

OBAMACARE: WHY THE NEED FOR WAIVERS?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF
COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

OF THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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OBAMACARE: WHY THE NEED FOR WAIVERS?

TUESDAY, MARCH 15, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF
COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:35 p.m., in room 2247, Rayburn House Office Building, Hon. Trey Gowdy (chairman of the subcommittee) presiding.

Present: Representatives Gowdy, Gosar, DesJarlais, Walsh, Norton, Clay, and Davis.

Also present: Representatives Issa and Cummings.

Staff present: Ali Ahmad, deputy press secretary; Molly Boyl, parliamentarian; Drew Colliatie, staff assistant; John Cuaderes, deputy staff director; Christopher Hixon, deputy chief counsel, oversight; Keven Corbin, minority staff assistant; Jill Crissman and William Miles, minority professional staff members; Carla Hultberg, minority chief clerk; Chris Knauer, minority senior investigator; Dave Rapallo, minority staff director; and Suzanne Sachsman Grooms, minority chief counsel.

Mr. GOWDY. The committee will come to order.

Let me thank everyone for their patience and indulgence. I apologize for the vicissitudes of our voting schedule. We are sorry for any inconvenience.

I will start this hearing as we do all of our oversight hearings by reading the mission statement.

We exist to secure two fundamental principles: First, Americans have a right to know that the money Washington takes from them is well spent, and second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold Government accountable to taxpayers because taxpayers have a right to know what they get from their Government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This the mission of the Oversight and Government Reform Committee.

If the witnesses would like, they can come to the table at this point. Thank you.

I will recognize myself for an opening and then recognize the gentleman from Illinois.

The purpose of the Oversight Committee is not necessarily to balance the relative merits or demerits of a law or proposed legisla-

tion. Other committees do that. Oversight is calculated to ensure trust and confidence in the institutions of Government, to investigate areas that demand transparency and accountability. Our duty is to ask fair questions with an expectation of an honest and complete answer on behalf of the people we represent. That is why we are here today.

Many in this room, including myself, fundamentally oppose the health care legislation passed last year. We have serious concerns with Federal mandates on individual citizens and massive new government spending programs in such an austere fiscal environment, but those conversations are reserved for other forums.

The current health care law was marketed to the American people as a means to provide high quality health coverage options to every citizen in our country while ensuring that those who like their current coverage can keep it. Over the past year, it has become abundantly clear that companies are having trouble complying with the new law. In order to escape the onerous burdens placed on businesses by this legislation, many of these companies have sought waivers from the Secretary for Health and Human Services, with varying levels of success.

The necessity of these waivers arose because many companies employ a health coverage strategy that provides some employees with mini-med plans that run afoul of current Federal rules mandated by the new health care law that set a minimum annual dollar limit on essential benefits that health care plans must provide in 2011, 2012, and 2013. Thus, the myth that if you like your current health care you can keep it has been exposed for around three million employees.

Through an amorphous process shrouded in ambiguity and understood by few, the administration has exempted over 1,000 companies from certain requirements and at the same time has neglected to afford others the same accommodation.

Our first question today is substantive: In light of over 1,000 companies requesting waivers from the burdens of this law, what did the President mean when he said, "If you like your health insurance, you can keep it," and what are the failings of this law that necessitate a waiver process to begin with?

Further, the entire waivers process is predicated on the ability of the Secretary to grant waivers in the first instance. However, this seemingly fundamental step—the statutory basis for waiving compliance with the law—appears to have been wholly neglected by the plain language of the statute. What is the legal authority by which the Secretary can grant waivers? Where in the health care law does it specifically grant the Secretary the authority to waive compliance with the law?

Congress all too often in recent memory has abdicated its law making responsibilities to employees or appointees in the executive branch who are not elected and are not accountable via popular election to the American people. It is not Congress' job to simply pass big ideas and leave the details to another entity. It is also not the job of agencies to invent statutory authority where none exists.

However, the most important questions today concern the procedural aspects of this highly nebulous process. Initially, how were these waivers advertised before a link was placed on the HHS Web

site? What was the process by which subsequent waivers were applied for, reviewed, accepted, denied, determined, and appealed?

The American people expect open and honest answers to these legitimate questions. Waivers to the health care law have widespread implications, implications that demand transparency and accountability from the Federal Government.

