased to $8,680 per person or 17.9% of the gross domestic product.[205] In that period of time, spending on private health insurance increased from 5.8 billion dollars a year to 896.3 billion dollars a year in current dollars.[206] The United States now pays significantly more on health care than other developed nations, both on an absolute and per capita basis.[207] Since 1960, life expectancy in the United

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[205] Centers for Medicare and Medicaid Services, *Table 1 National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution: Selected Calendar Years 1960-2011* available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf.

[206] Centers for Medicare and Medicaid Services, *Table 3 National Health Expenditures; Levels and Annual Percent Change, by Source of Funds: Selected Calendar Years 1960-2011* available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/tables.pdf.

[207] The Organization for Economic Co-operation and Development (OECD), *United States Briefing Note 2012, OECD Health Data 2012: How Does the United States Compare*, Pg. 2. available at:

States increased approximately 8.5 years, with a corresponding increase in the number of older individuals (in 1960 approximately 7% of the population reached 90 years old while in 2008 that number had increased to over 22%).[208] Although the increase in life expectancy is impressive and a proportion of it is probably attributable to better health outcomes resulting from improved (and more expensive) medical technology, the United States went from having a life expectancy 18 months longer than the average Organization for Economic Co-operation and Development ("OECD") country in 1960 to one year less than the average OECD country in 2010.[209] The government has had an increased interest in regulating the health insurance industry based on both the growing share that health care expenditures are as a part of the economy, as well as some evidence that the return on these health care expenditures is not keeping up with other countries,

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http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf.

[208] Arias, Elizabeth, *National Vital Statistics Reports, United States Life Tables, 2008*, Sept. 24, 2012.Pg. 46 *Table 19. Estimated life expectancy at birth, in years, by race and sex: Death-registration states, 1900–1928, and United States, 1929–2008* and Pg. 48 *Table 20. Survivorship by age, race, and sex: Death-registration states, 1900–1902 to 1919–1921, and United States, 1929–1931 to 2008* available at http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_03.pdf.

[209] OECD, Pg. 2.

which also may have an impact upon the overall economy.[210]

Secondly, government involvement may be necessary as consumer interests may not be adequately protected by the complex nature of insurance policies in an unregulated environment. At its core, the relationship between an insurer and an insured is a contractual one. The insurer promises remuneration to the insured if certain events occur. In exchange, the insured compensates the insurer with specified payments. However, the wording of an insurance policy can be incredibly complex. Insureds are likely not to completely understand what is specifically covered and what is not covered. Because, as the drafter of the contract, the law will hold all ambiguities against the insurance company, contracts are carefully constructed so as to reduce the necessity of paying claims by being very specific regarding claims eligibility. The resulting contracts are so long and technically worded that few policy holders can be expected to read them, let alone understand them. In theory, the insured is protected by contract law if the insurer breaches the contract. However, from a practical standpoint, a protracted court battle

[210] For an analysis of the impact of higher health costs see: *The Effect of Health Care Cost Growth on the U.S. Economy,* Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services. Final Report for Task Order # HP-06-12 available at: http://aspe.hhs.gov/health/reports/08/healthcarecost/report.pdf.

over a claim can be expensive for the insured and the payment may not come in time to treat the health problem. For these reasons, insurance companies may believe that private actions against them are unlikely, and absent other regulation, it may be in their interest to lower costs by denying valid claims. Given this environment, it is understandable that the government may believe that regulation of the insurance industry is necessary.

Finally, the provision of health care has societal implications and government may want to promote certain health care policies through regulation. In a general sense, society and the government benefit from better health care outcomes. A healthy workforce leads to increased worker productivity as well as increased tax revenues for the government. Also, a health insurance system that results in many uninsured individuals discourages preventative health care which imposes a greater amount of health costs onto the government and society and impacts the economy by creating debt burdens on some uninsured that cannot realistically be paid back. The government has an interest in the structure of the health insurance industry insofar as it results in favorable health care outcomes. Toward this end, the government may wish to promote particular social policies through regulation. For example, the government

may require insurance companies to cover dependent children or breast reconstructions after a mastectomy.

3. Consumer Protection Regulations

Although the states have been regulating insurance since the 18th century, specific laws targeting health insurance were not enacted until the advent of health insurance in the 1930s.[211] In Pennsylvania, The PID was first established under the Act of Assembly of April 4, 1873, P.L. 20, and reorganized under the Insurance Department Act of May 17, 1921, P.L. 789. The purpose of the PID is to administer the laws relating to the regulation of insurance within the Commonwealth of Pennsylvania. The foundational documents in the arena of Pennsylvania insurance regulation are the Insurance Company Law of 1921 and the Insurance Department Act of 1921. However, as the insurance industry became more complex over time, additional legislation was passed which supplemented, amended and repealed parts of these original laws. The current authority of the PID to regulate insurance is comprised of dozens of statutes and amendments to statutes

[211] Jost, Regulation of Private Insurance, Pg. 8.

which are located in both Title 40 of the Unconsoldiated Pennsylvania Statutes and Title 40 of the Consolidated Pennsylvania Statutes. Some of the more significant legislation related to health insurance includes the Health Plan Corporations Act of 1972 (colloquially known as the "Blue Plans Act") , The Health Maintenance Organization Act (formerly the Voluntary Nonprofit Health Service Act of 1972), the Unfair Insurance Practices Act of 1974, Nondiscriminatory Reimbursement (Act 78 of 1971), the Medicare Supplement Insurance Act of 1982, the Accident and Health Filing Reform Act of 1996, The Pennsylvania Health Care Insurance Portability Act of 1997, and Act 134 of 2011. These statutes, and others, have been used to create the PID's regulations, which are located in Title 31 of the Pennsylvania Code.

