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MEASURE: SB 165
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S. HEALTHCARE & HUMAN SERVICES
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Sent via email only
Senator Laurie Monnes Anderson
Chair, Senate Health Care and Human Services Committee
Oregon State Senate
State Capitol Building
900 Court Street NE, SD 25
Salem, Oregon 97301

Re: Senate Bill 165

Dear Senator,

I am writing to you about Senate Bill 165, which is scheduled for public hearing today before your committee, on behalf of Lou Savage, the State of Oregon Insurance Commissioner. Commission Savage asked me to explain specific aspects of the bill that may be important for you to consider as it moves through the process. These aspects include the following:

- SB 165's definition of "essential health benefits" (EHB) conflicts with the definition in HB 2240, the State of Oregon's bill to align the Oregon Insurance Code with the Affordable Care Act (ACA).
- SB 165's limits on EHB and total cost sharing are not consistent with each other or with the ACA.
- SB 165 imposes limits on large group and grandfathered health benefit plans that are not otherwise imposed by the ACA.

Background

Since President Obama signed the ACA into law on March 23, 2010, the Insurance Division of the Department of Consumer and Business Services (Insurance Division), in coordination with the Governor's Office and the Oregon Health Authority, has taken a very deliberate approach to implantation of the federal law to limit market disruption and mitigate costs for consumers. In 2011, the Oregon Legislative Assembly passed Senate Bill 89, which implemented the early reforms of the ACA. Oregon was one of only a handful of states able to enact such legislation.

In implementing the ACA, the state has decided to make changes to the Oregon Insurance Code in a way that removes impermissible inconsistencies. This approach has allowed Oregon to implement the ACA while keeping the integrity of its regulatory structure and consumer protections intact. The implementation process has been transparent and collaborative over a period of years.

Senate Bill 165

Senate Bill 165 does the following:

- Defines essential health benefits to include:
  - The ten general categories required by the Affordable Care Act and
  - "Other items and services prescribed by the department as required or permitted by federal law."
- Limits annual cost-sharing on essential health benefits to the "amounts specified in 42 U.S.C. 18022."
- Limits total cost sharing on all benefits to $5,950 for an individual and $11,950 for a family.

SB 165's Definition of "Essential Health Benefits"

House Bill 2240, the Governor's bill to align the Insurance Code with the ACA, defines EHB to be consistent with the ACA and consistent with the state's selection of the PacificSource Codeduct Value Plan as its EHB base-benchmark plan. The PacificSource plan was selected by the Governor after an exhaustive transparent, public process involving multiple stakeholders and interests. HB 2240 is the product of stakeholder input and consultation and several months of analysis, drafting, and redrafting. SB 165's definition is inconsistent with HB 2240's definition.

SB 165's Limitations on Annual Cost-Sharing

SB 165 imposes limits on annual cost-sharing for essential health benefits that do not exceed "amounts specified in 42 U.S.C 18022." For non-grandfathered health benefit plans, 42 U.SC. 18022 ties the annual limitation on cost sharing for plan years beginning in 2014, to the enrollee out-of-pocket limit for high deductible health plans (HDHP), as calculated pursuant to section 223(c)(2)(A)(ii) of Internal Revenue Code of 1986 (the Code) based on section 1302(c)(1)(A) of the Affordable Care Act. For the year 2013 these amounts are $6,250 for self-only and $12,500 for non-self only coverage. In 2014, it is believed these amounts will increase to $6,400 and $12,800 respectively. Additionally, 42. U.S.C. 18022 specifies maximum deductible limits on small group plans at $2,000 for individual and $4,000 for individual plus.

In 2011, the Legislative Assembly passed Senate Bill 91, which directs the Insurance Division to develop standard bronze and silver plans for the small group and individual health benefit plan markets inside and outside of the exchange. Over the course of several months, the Insurance Division, through a process similar to that used by the governor for selection of EHB, hired an actuarial consultant and collaborated with consumers, insurers, insurance producers, and small business interests to develop the standard plans. Issuers are relying on the development of these plans to design plan offerings for small group and individual plans sold in and outside of the exchange in 2014.

The SB 91 standard plans are based on the cost-sharing amounts prescribed in the ACA ($6,400 and $12,800). These plans are also based on subsequent federal rules allowing for higher deductibles than the amounts specified in 42. U.S.C. 18022.

SB 165 requires that *total* cost-sharing be limited to no more than $5,950 and $11,950. Because this limitation applies to total benefits and not just essential health benefits, cost-sharing for essential health benefits and for the standard plans would need to be significantly reduced. This means that plans filed after January 1, 2014 (the Insurance Division anticipates that a number of plans will be issued in early 2014) would need to undergo significant revision, resulting in market disruption, something the state has been working hard to minimize.

Finally, the ACA cost-sharing limits are tied to a measure that changes year to year. Including separate fixed cost-sharing limits in statutes would impede the market from adjusting as this measure and costs change.

SB 165's Application to Large Groups and Non-Grandfathered Plans

SB 165 imposes cost-sharing limits on all health benefit plans, including grandfathered plans and large group plans. Grandfathered plans under the ACA are plans that allow consumers an option to maintain coverage that they had prior to the ACA. Changes to annual cost-sharing of these plans are limited by federal law. Imposing the cost-sharing required by SB 165 on grandfathered plans could potentially result in the inability of some of these plans to maintain grandfathered status.

The terms of large group coverage are often negotiated between the insurer and the employer. These plans are not subject to the cost-sharing limitations or actuarial value requirements of the ACA. Imposing cost-sharing limitations on these plans would be a significant departure from current market practices and would likely lead to significant market disruption at a time when the Oregon insurance markets are prone to significant uncertainty.

I hope that this information is helpful to you as you consider this bill. I plan to be at the public hearing today but will testify only if you wish me to do so.

Sincerely,

/s/

Anthony A. Behrens
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State of Oregon Insurance Division
Department of Consumer and Business Services