In order for companies to compete on a level playing field, as is the custom in our country, they must know their burden of proof—the standards their applications will be evaluated by. They must know why certain companies' applications were accepted and others were denied. There must be an identifiable process, not a labyrinthine morass of vague standards with no statutory definitions.

The waivers process, such as it is, lends credence to the conventional wisdom surrounding enactment of this transformative law. People don't know what is in it or how specific provisions are affecting America's business and individuals. These are due process, equal protection, and fundamental fairness questions that are essential to be asked and also to be answered.

[The prepared statement of Hon. Trey Gowdy follows:]

OPENING STATEMENT**CHAIRMAN DARRELL ISSA/CONGRESSMAN TREY GWODY****“Obamacare: Why the need for waivers?”****March 15, 2011**

On March 23, 2010 President Obama signed into law the so-called “Patient Protection and Affordable Care Act.” Instead of sending this bill, which affects 17% of our gross domestic product into conference, the Democrats on Capitol Hill simply passed another bill reconciling PPACA. Rather than go through the tedious process of debating controversial provisions, they chose to charge ahead with no regard for the implications.

It has been almost a year since the implementation of PPACA, but one thing seems clear. Though the bill name included the word “affordable,” it does not seem to control the costs of health care. And although the name also included the words “patient protection,” as we will see in this hearing today, it does not seem to be protecting patients.

According to PPACA, Title I would provide “quality affordable health care for all Americans.” These protections included Section 1001, which eliminated lifetime and annual limits on the amount of health insurance coverage provided by employers.

Even before the bill passed, the private sector protested this provision, saying it would dramatically increase costs and would result in employers dropping coverage for 1.7 million Americans who have limited coverage plans, known as “mini-med” plans. While these plans weren’t full coverage, these Americans – usually hourly workers in

restaurants or retail stores, part-time construction employees or seasonal workers—were able to get health insurance coverage in line with their salaries.

The law passed despite these protests, but when HHS was confronted with the reality of having 1.7 million Americans lose the health care coverage they liked, HHS created a waiver process out of thin air and behind closed doors.

HHS issued an interim final regulation, without seeking any public comment, determining an incremental increase in annual limits until 2014, when state Health Insurance Exchanges would go into place. The incremental increase was decided by HHS alone to be \$750,000 in 2010, increasing around a quarter million dollars every year until 2014 when the waiver process would be totally eliminated.

But considering that the average annual limit of mini-med plans was \$200,000, this HHS-created number was beyond what employers offering those plans could absorb. So HHS began accepting applications for waivers even before a waiver process was established.

At least three applicants sent waiver requests to the Secretary of HHS before guidance was ever issued by the Department. This Committee has discovered these applicants had a close personal relationship with the Secretary. They were the lucky ones who were able to email a letter requesting a waiver directly to Secretary Sebelius, often referring to her as “Kathy.”

But the general public did not know a waiver process even existed until October 2010, when news reports revealed that 222 waivers had been granted. With the increased focus on waivers, HHS began to create an arbitrary process and methodology, using terms not publicly defined.

According to September 3, 2010, guidance, HHS employees merely had to determine, according to their own personal judgment, whether a premium increase was either “large” or “significant” or whether access to care would “decrease significantly.” HHS did not publicly disclose the basis for these determinations.

Instead, what HHS did internally, behind closed doors, is create a waiver application system favoring their friends. This Committee wrote to Secretary Sebelius requesting documents relating to the waiver process. HHS remains substantially deficient in their document production, but what we did receive last Thursday was a copy of the HHS “Annual Limits Waiver Application Review and Evaluation: Standard Operating Process.”

The Department’s SOP regarding waivers specifically mandates HHS employees to consider whether waiver applicants are unionized. In fact, the HHS documents contained an email showing an employee asking an applicant whether they were union or non-union – as though this should be a determining factor.

The favoritism towards unions is offensive. Why should entities close to the current Administration receive special consideration? Why didn’t the SOP create

equivalent criteria for small businesses or even minority-owned businesses or any other form of business? Why just unions?

No wonder of the 1,040 applicants granted waivers more than 40% are unions.