On the other hand, the federal government had been prohibited from regulating insurance until the United States v. South-Eastern Underwriters Association decision in 1944.[212] In that decision, the Supreme Court found that insurance activity was a part of interstate commerce and could therefore be regulated by Congress under Article 1,

[212] United States v. South-Eastern Underwriters Association, 322 U.S.

Section 8, Clause 3 of the United States Constitution, generally referred to as the Commerce Clause. In response, Congress passed the McCarran-Ferguson Act in early 1945 which explicitly gave jurisdiction over the regulation of insurance to the states absent an "Act of Congress" that explicitly purports to regulate "the business of insurance." [213] Except for the 1965 establishment of Medicare and Medicaid, which did preempt some types of state regulation, Congress largely stayed out of the regulation of insurance until the 1970s.[214] Since then, there has been increasing federal involvement into health care regulation, including the Employee Retirement Income Security Act of 1974 ("ERISA"), the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), the Health Insurance Portability and Accountability Act of 1996 ("HIPPA), the Americans with Disabilities Act ("ADA"), the 2009 Patient Protection and Affordable Care Act ("PPACA"), the Health Care and Education Reconciliation Act of 2010, and various amendments to the Public Health Services Act ("PHSA"), originally passed in

533 (1944).
[213] 15 U.S.C. § 1012.
[214] Jost, Regulation of Private Insurance, Pg. 9.

1944. Taken together, these acts, as well as other federal legislation, have a significant impact on the regulation of health insurance at the state level because the federal law generally preempts state law when there is a conflict between the two. For this reason, in order to identify any gaps in consumer protections existing in Pennsylvania, federal legislation must also be considered.

The interplay of the various health insurance regulations that have been promulgated has resulted in a complex regulatory environment for health insurance providers in Pennsylvania. First of all, state and federal regulations sometimes conflict. Although the general rule is that federal laws take precedence over state laws, the interplay between federal and state laws often are extremely nuanced. One complicating factor is that Title I of PPACA states "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."[215] This allows states to maintain regulatory control if the state law meets the minimum federal standards. However, within PPACA there are exceptions to this general rule. Attempts by

[215] PPACA §1321(d).

insurance companies to navigate in these regulatory environs can be difficult. Second, regulations typically are directed at only a narrow part of the health insurance industry. These regulations can overlap, which creates a myriad of different sets of rules that apply to any individual policy. Regulations can pertain to the type of insurer (for-profit or non-profit), the type of plan (e.g., Health Maintenance Organization), the type of policy (e.g., individual or small group), the terms of the policy, and even the age of the policy, (PPACA has different rules for grandfathered vs. non-grandfathered policies).[216] Hospital Plan Corporations, Professional Health Services Organizations, and HMOs are not subject to state laws relating to insurance unless specifically mentioned in the statute. A Preferred Provider Organization (PPO), on the other hand, does not have to be mentioned specifically to be subject to general insurance laws unless they also qualify as an HMO. The regulations for a for-profit insurer offering a PPO plan for individuals that is grandfathered under PPACA are different than the rules that apply for a

[216] PPACA has a different, and more lenient, set of regulations for grandfathered plans. These plans are ones that were in existence at the time that PPACA was passed and meet certain other requirements.

non-profit HMO small group policy that is not grandfathered under PPACA.

The federal government and states regulate health insurance in a number of ways, many of which could arguably be considered consumer protection measures. Initially, the basis of state regulation of insurance companies was primarily to make sure they had enough assets in order to pay insured's claims.[217] As the role of health insurance changed over time, the number of consumer protection measures has expanded rapidly. Today, there are regulations regarding the rates charged by insurance companies, their financial health, their marketing and competition practices, consumer access to insurance, the terms of health insurance policies, and the business practices of insurance companies regarding enrolled customers.

4. Health Care Quality Regulation

The PID does not directly regulate health care quality or costs. For instance, if an insurer negotiates a rate of $500 as the standard payment for a particular procedure with a healthcare provider, the PID does not analyze

[217] Jost, pg. 10.

whether the $500 is a reasonable amount or whether the healthcare provider has had good outcomes performing the procedure. Instead, the PID assumes that $500 is a reasonable amount because it was the product of negotiations between the healthcare provider and the insurer.

Under Act 68 of 1998, the Pennsylvania Department of Health has the responsibility of regulating the quality of care for managed care organizations. PPACA also requires that plans submit annual reports regarding health outcomes.[218]

5. The Current Status of Consumer Focused Regulations

The passage of PPACA has changed the landscape of consumer regulations applicable to health insurance in Pennsylvania. This section focuses on the current and forthcoming regulations that will apply to the health insurance industry in Pennsylvania. Some of these are based on Pennsylvania law while others are based upon Federal law that has precedence over state law. In these

[218] PPACA Section 1001 Modifying PHSA Section 2717.

cases the statutory authority of the PID is moot given the superceding Federal statute.

a. Rate Regulation

One of the more important functions of the PID is its process for approving or disapproving proposed base rates and rate increases. The legislation that underpins the authority of the PID to review and potentially disapprove accident and health insurance rate filings is the Accident and Health Filing Reform Act (Act 159 of 1996). This Act required that all insurers file their rates for *individual* accident and health insurance policies with the PID.[219] For small group accident and health insurance policies, only hospital plan corporations, professional health services plan corporations, and HMOs were required to file a base rate with the PID along with any subsequent changes to the rate.[220] The standard used to determine if a rate is proper is that it not be "excessive, inadequate or unfairly discriminatory".[221] *Though all rate changes were reviewed, any proposed changes under 10% did not require prior*

