



TESTIMONY

**HOUSE BILL 1
OHIO DEPARTMENT OF INSURANCE BUDGET**

**AGRICULTURE AND DEVELOPMENT SUBCOMMITTEE
HOUSE FINANCE COMMITTEE**

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AARP OHIO

Chairman Slesnick, ranking member Goodwin and members of the Agriculture and Development Subcommittee, I am Ron Bridges, the government affairs director for AARP Ohio. On behalf of AARP Ohio, I appreciate this opportunity to provide input, which supports the Executive Budget recommendations related to the Ohio Department of Insurance "ODI".

AARP Ohio is proud to represent and serve 1,671,397 AARP members age 50+ in the state. As their representative, we are committed to championing access to affordable, quality health care for all generations, especially the estimated 196,063 uninsured Ohioans age 50-64.

In the 2008 election, seventy-three percent (73%) of Ohioans age 50+ voted and sent a clear message that it's time for elected officials from both sides of the aisle to come together to solve our nation's problems at the local, state and federal levels. The first milestone these voters will use to gauge the legislature's progress toward bipartisan solutions will be its' disposition of the individual market and transparency reforms outlined in the ODI budget.

Individual Insurance Market Reform

Individuals shopping for coverage on their own generally pay more for less generous benefits than their counterparts who get insurance through their employers. Forty-three percent of Americans enrolled in an individual plan spend more than 10 percent of their incomes on premiums and out-of-pocket medical expenses. Those with pre-existing conditions may not be able to find an insurer willing to cover them at all, or they may face outlandishly high premiums and still not be able to get coverage for the conditions that most need treatment.

The individual health insurance market cannot work for Ohioans until we fix the severe barriers that prevent many who want coverage from purchasing it. As you consider the concerns of those Ohioans currently priced out of coverage, we ask members of the Subcommittee to consider the fact that rules of competition that work well in a market for TVs or cars do not work well in a market where bottom-line profitability depends on who is purchasing the product (in this case, an insurance policy).

Paying claims costs insurers money, so they have a powerful incentive to protect themselves against covering individuals in less-than-perfect health. A competitive environment where insurance companies compete by avoiding the sickest applicants, leads to denial of coverage or unaffordable premiums for people with pre-existing conditions and risk pools that divide the healthy from the sick.

A handful of states prohibit insurers from discriminating on the basis of health status, but in most places including Ohio, insurers can deny coverage to individuals with pre-existing conditions, exclude coverage for their pre-existing conditions, or charge enrollees higher premiums without restriction. Subsequently, the premiums are unaffordable for almost everyone.

According to a recent survey by the Commonwealth Fund, more than two-thirds of people who investigated buying an individual policy found it difficult or impossible to find adequate coverage. Ninety-two percent of people with a health problem never bought a plan, presumably because they were denied coverage or could not afford the plans offered to them. This could be because they have pre-existing medical conditions—whether a chronic disease like diabetes or a one-time event like delivering a baby by Caesarean section—that lead insurers to raise their rates or reject covering them altogether.

The Open Enrollment Program proposed in the Executive Budget is a prudent approach to fixing the marketplace. It will limit “cherry picking” to prevent discrimination against individuals with health risks or perceived health risks. It will also narrow the wide variation in premiums.

The open enrollment proposal promises help to many Ohioans, who are currently locked out of coverage because of cost. The proposal offers consumers without insurance substantial relief in obtaining coverage, while imposing just a modest cost on those with insurance. This proposal incorporates the foundation of insurance. The more people who share the risk, the less each individual needs to pay in to the pool.

Additional changes need to be implemented for the individual market to become an accessible option for higher risk Ohioans. Steps needed to protect these consumers include prohibiting post-claim underwriting, prohibiting exclusion riders,

establishing minimum medical loss ratios and standardizing plans so they can be compared side-by-side.

Minimum Medical Loss Ratio

Minimum Medical Loss Ratio standards encourage health insurers to increase efficiency and reduce administrative waste. If an insurer does not spend enough premium dollars on medical care, it must either refund consumers or adjust its premiums accordingly for the following year. Ohio should require insurers in the individual health insurance market to spend at least **75 cents** of every premium dollar on medical care.

Post Claims Underwriting

ODI should be given enforcement authority to shield consumers from predatory post-claims underwriting through the following provisions:

- ❑ Require insurers to define pre-existing conditions that consumers must disclose on their application as treatment that has been received or recommended by a medical professional within the last two years. Using this kind of objective standard prevents insurers from alleging that policyholders should have known they had a medical condition, even though no medical professional told them as much.
- ❑ Require insurers to present clear questions on insurance applications and to communicate the importance of answering completely.
- ❑ Require insurers to complete all medical underwriting at the time of application and contact applicants or review additional health information to clarify any confusing or incomplete answers before issuing a policy.
- ❑ Prohibit insurers from limiting or revoking policies, or at least prohibit limitations and revocations after policyholders have had their policies for a period of time.
- ❑ Prohibit insurers from refusing to pay providers for treatment that they have already authorized after policies are cancelled.

Coverage Revocation

Important statutory protections, oversight, and stringent enforcement are necessary to shield consumers from unfair coverage revocation or rescission. ODI should be given explicit authority to establish and enforce the following provisions:

- ❑ Require that insurers submit requests to revoke policyholders' coverage to the state insurance commissioner for review.
- ❑ Require notification to insured individuals that the insurer is pursuing a policy cancellation and to provide the consumer with its reasons for doing so.
- ❑ Give consumers the opportunity to participate in any investigations about whether they willfully misrepresented their health on applications, and allow consumers to appeal decisions both through their health plan and through an outside government agency.
- ❑ Require that insurers prove that a patient knowingly made misstatements or withheld information during the application process and receive state approval before a policy can be rescinded.
- ❑ Stipulate that policies cannot be rescinded more than two years after the policy began.

Elimination Riders

Prohibit insurers in the individual health market from amending individual health insurance contracts to exclude coverage of health problems that were properly disclosed at the time of application.

While these four reforms are not explicitly addressed in HB 1, we view the approach taken by the Department provides consumers with important protections that serve as building blocks for future reforms.

AARP looks forward to working with members of the Committee to make our members aware of the important reforms outlined in the ODI budget.

Thank you.