Furthermore, 79 applicants have been denied waivers. That's almost 300,000 Americans who will lose the health care coverage they like. This is despite the fact that President Obama told the American people, "if you like your health insurance, you can keep it." And the Department's criteria for denying these waivers are as arbitrary as the criteria for approving waivers.

A review of the 27 applications that were denied shows a chaotic, arbitrary evaluation approach. For example, a school in Iowa was denied an application even though they produced evidence showing a 300% increase in premiums. Compare this to fact that the Department granted a waiver to a union for only a 6% increase.

Another applicant was denied for not filling out the correct application. The only problem is that the application HHS was referring to wasn't even created until December 8, 2010. Yet this business was denied a waiver on December 7, 2010.

Still another waiver applicant was denied three times before HHS finally realized they had, in Department's own words, "*dropped the ball.*" It took HHS almost three months to realize this business had an 8.7% increase in premiums. They ultimately granted the waiver.

It is difficult to understand how HHS can allege the waiver granting process was “fair” and “transparent” when their own documents show neither.

The Majority in last Congress chose to ignore the fact that 1.7 million Americans would lose access to healthcare through mini-med plans. Now, we watch as a chosen few are exempted from this onerous provision of the law. It is unfair, clearly; yet there is another important issue at hand: cost. The Congressional Budget Office score for Obamacare ***did not include*** the possibility of 1.7 million Americans with mini-med plans going into the Exchange. How much will the cost of Obamacare rise because these workers, who used to have health insurance costs covered by employers, will now have the taxpayers foot the bill?

This is but one of the many questions we have on the implementation of Obama care and—just one year into law’s existence—the need to waive certain provisions.

END OPENING STATEMENT

Mr. GOWDY. I will now recognize the distinguished ranking member, Mr. Davis, for his opening statement.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Let me just say that in the relatively short time that you have been chairman, you have selected two hearings that I think are very important. I thank you first for the one dealing with education and trying to make sure that all of our citizens have access, especially those in the city of Washington, DC. I also thank you for dealing with health care, which is what we are going to be discussing today. So I thank you for yielding.

The subcommittee's first hearing was on the issue of improving access to quality public education. The second one we convened to discuss how best to ensure the public's access to quality health care coverage. Given the significance of these two issues for the American people, I think this subcommittee is off to a great start.

However, I do want to point out that our colleagues on the Energy and Commerce Committee conducted a similar hearing on this topic less than a month ago that pretty much already answered the question as to why the waivers are needed during the 3-year implementation period. So it is my hope that today's hearing will actually provide us a chance to conduct oversight of HHS's mini-med waiver process with the intent of discussing how the process could be improved versus spending time debating whether such a process should even exist.

With the 1-year anniversary of the enactment of the Patient Protection and Affordable Care Act just a little over a week away, today's hearing, entitled *Obamacare: Why the Need for Waivers?*, basically helps to show why passing health care reform and ensuring quality affordable coverage for all Americans was so important. The landmark legislation called for the end of low cost mini-med health plans which offer far too many hard working Americans inadequate benefits and a false sense of protection.

While the elimination of lifetime and annual limits on the amount of coverage to be paid by a health insurance plan was a key aspect of health care reform, no one really expected this sweeping and monumental change to be fully implemented overnight. This is why the act envisioned a transition period between 2010 and 2014 to allow for the reasonable conversion of millions of people from poorly designed, limited benefit plans to plans that provide more comprehensive health care coverage.

I understand that in order to get us to the point where all Americans have access to enhanced health care coverage, the Secretary of Health and Human Services is gradually phasing out these substandard plans in a manner that does not subject consumers to hefty premium increases or reduce overall access to coverage. Hence the issuance of 1 year waivers to businesses that have demonstrated their inability to meet new coverage limits this year.

Despite claims to the contrary, HHS's Section 1001 waiver process has been transparent, as evidenced by the multiple publications of regulations governing process in the Federal Register and the wealth of information and guidance on the annual limit waiver application process available on HHS's Web site.

In addition to transparency, the process has also been fair. More than 94 percent of applicants who applied for waivers received

them. And let the record show that most of the waivers issued went to non-union plans.

In fact, the waiver process we are discussing this afternoon may actually serve as a best practice example of good governance for other agencies to follow when engaging American public and business communities.