[219] Act 159 of 1996. Section 303(c).
[220] Act 159 of 1996. Section 303(e)(1) to (3).
[221] Act 159 of 1996. Section 303(e)(1) and 304(b).

approval by the PID.[222]

The passage of PPACA complicated matters because it requires the U.S. Department of Health and Human Services ("HHS") Secretary "in conjunction with the States, [to] establish a process for the annual review, beginning with the 2010 plan year … of unreasonable increases in premiums for health insurance coverage."[223] This review does not apply to grandfathered plans under 45 CFR 154.103(b); and under 45 CFR 154.101(b) only applies to individual and small group coverage. The established process to review rate increases requires the Centers for Medicaid and Medicare Services ("CMS") to determine whether an increase is reasonable, unless under 45 CFR 154.210 CMS cedes that determination to the State. However, under 45 CFR 154.210(b), CMS will only accept the State's determination or reasonableness if the State has an "Effective Rate Review Program" under 45 CFR 154.301 and the State explains how it determined whether the rate was reasonable or unreasonable; this is done by assessing "the reasonableness of the assumptions used by

[222] Act 159 of 1996. Section 303(e)(2).
[223] PPACA Section 1003 amending Section 2794(a)(1), Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.),

the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions" and "the health insurer's data related to past projections and actual experience."[224]

The examination under PPACA takes into account the factors set forth in 45 CFR 154.301(a)(4) including the impact of medical trend changes by major service categories; the impact of utilization changes by major service categories; the impact of benefit changes; the impact of changes in enrollee risk profile; the impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase; the impact of changes in reserve needs; the impact of changes in other administrative costs; the impact of changes in applicable taxes, licensing or regulatory fees; medical loss ratio; and the health insurance issuer's capital and surplus. Since, under Act 159 of 1996, the PID did not review all of the small market rate increases, namely for-profit insurance rates, the HHS made the determination in the Fall of 2011 that Pennsylvania did not have an "Effective Rate Review Program" and therefore could not review all rates under

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as amended by section 1002.

PPACA.[225]

In response to the passage of PPACA, the Pennsylvania legislature passed Act 134 of 2011, which amended the Accident and Health Filing Reform Act of 1996 by expanding the authority of the PID to review and disapprove rate increases. Prior to the enactment of Act 134, the PID could not review rate increases by commercial insurance companies and the for-profit subsidiaries of the Blues. Act 134 expanded the PID's rate review authority to all small group and individual policies so that Pennsylvania would have an "effective rate review program." On January 26, 2012, HHS informed the PID that the rate review did qualify under PPACA except for "association products offered in the individual or small group markets by associations not sitused in [Pennsylvania]"[226]

Chapter 3 of Act 134 applies to all small group and individual policies. Individual rates, small group base rates,

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[224] 45 CFR 154.301(a)(3).

[225] Correspondence from Kathleen Sebelius, HHS Secretary to Michael F. Consedine, Pennsylvania Insurance Commissioner on September 27, 2011.

[226] Correspondence from Steven B. Larsen, Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Department of Health and Human Services to Michael F. Consedine, Pennsylvania Insurance Commissioner on January 26, 2012 regarding rate review procedures.

and small group rate increases over 10% are reviewed by the PID and deemed approved after 45 days unless the PID disapproves the rate or extendes the period for approval. *Any rate increases for small group plans less than 10% are not reviewed by the PID under Chapter 3.*[227] Grandfathered plans under PPACA, which are not subject to rate review under Federal law, are still reviewed by the PID under Chapter 3. Beginning in 2014, any qualified health plans offered through an Exchange will need to report any rate increases (there will not be a 10% threshold) to the Federal Health Information Oversight System ("HIOS"). It is possible that qualified health plans will also be reviewed by HHS.[228]

Act 134 also expanded the scope of public notice and response. Act 134 requires that insurers provide notice for each rate filing that is subject to review by PPACA so that it can be placed on the PID's and HHS's websites.[229]

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[227] Act 134 of 2011. Section 303(e)(3). Note: under 303(f) this 10% threshold can be adjusted to match a state-specific percentage determined by the HHS Secretary under PPACA.

[228] National Association of Insurance Commissioners, *Adopted by the NAIC Health Insurance and Managed Care (B) Committee on June 27, 2012 Form Review White Paper*, pg. 7, available at: http://www.naic.org/documents/committees_b_related_wp_form_review.pdf.

[229] Act 134 of 2011. Section 311(a) as required by Section 2794 of the

In addition, under Act 134 Section 311(c), the PID may now establish a public comment period on any filing; although there is no requirement for them to do so.

The specific Pennsylvania regulations regarding rate review are located in 31 Pa. Code 89.93 and state that "filings will be examined for actuarial adequacy, consistency and equity, including nondiscrimination aspects." Initial rates must initially meet a 50% loss ratio threshold, while revised rates must be at least 60%.[230] However, these requirements are superseded by Sections 2718(b)(1)(A)(i) and 2718(b)(1)(A)(ii) of the Federal Public Health Services Act ("PHSA"), which require a medical loss ratio of at least 85% for the large group market and 80% for the small group and individual markets.[231]

In practice, when the PID reviews a rate filing, it looks at two specific aspects of the filing when determining if rates are excessive. First, it looks at the "pure premium" which is the projected cost of paying claims taking into account inflation. The second thing it examines is other

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Public Health Services Act.