Mr. Chairman, I am glad that today's hearing provides us an opportunity to discuss some of the benefits of the Affordable Care Act and its ultimate impact on improving access to high quality and affordable coverage for all Americans. I thank our witnesses for being here with us this afternoon and look forward to their testimony.

[The prepared statement of Hon. Danny K. Davis follows:]

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OPENING STATEMENT OF

RANKING MEMBER DANNY K. DAVIS,

Subcommittee on Health Care, District of Columbia, Census and the National Archives

“Obamacare: Why the Need For Waivers?”

March 15, 2011

Mr. Chairman, thank you for yielding. I must say – in your short time as Chairman, you’ve elected to have the Subcommittee’s first hearing on the issue of improving access to quality public education and now we convene for the Subcommittee’s second hearing, which discusses how best to ensure the public’s access to quality healthcare coverage. Given the significance of these two issues for the American people, I believe the Subcommittee is off to great start, Mr. Chairman.

With the one year anniversary of the enactment of the Patient Protection and Affordable Care Act just a little over a week away, today’s hearing entitled, “Obamacare: Why the Need for Waivers?,” actually goes to show why passing healthcare reform and ensuring quality, affordable coverage for all Americans was so important.

The landmark legislation called for the end of low-cost “mini-med” health plans, which offer far too many hardworking Americans inadequate benefits and a false sense of protection. While the elimination of lifetime and annual limits on the amount of coverage to be paid by health insurance plans was a key aspect of healthcare reform, no one really expected this sweeping and monumental change to be fully implemented over night. This is why the Act envisioned a transition period between the 2010 and 2014 to allow for the reasonable conversion of millions of people from poorly designed limited benefit plans to plans that provide more comprehensive healthcare coverage.

I understand that in order to get us to the point of where all Americans have access to enhanced healthcare coverage, the Secretary of Health and Human Services (HHS) has had to create a process that allows for the gradual phasing out of substandard plans, while being careful not to subject consumers to hefty premium increases or reduce overall access to coverage. Hence, the

issuance of one-year waivers to businesses that have demonstrated their inability to meet new coverage limits this year.

Despite claims to the contrary, HHS' Section 1001 waiver process has been transparent, as evidenced by the multiple publication of regulations governing the process in the federal register and the wealth of information and guidance on the annual limit waiver application process available on HHS's website. In addition to transparency, the process has also been fair, as more than 94 percent of applicants who applied for waivers received them. And let the record show that most of the waivers issued went to non-union plans. In fact, the waiver process we are discussing this afternoon may actually serve as a best practice or good governance example for other agencies to follow when engaging the American public and business community.

So, Mr. Chairman, while I'm glad that today's hearing provides us an opportunity to discuss some of the benefits of the Affordable Care Act one year after its adoption, I do think that it is necessary to point out that our colleagues on the Energy and Commerce Committee conducted a similar hearing of this topic less than a month ago that pretty much already answered the question as to "why the waivers are needed" during the three year implementation period. To that end, I hope today's hearing will actually provide us a chance to conduct oversight of HHS' mini-med waiver process, with the intent of discussing how the process could be improved, if need be, versus spending our time debating whether such a process should even exist.

I thank our witnesses for being here with us this afternoon and I look forward to hearing your testimony.

###

Mr. DAVIS. Mr. Chairman, while I am closing, I know that there are a number of members of the Committee on Oversight and Government Reform who are not members of this subcommittee who may wish to participate this afternoon. I would ask unanimous consent that they be allowed to do so.

Mr. GOWDY. Without objection, so ordered.

Thank you, Mr. Davis.

The Chair would recognize the gentleman from Arizona, Dr. Gosar, for his opening statement.

Mr. GOSAR. Chairman Gowdy, Ranking Member Davis, and our tireless committee staff, thank you for holding this important hearing today. I look forward to delving into the important issues at hand. Thank you also to our witnesses for sharing and appearing today on our behalf.

Almost 1 year ago, the President signed into law what he and the House at the time called comprehensive health care reform. At the time, House Speaker Nancy Pelosi said, "We have to pass a bill so we can find out what is in it." As we learn more about this immense piece of legislation, we find it gives unelected bureaucrats unprecedented ability to dictate the parameters of an individual's health care. It also dictates what type of coverage small business owners can offer their employees. Needless to say, there is much cause for concern.