[230] 31 Pa. Code 89.83(b)(1) and 31 Pa. Code 89.83(c)(1).

[231] Note: these percentages may be adjusted by the HHS Secretary

"loads" which include administrative expenses, taxes, and profits.[232]

b. Financial Health of Insurance Companies

The question of the levels of reserves and surplus that an insurance company should have has been a very contentious issue in Pennsylvania. *Reserve* levels are the amount of money set aside to pay for the estimated outstanding claims while a *Surplus* represents the assets accrued after all liabilities have been settled. Pennsylvania's Health Plan Corporations Act allows the PID to investigate the level of reserves and surpluses for non-profit insurers as well as request materials to help in that investigation.[233] Additionally, both non-profit and for-profit insurers can be subject to financial examinations under Act 177 of 1992.[234]

In order to determine the correct level of capitalization for a non-profit insurance company, the PID

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under Section 2718(d) of PHSA.

[232] *In Re: Application of Capital BlueCross, Highmark Inc., Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania and Independence Blue Cross for Approval of Reserves and Surplus*, Misc. Docket No. MS05-02-006, Determination and Order, 2/9/2005, pgs. 16-17.

[233] 40 C.S.A. §§6601(e); 6124(a),(b); 6329(a),(b).

[234] 40 P.S. §§323.1-323.8.

looks at the Risk Based Capital ("RBC") ratio which was developed by the National Association of Insurance Commissioners (NAIC).[235] The RBC is the ratio of a insurer's net worth to the assets that the insurer is required to hold to pay estimated claims based upon several risk factors. For example, if an insurance company had $100 dollars in assets and was required by the NAIC formula to hold $50 to pay claims, they would have a RBC of 200%.This ratio is an attempt to measure the financial strength of an insurance company. NAIC requires that insurers have a RBC of at least 200% while the Blue Cross and Blue Shield Association requires its licensees to have a RBC of at least 375%.[236] In general, the RBC ratio should be higher for plans facing higher amounts of risk, such as underwriting risk and lack of diversification in products. The PID determines the proper range for the RBC and the corresponding operating surplus levels based on the

[235] The RBC formulas were established by Act 40 of 1997 for stock and mutual companies and by Act 62 of 2000 for hospital plan corporations, professional health services plan corporations, and preferred provider organizations that are not stock or mutual companies. 40 P.S. 221.1-A to 221.15-A; 40 P.S. 221.1-B to 221.15-B.

[236] Davis, Steve. Health Business Daily, *Will Record Surpluses Among Not-for-Profit Blues Plans Trigger Price Wars in 2011?*, January 10, 2011 reprinted at: http://aishealth.com/archive/nhpw122010-01.

amount of risk faced by each insurance company. This determination may indicate that the capital levels are insufficient or sufficient to meet expected future claims based on risk factors. In addition, this determination can be used to determine if the capitalization is efficient or inefficient because there is too much capital surplus.[237]

In 2005, the Insurance Commissioner determined that a sufficient and efficient RBC ratio for Highmark and Independence Blue Cross was between 550 and 750%, while a sufficient and efficient RBC ratio for Capital Blue Cross and Blue Cross of Northeastern Pennsylvania was 750% and 950% because of the higher level of risk they faced.[238] This means that for every dollar that the NAIC has determined that is the minimum amount that needs to be held to cover current claims based upon risk factors, Highmark should hold between $5.50 and $7.50 in reserve. Levels above these ranges were considered inefficient without additional justification and probably represented surplus amounts in excess of what would be consistent with the non-profit status of the insurers.

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[237] *In Re: Application of Capital BlueCross*, Misc. Docket No. MS05-02-006, Determination and Order, 2/9/2005, pg. 34.
[238] *In Re: Application of Capital BlueCross*, Misc. Docket No.

c. Marketing Issues

Insurance policies are long and complicated. In order to compare available policies, consumers do not read through the policies themselves, but rely on marketing materials summarizing those policies. Under Pennsylvania's Unfair Insurance Practices Act of 1974 ("UIPA"), an insurance company may not use "unfair or deceptive acts or practices" including "making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which…misrepresents the benefits, advantages, conditions or terms of any insurance policy."[239] The PID Commissioner may conduct an investigation and hold a hearing to determine if there was a violation of the UIPA.[240] In addition, the PID Commissioner may levy administrative and civil penalties.[241]

PPACA affirmatively requires that all plans provide information to the public in clear language regarding claims payments, financial disclosures, enrollment data,

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MS05-02-006, Determination and Order, 2/9/2005, pg. 37.

[239] Unfair Insurance Practices Act of 1974. Sections 4 and 5(a)(1)(i).

[240] Unfair Insurance Practices Act of 1974. Sections 7 and 8.