Specifically, Section 1001 of this onerous law eliminates lifetime and annual limits on the amount of coverage a health insurer is required to pay. It turns out that millions of Americans use these annual limit plans and are satisfied with them. So the Center for Consumer Information and Insurance Oversight, CCIIO, was instructed by the Secretary to grant waivers to this elimination and therefore allow businesses to continue offering annual limit plans.

On March 14, 2011, CCIIO Director Steve Larsen, who is here with us today, said that for the first year we will set up this fairly straightforward, simple process and that we are now in the process of evaluating the plans out there and what is the best guidepath to 2014. I think that today we will discover that, indeed, the waiver process was not straightforward or simple at all.

On March 23, 2010, the so-called Health Care Reform bill was signed into law. Only 3 months later on June 28th, Health and Human Services issued an interim regulation that created a Section 1001 waiver. On September 3rd, the Agency issued further guidance listing vague criteria through which individuals and employers could qualify for a waiver. On December 8th, HHS finally issued a waiver application.

Yet even without this application, HHS granted over 300 waivers. How? What day was the first waiver granted? To date, over 1,000 waivers have been granted to Section 1001, saving 2.4 million Americans from being kicked off their health care coverage. I submit to you, ladies and gentlemen, that HHS has not whatsoever made this process straightforward or simple.

Take, for example, HHS's Web site on the screen above. There is no provision on the homepage for a waiver application or even for OCIIO, which is now called CCIIO. Or is it EE-I-EE-I-O? I feel like Old MacDonald Had a Farm with these acronyms.

Let us assume that you are well acquainted with this arduous process to search for CCIIO. It turns out that CCIIO has a homepage. If you click to the bottom of that page—follow us along—and scroll all the way down to the bottom left, you will see Regulations and Guidance. This is far from clear to the average Joe, who turns out to need to click right here. Under Regulations and Guidance see Annual Limit Waivers. Under Annual Limit Waivers there are four, count them, four guidance regulations. Good luck combing through those.

As you can all see from this demonstration, there is a long way to go and a lot to examine before we can claim to have a transparent, easy process for America's job creators to navigate this law.

Add in the cost. Where did the money for CCIIO come from? Was it shifted from our priorities in HHS's or CMS's budgets like dialysis centers and others services for the needy and sick?

How did these special waivers find their way into the earliest days of this timeline without a waiver process? Were special favors involved? Why wasn't a blanket waiver issued as with other flawed parts of this attempted Government takeover of health care?

These are a mere sampling of questions I hope you are ready to answer. I know inquiring minds throughout America want and need to know.

Thank you, Mr. Chairman.

Mr. GOWDY. Thank you, Dr. Gosar.

HHS produced to this committee guidance concerning standard operating procedures. I would ask unanimous consent to insert into the record the HHS guidance governing standard operating procedures.

Hearing no objection, it is so ordered.

[The information referred to follows:]

[Proposed Effective Date: December 2010]

ANNUAL LIMITS WAIVER APPLICATION REVIEW AND EVALUATION:
STANDARD OPERATING PROCEDURE

- I. Application Intake Process**
- a. Applicant submits application materials (specified in the September 3, 2010 Sub-Regulatory Guidance, OCIO 2010-1 or November 5, 2010 Supplemental Sub-Regulatory Guidance, OCIO 2010-1A) (Attachments A and B) through one (1) of the two (2) options:
 - i. e-mail to:
 1. healthinsurance@hhs.gov, or
 2. OCIOOversight@hhs.gov, or
 - ii. via U.S. Post to HHS, Office of Consumer information and Insurance Oversight, Office of Oversight/ Attn: James Mayhew, Room 737-F-04, 200 Independence Ave., SW, Washington, DC 20201
 - b. Intake Manager collects application materials and performs the following tasks:
 - i. Scans paper documents,
 - ii. Logs new applications (including date of HHS receipt),
 - iii. Ensures folder name matches name in application and provides full name, not abbreviated names,
 - iv. Creates a file on shared drive (G: drive) for new application and keeps paper copies of all documents, then sends a list of the new applications to a Project Manager.
 - c. *[Effective December 2010, applicants will begin to submit discrete information via online excel spreadsheet. This information will also be collected by the Intake Manager and provided to the Project Manager.]*
 - d. Project Manager assigns each new application an identification (ID) number and performs the following tasks:
 - i. Designates administrative assistants to print out a copy of the scanned or saved application,
 - ii. Assigns each Reviewer applications for review, and
 - iii. Logs the application into the excel worksheet.
- II. First Level Review**
- a. **Substantive Review of Application**
 - i. A Reviewer reads through application to determine whether the information required from the September 3, 2010 and November 5, 2010 Sub-Regulatory Guidance Bulletins is provided. Specifically, the Reviewer is considers the six standards stated in the November 5, 2010 guidance to determine whether the waiver should be granted:

[Proposed Effective Date: December 2010]

1. **The application's explanation as to how compliance with the restriction on annual limits would result in a significant decrease in access to benefits.** Such a decrease in access could result from the dropping of coverage by a plan, plan insolvency, reducing benefits (i.e., increasing deductibles, coinsurance, or copayments), or restricting eligibility significantly if the waiver is not granted.
 2. **The plan or policy's current annual limits.** Plans with higher annual limits would be expected to experience lower premium increases to become compliant with the restricted annual limit requirement than plans with lower limits.
 3. **The change in premium in percentage terms.** A change in premium below 6% may not be deemed significant. If the change is 7-9%, it may be considered significant, subject to the existence of other factors. If the increase is 10% or greater, the premium increase may be considered significant and sufficient to grant a waiver. (*Note:* These figures are based on independent studies indicating that employees are likely to drop coverage if their premiums are raised more than 7 to 9% (see Attachment C: Memorandum on Consumer Price Sensitivity and References)).
 4. **The change in premium in absolute dollar terms.** While percentage increase can be relevant to the determination of "significance," for policies with very low premiums, a seemingly high percentage increase may translate to a relatively low dollar-amount and therefore may not be "significant."
 5. **The number and type of benefits affected by the annual limit.** Some policies have limits only on some essential health benefits (such as prescription drugs), which might not increase overall cost across all enrollees significantly.
 6. **The number of enrollees under the plan seeking the waiver.**
- ii. **Special considerations.** Plans with annual limits on certain essential benefits may not be in compliance with other sections of the ACA or other federal laws.
1. **Preventive Care.** The requirements to cover recommended preventive services without any cost-sharing requirements do not apply to grandfathered health plans. See 26 CFR 54.9815-1251T, 29 CFR 2590.715-1251, and 45 CFR 147.140 (75 FR 34538, June 17, 2010). If a plan places limitations on preventive care, the Reviewer should determine whether the plan maintains grandfather status.

[Proposed Effective Date: December 2010]

- a. A grandfathered plan is not required to provide preventive care without cost-sharing.
- b. A non-grandfathered plan must provide preventive care without cost-sharing.
- c. Reviewers may not grant a waiver for plans with an annual limit requiring first dollar coverage on preventive care, a violation of the Section 2713 of the Affordable Care Act (ACA).
- 2. Mental Health Parity Act (MHPA) and Mental Health Parity and Addiction Equity Act (MHPAEA).**
 - a. [Reserved]
- 3. Women's Health and Cancer Rights Act (WHCRA)**
 - a. [Reserved]
- 4. Newborns' and Mothers' Health Protection Act (NMHPA)**
 - a. [Reserved]
- iii. If the plan is a **Taft-Hartley plan**, the date the last collective bargaining agreement will expire.
 - 1. A Taft-Hartley Multi-Employer Health and Welfare plan is a plan available to private-sector unionized employees with the following characteristics:
 - a. One or more employers contribute to the fund,
 - b. The fund is collectively bargained with each contributing employer,
 - c. The fund and its assets are jointly managed by a board of trustees equally representative of management and labor,
 - d. Assets are placed in a trust fund legally distinct from the union and its employees, for the sole benefit of the employees and their families,
 - e. Mobile employees can change jobs and not lose coverage under the fund provided the new job is with an employer who contributes to the same Taft-Hartley Fund.
 - 2. The procedure for evaluating Taft-Hartley plans is the same as for evaluating a plan that is not pursuant to a collective bargaining agreement (CBA) with the following possible differences:
 - a. Request premium equivalents (COBRA premiums) or employer contributions per hour for premiums when calculating increase in cost due to the ACA.
 - b. Request a range of employer contributions, such as a high and low, or an average contribution, depending on how many employers contribute to