[241] Unfair Insurance Practices Act of 1974. Sections 9 and 11.

disenrollment data, and data on claims denials.[242]

d. Access to Insurance

i. *Dependent Coverage*

Under PPACA, plans that offer dependant coverage must cover adult children up to the age of 26.[243] Pennsylvania provides dependant coverage to adult children through 29 years of age.[244] Under PPACA's preemption rules, dependents would typically be covered through 29 years of age. However, Pennsylvania's statute is more narrowly tailored than PPACA. For example, under commonwealth law, a dependent would not qualify for coverage if they were entitled to benefits under a government health care benefits program.[245] This creates a situation where those that qualify under the state law are required to be offered dependant coverage through 29 years of age, while those who do not qualify may qualify under PPACA and therefore would be eligible for dependant coverage until age 26.

ii. *Guaranteed Issue and Renewability*

In 1996, HIPAA required all insurers to sell all their

[242] PPACA Section 1001 Amending PHSA Section 2715A.
[243] PPACA Section 1001 Amending PHSA Section 2714.
[244] Act 4 of 2009, Section 617.1(A).

small group policies on a guaranteed-issue basis, which means that a policy must be offered to any eligible applicant without regard to health status.[246] All group and individual health insurance policies must be guaranteed renewable. Although HIPAA does not prohibit insurers from canceling all their policies and leaving the market, there is a penalty on market reentry of 5 years.[247] PPACA extended these protections, requiring universal guaranteed issue and renewability for all non-grandfathered fully-insured plans.[248]

iii. *Discrimination Based on Health Status*

Under PPACA, no non-grandfathered individual or group plans can establish rules to restrict the eligibility of an applicant to enroll in the plan based upon health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status as determined by the HHS Secretary.[249]

e. Health Insurance Policy Terms

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[245] Act 4 of 2009, Section 617.1(A)(4).
[246] Health Insurance Regulation by States…
[247] Id.
[248] PPACA Section 1201 modifying PHSA 2702 and 7203.
[249] PPACA Section 1201 modifying PHSA 2705.

i. *Mandated Benefits*

Pennsylvania currently mandates that individual, small group, and large group insurance cover maternity minimum stay (40 P.S. §1583), orthotics/prosthetics (40 P.S. §764(e)), childhood immunizations (40 P.S. § 3502), mammographic examinations (40 P.S. §764(c)), annual gynecological and routine pap smears (40 P.S. §1574), children and developmentally disabled patient access to quality dental care (40 P.S. §3510.2), mastectomy/reconstructive surgery (40 P.S. §764(d)), diabetic supplies and education (40 P.S. §764(e)), medical foods (40 P.S. §3901), and chemotherapy (40 P.S. §764b; HMO's are excepted). In addition, both small and large groups must cover outpatient and inpatient services for alcohol abuse and dependency (40 P.S. V908-2). Large groups must also cover outpatient and inpatient services for serious mental illness (40 P.S. §764g), habilitation services for autism spectrum disorders (40 P.S. §764h), and colorectal cancer screening (40 P.S. §764i).

Starting in 2014, PPACA requires that all non-grandfathered individual and small group plans cover

certain essential health benefits ("EHBs").[250] These EHBs are based upon a benchmark plan, but at a minimum must include ten benefit categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Pennsylvania had an opportunity to recommend an EHB benchmark plan. However, because of time constraints and a lack of guidance from HHS, the PID simply sent the HHS a study of the ten most popular small group plans.[251] Eventually, the EHB package defaulted to the health benefits included in the largest small-group plan in Pennsylvania, i.e., "Aetna POS Cost Sharing 34 1500 Ded". The covered benefits include: primary care visit to treat an injury or illness, specialist visit, other practitioner office visit (Nurse,

[250] PPACA §1201 modifying §2707 of the Public Health Service Act.
[251] Correspondence from Michael F. Consedine, Insurance Commissioner to The Honorable Kathleen Sebelius, Secretary, United States Department of Health and Human Services on September 26, 2012 regarding essential health benefits.

Physician Assistant), outpatient facility fee, outpatient surgery physician and surgical services, hospice services, routine eye exam (adult), urgent care centers or facilities, emergency room services, emergency transportation/ambulance, inpatient hospital services, inpatient physician and surgical services, skilled nursing facility, prenatal and postnatal care, delivery and all inpatient services for maternity care, mental/behavioral health inpatient and outpatient services, substance abuse disorder inpatient and outpatient services, generic drugs, preferred and non-preferred brand drugs, , specialty drugs, outpatient rehabilitation services, chiropractic care, durable medical equipment, diagnostic test (x-ray and lab work), imaging (CT/PET Scans, MRIs), preventative care/screening/ immunization, routine eye exam for children, eye glasses for children, dental check-up for children, basic dental care - child, major dental care – child, and orthodontia – child. Benefits that are not mandatory include: non-emergency care when traveling outside the U.S., routine adult dental services, infertility treatment, long-term custodial/nursing home care, private-duty nursing, bariatric surgery, cosmetic surgery, habilitation

services, hearing aids, routine foot care, acupuncture, and weight loss programs.[252] Pennsylvania's lack of coverage for habilitation services will mandate a modification of the EHB package before the beginning of 2014.

ii. *Annual and Lifetime Limits*

Under PPACA, no plans will be able to establish lifetime limits on the dollar value of essential health benefits.[253] The June 28th interim final rule promulgated by HHS indicated that individuals that have previously hit their lifetime limits and therefore lost their coverage may re-enroll with their plans as long as it was a group plan or it was an individual plan that is still active.[254] Annual limits on EHBs are allowed, but restricted through the end of 2013 on all plans except for grandfathered individual market plans, which still may have annual limits.[255] However, all plans may have annual and lifetime limits on benefits that are not EHBs.

iii. *Insurance Premiums*

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252 http://cciio.cms.gov/resources/EHBBenchmark/pennsylvania-ehb-benchmark-plan.pdf

253 PPACA Section 1001 modifying PHSA Section 2711.

254 Federal Register, Vol. 75, No. 123, Pg. 37191-37192. June 28, 2010.

255 Federal Register, Vol. 75, No. 123, Pg. 37191. June 28, 2010.

Under PPACA, fully insured small group and individual plans that are not grandfathered, as well as large group plans in states that include large group plans in their Exchange may not vary insurance premiums except for four characteristics. Specifically, insurers may vary premiums for age, tobacco use, geographic rating area, and whether the coverage is for an individual or a family.[256] However, the amount of variation is limited to a 3:1 ratio for age and a 1.5:1 ratio for tobacco use. Since Pennsylvania does not have regulations regarding premium pricing based upon an individual's characteristics, grandfathered plans under PPACA can charge some consumers much more than others for the same coverage without restriction.

iv. *Preexisting Condition Exclusions*

PPACA does not allow for a plan, except for grandfathered individual market plans, to impose any preexisting condition exclusion.[257]

f. Business Practices of Insurance Companies

i. *Prohibition on Rescissions*

[256] PPACA 1201 amending PHSA 2701.
[257] PPACA Section 1201 modifying PHSA Section 2704.

Coverage cannot be rescinded under PPACA, unless there is fraud or intentional misrepresentation of material fact and the terms of the coverage allow for rescission.[258] However, one of the weaknesses in the law is that it is the insurance company that initially determines whether, in their opinion, fraud or an intentional misrepresentation occurred.

ii. *Claims Handling*

In interpreting Section 4 of the Unfair Insurance Practices Act, the PID has promulgated regulations regarding unfair claims settlement practices.[259] Insurers are required to complete claims investigations within 30 days after notification unless the insurer notifies the insured that an extension is necessary.[260] In addition, insurers must disclose all pertinent coverages under the contract when a claim is presented; it is not up to the insured to guess which provisions are relevant to a specific claim.[261] If a claim is denied based upon a specific policy provision, the insurer must identify it in the denial, which is to be given to the

[258] PPACA Section 1001 modifying PHSA 2712.
[259] 31 Pa Code Chapter 146.
[260] 31 Pa Code Chapter 146.6.
[261] 31 Pa Code Chapter 146.4(a).

claimant in writing.[262] Any files of the insurer shall be accessible to the PID for investigative purposes.[263] HMOs are subject to the Unfair Insurance Practices Act.[264] [Note: under 40 Pa. C.S.A. 6103(a), hospital plan corporations are exempt from "laws of this Commonwealth now in force relating to the business of insurance" unless statute specifically refers to HPCs and under 6307(a) there is a similar provision for certificated professional health service corporations.]

6. Large Group and Self-Insured Plans

It needs to be noted that while this paper is focusing on the regulation of individual and small group markets, there are two other market segments. First there is the large group market which refers to the section of the health insurance industry providing coverage for groups of over 50 employees.[265] Large groups typically are less regulated at the state level based on the belief that larger employers are in a better position to aggressively negotiate rates and

[262] 31 Pa Code Chapter 146.7(a)(1).
[263] 31 Pa Code Chapter 146.3.
[264] 40 P.S. §1560(b)(1).
[265] Note: Under PPACA §1304(b)(1), the threshold for large group market is groups with more than 100 employees. However, in

terms with insurers. However, at the federal level, large group coverage is regulated by the Employee Retirement Income Security Act (ERISA) if the employer purchases the insurance for their employees.[266] Although ERISA has extensive regulations regarding reporting requirements, claims procedures, and remedies, there are relatively few regulations regarding what the health insurance actually covers.[267] The other market segment is those companies that choose to self-insure, which means that the company directly pays for medical claims of its employees out of its own assets. Companies that self-insure are allowed to reduce their risk by purchasing reinsurance that pays part of the claims when certain events occur, such as unusually large claims. Under ERISA, self-insured companies are exempt from all state insurance laws and bear the lowest regulatory burden.[268] In fact, until the passage of PPACA,

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Pennsylvania this will not happen until 2016.

[266] Monahan, Amy J., *The ACA, The Large Group Market, and Content Regulation: What's a State to do?*,Saint Louis University Journal of Health and Policy Vol. 5.83, pg. 85.

[267] Monahan, Amy J., *The ACA, The Large Group Market, and Content Regulation: What's a State to do?*,Saint Louis University Journal of Health and Policy Vol. 5.83, pg. 85.

[268] Monahan, Amy J., *The ACA, The Large Group Market, and Content Regulation: What's a State to do?*,Saint Louis University Journal of Health and Policy Vol. 5.83, pg. 86.

self-regulated plans did not even have to provide external review for claims denials.[269] Although the number of people covered by large group and self-insured plans is significant, this paper does not address the ramifications of PPACA on these markets since they are not the focus of PPACA, and in the case of self-insured plans, Pennsylvania is barred from regulation.

[269] Monahan, Amy J., *The ACA, The Large Group Market, and Content Regulation: What's a State to do?*,Saint Louis University Journal of Health and Policy Vol. 5.83, pg. 98.

Appendix C

The SERFF System

While there is a mass of data available over the PID website "approved rate and form filing" search page, the user interface leaves much to be desired. The lack of consistency in the way SERFF filings are posted makes it tedious to locate the information one seeks. For instance, one cannot search by policy name. The SERFF system does not have a field for policy name, and the "product name" field usually contains a code established by the insurer to denote the name of the filing, and thus often contains a year indicator. Other times it is left blank. The only fields that can be searched are "Insurance Company Name," "Tracking Number," NAIC #," "Line of Business," "Filing Type," "TOI," "Sub-TOI," and "Date Filing Closed." Insurance Company Name and NAIC # both identify the company, although companies may have multiple names and multiple NAIC numbers.

The Tracking Number is unique to each filing, and contains four letters that denote the company, a hyphen, and typically nine digits that seem to be a serial code. If you already know the Tracking Number it is a shortcut to

the filing, but otherwise it is of no help. The Line of Business only has three categories: health, life, and property & casualty, so it does not narrow the search very much. Filing Type only distinguishes between rate, form, and rule. "Date Filing Closed" allows the user to restrict the search to between two dates. The utility of this function is limited by the irregularity in the dates that a company chooses to submit a rate filing for a given policy and the varying amount of time it takes to gain PID approval. The last two searchable fields, TOI (type of insurance) and Sub-TOI (sub-type of insurance) have their utility compromised both by the vast number of selections (there are 138 types of insurance and 493 sub-types) and by the fact that the types overlap and are not used regularly.

For instance, Highmark Blue Cross Blue Shield's DirectPay PPO rate filing in 2008 used "Non-Profit" as the type of insurance and "Indiv PPO Rates" as the subtype. In 2009 for the same policy they used "Non-Profit- M.U.PPO" as the type and "CompMajMed" as the subtype. In 2011 for the same policy they used "H16I Individual Health – Major Medical" as the type and "H16I.005A Individual – Preferred Provider (PPO)" as the subtype. This

inconsistency makes it difficult to find a filing for a particular policy in a particular year and even more difficult to try to follow that policy over a number of years in order to track its price trends.

The following are recommendations for the improvement of the SERFF system that are in addition to the recommendations made for improving the functioning of the PID made in the summary of Section D:

(1) Creating a single database for all filings, whether approved, disapproved, or current. At present the PID has one search engine for approved filings and a separate list of current filings, but nothing for disapproved filings.

(2) Improve the presentation of data within each filing. The data is poorly organized and often incomplete. Key data fields such as "product name" should not be left blank or filled in with generic terms. In most filings the SERFF field that specifies the amount of the rate hike is left blank. Rather, the data for what percentage increase is finally approved is typically found in an approval letter, which is usually part of the image data in SERFF filings and

therefore not searchable, and typically one must eyeball dozens of pages of unsearchable images in order to find it. Occasionally the approval letters do not specify the percentage rate increase that has been approved. It is also common for the *requested* (as opposed to approved) increase not to be specified. This makes it impossible to compile aggregate data on all rate hike requests and approvals. The information contained in the approval letters needs to be comprehensive and consistant.

(3) Put the most important information on the first page summary of each filing. The SERFF system provides an opportunity for standardization of data input that could make it easy for anyone to judge the impact of rate increases. Pertinent information such as loss ratios, number of policies impacted, date and size of most recent premium hike, requested premium hike, and approved premium hike should be standardized. This would make these records more user friendly to the public and to policy makers. It would also help everyone concerned keep better track of overall trends, individual products, and the success or lack thereof of the Department in regulating the industry.

(4) Include verbal agreements in the SERFF records. Written correspondences between PID regulators and insurance companies often refer to agreements reached during telephone calls without stating what those agreements were. This must stop. Any agreements must be reached on the record in a public format. To do otherwise reduces transparency in rate filings. The inconsistency of the documentation related to requested rate increases makes any outside review of the PID's decision difficult.[270]

(5) Input all relevant data into SERFF's data fields.

(6) Implement standard formats for approval letters so that it is always clear what products are being impacted and by how much.

[270] The 2008 Aetna filing for their individual HMO products is a case in point. The PA Bulletin announced that the company was seeking an average 19% rate increase, and the filing was ultimately approved, although there was no specification of the approved rate increase. A close examination of the originally submitted rate tables and the approved rate tables indicates that the rate hike that the PID approved was considerably less than 19%. In other cases, there is no specification of what rate hike was approved or any indication that the rate increase was different from the hike requested.

(7) Implement standard organization of supporting documentation, including rate tables, experience and actuarial data, and PA Bulletin announcements.

(8) Include company financial data. This is currently not the case.

The PA Bulletin is another valuable source of information. It often contains information such as the number of policies that will be impacted, the last time premiums were increased, and the amount of the last increase. Because the SERFF system does not provide fields for input of this data, the PA Bulletin is often the best way of accessing this information. However, there is no standardized format for how announcements are presented, and often some important information is left out. It is typically the companies themselves that draft the announcements, so the PID should

(9) Supply companies with a template to make sure that all relevant information is included in announcements. The information in the announcement should be automatically

inputed into SERFF.

Glossary

Accident and Health Filing Reform Act of 1996
A Pennsylvania statute providing for review procedures pertaining to accident and health insurance form and rate filings

Actuarial value
The proportion of medical payments incurred by the average person in a standard population (not just the group or market that the plan is sold to) that the plan would pay for. The Actuarial Value Calculator developed by the U.S. Department of Health and Human Services is based on claims data from the Health Intelligence Company, LLC (HIC) database for calendar year 2010. Actuarial values are calculated primarily with reference to deductibles, coinsurance rates, co-pays, and out-of-pocket maximums.

Annual, lifetime limits
Limits on the health benefits that an insured person can receive during a given plan year or during that person's lifetime with the plan. Lifetime and annual limits on the dollar value of "essential health benefits" are prohibited by PPACA for both new and grandfathered plans.

Blues
Blue Cross and Blue Shield organizations. Traditionally non-profit entities that provide health insurance to some 100 million Americans with Blue Cross plans providing coverage for hospital services and Blue Shield covering physicians' services. Some have converted to for-profit companeis

CHIP
Children's Health Insurance Program. A program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children with incomes that are modest but too high to qualify for Medicaid.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985. A federal law giving some employees the ability to continue health insurance coverage for a period of time after leaving employment.

Coinsurance
After an insurance policy holder has met their annual deductable, the plan typically pays for a given percentage of provider services after that until the out-of-pocket maximum has been reached. If the plan pays 80% of a bill in these circumstances, then the patient will be billed a coinsurance of 20%.

COLA
Cost of Living Adjustment

Copay
A flat fee that an insurance policy holder pays to a provider at the time of service.

Cost-sharing subsidies
Eligible individuals and families will receive cost-sharing credits to reduce the cost sharing (out-of-pocket) amounts when they receive medical services. These are to have the effect of reducing costs and increasing the actuarial value

of the basic benefit plan to the following percentages of the full value of the plan for the specified income level:

Deductable
A set dollar figure that must be paid by an insurance policy holder during a given plan year before the plan pays for services. Certain services may not be subject to the deductable, such as some preventative services.

Essential Health Benefits
Services that PPACA requires health plans in the individual and small group markets to offer. These include following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Federal Poverty Limit (FPL)
A dollar value for income based on family size that is the basis for qualifying for many poverty alleviating government programs, including PPACA's subsidies. (FPL 2013: individual $11,490; family of four $23,550)

Grandfathered plan
Certain health insurance plans that were in force before passage of PPACA are exempt from some provisions of PPACA provided they do not make fundamental changes to their benefit packages.

Guaranteed issue
Policies offered to any eligible applicant without regard to health status.

Health Plan Corporation Act of 1972
A Pennsylvania law which, in part, added additional regulations for non-profit hospital plans such as Blues Plans.

HMO
A Health Maintenance Organization. An organization that provides managed care for health insurance on a prepaid basis. Unlike traditional indemnity insurance, an HMO covers care rendered by those doctors and other professionals who have agreed by contract to treat patients in accordance with the HMO's guidelines and restrictions in exchange for a steady stream of customers.

HSA
Health Savings Account

Indexing
Adjustments in the price or value of an aggregate of goods, services, or wages in comparison with a reference level for a previous period of time. For instance, Social Security payments are indexed based on the cost of living.

Insurance Company Law of 1921
A comprehensive law representing the consolidation and amendment of previous insurance laws in the Commonwealth. This Act is the foundation of much of insurance regulation today, though it has been amended on dozens of occasions to reflect the growth in scope of the

insurance industry.

Insurance Department Act of 1921
A law which reorganized the Pennsylvania Insurance Department and granted the PID authority to regulate insurance under the Insurance Company Law of 1921 and other subsequent statutes.

Medical Loss Ratio
The Congressional Budget Office defines medical loss ratio or MLR, as the proportion of premium dollars that an insurer spends on health care. It is commonly calculated as the amount of claims incurred plus changes in reserves as a fraction of premiums earned."

Medical Underwriting
The process whereby an individual's health information is used in deciding whether to offer or deny coverage; and then what premium rate to set for the policy should coverage be offered.

Medicaid
A program run jointly by the federal and state governments to provide health insurance to very low-income people.

Medicare
A federal government program to provide health insurance to the elderly (65 and over) and the disabled.

Network
Health care providers with whom an insurance plan has contractual agreements to treatment of policy holders.

Out-of-pocket maximum
A total limit of co-pays, coinsurance, and deductibles beyond which the plan will pay all provider charges for the remainder of the plan year.

Personal responsibility mandate
The PPACA requirement that all people who meet certain income requirements and are not in exempted categories purchase their own health insurance or pay a tax penalty.

PID
Pennsylvania Insurance Department

PPACA
Patient Protection and Affordable Care Act. Also known as the Affordable Care Act (ACA), the federal health care reform law, and ObamaCare

Pre-existing conditions
A medical condition or elevated risk that was present and diagnosed before enrollment in an insurance plan. Pre-existing conditions are typically excluded from coverage during the first year that the policy is in force. The rationale is to discourage people from waiting until they are sick before they enroll in health insurance.

Premium Credit
One of the major provisions of PPACA designed to extend health care to people currently uninsured. Refundable (in other words, available even to families with no tax liability), advanceable (the family does not have to wait until they file) tax credits are to be paid by the government directly to health insurance policies on behalf of low-income people

(those between 100% and 400% of the FPL)

Public Health Service Act
A federal law enacted in 1944 for the purpose of consolidating and revising the laws relating to the Public Health Service. It was significantly amended with the passage of PPACA.

Rate filing
When certain categories of insurers wish to raise premium rates, they must file with the state insurance department for approval or acknowledgement.

Rescission
The practice of canceling a policy (usually during the first two years after being issued) based on misrepresentations made by the policy holder on application forms.

Self-insured
A self-insured group health plan (or a 'self-funded' plan) is one in which the employer assumes the financial risk for providing health care benefits to its employees.
Self-insured employers pay for each out of pocket claim as they are incurred instead of paying a fixed premium to an insurance carrier, although they may contract with an insurance company to administer the plan.

SERFF
System for Electronic Rate and Form Filing – Started in 1996, the SERFF system is designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings.'

Single Payer
A health care financing system where there is one payer, normally the government, similar to Medicare.

Wellness programs
A health promotion program, activity, or policy designed to support healthy behavior and improve health outcomes.

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