[Proposed Effective Date: December 2010]

the fund: if a very large number of employers contribute then a high and low may be easier to obtain than an average contribution.

iv. Retiree Only Plans

1. Generally, if the plan is a retiree-only plan, it is not subject to the ACA's annual limits (145 CFR 147.126 Preamble, Part II B). The Reviewer may contact the applicant to notify them that the plan does not need to apply for a waiver, and ask to withdraw the application.
2. However, if the retiree-only plan is funded by contributions from active workers (for example, by a trust that also funds active worker plans and is considered a single ERISA plan by the Department of Labor), it may be subject to the ACA's annual limits.
3. The Plan's counsel determines whether the retiree-only plan is separate or subject to the ACA. Reviewers should not make a legal determination as to whether a plan is a retiree-only plan and not subject to the annual limits.

v. Health Reimbursement Account (HRA)

1. If the plan is an HRA and integrated into other complying coverage, it need not apply for a waiver. The Reviewer may contact the applicant and ask to withdraw the application.
2. If the plan is a **standalone HRA** that does not insure the enrollee up to the ACA limits, or if the plan with which it is integrated is not compliant, it may apply for a waiver.
3. If the HRA does not have knowledge whether the HRA is integrated with other complying coverage, it may apply for a waiver.

- vi. If the plan is a **health Flexible Spending Arrangement (FSA), Health Savings Account (HSA), or Medical Savings Account (MSA)**, it is not subject to the ACA's annual limits (145 CFR 147.126 Preamble, Part II B).

b. Correspondence Procedures

- i. **Missing Information.** If the application is missing information, the Reviewer corresponds with the contact person to obtain all the information needed to fully evaluate the application (**Attachment D: redacted sample email to applicant**).
 1. Every correspondence email with an applicant is copied (cc-ed) to a Correspondence Coordinator, who saves it to the applicant's G: drive folder.
 2. The Reviewer should note in each item of correspondence until the application is completed that the 30-day review

[Proposed Effective Date: December 2010]

period will not begin until the application is complete with the following suggested language: *“Please note that the 30-day processing period begins on the date the complete application is received, per the September 3, 2010 Sub-Regulatory Guidance (OCIO 2010-1).”*

3. If the applicant does not respond after two attempts by the Reviewer at contact over two weeks, at least one of which should be a telephone call, the Reviewer should e-mail and call the applicant to offer to withdraw the application if the applicant does not respond to the third attempt within two business days.
 4. If HHS does receive a response within two business days, HHS may issue a denial to the applicant.
- ii. **Complete Applications.** Upon receipt of a complete application, the HHS has 30 days to complete review and have a final decision. When all information has been collected, Reviewers input the data into copies of a master spreadsheet which include cells for plan identifying information, type of coverage, details about the plan (i.e., current annual limits, current essential benefits, current premium or premium equivalents), and projections for the next plan year without the \$750,000 annual limits and with the \$750,000 annual limits. Reviewers also:
1. Calculate the percent increase attributable to the ACA and the overall percent increase;
 2. Detail the explanation for decrease in benefits; and
 3. Enter a write-up corresponding to the reason(s) for the approval or denial as it corresponds to Evaluation Criteria 1-6 in the November 5, 2010 Sub-Regulatory Guidance. These Evaluation Criteria correspond to (a)(i-vi) above.
 4. Reviewer should email applicant upon receipt of all information notifying applicant that the 30 day processing period is beginning that day.
- iii. **Changes to Applications.** When an applicant makes changes to their data after an application has been reviewed and approved by leadership, the first level reviewer should read through the additional information provided to determine whether the initial recommendation is still valid. If so, the Reviewer should make any minor adjustments to the spreadsheet and document the percent changes in the comment section. If the recommendation would change, the reviewer should process the application again, using the date of receipt of the new material as the date of completion.

[Proposed Effective Date: December 2010]

- III. First-Level Quality Assurance (Q.A.)**
- a. After data is inputted, the Reviewers will send completed spreadsheets with approval and denial recommendations to the Q.A. Reviewer.
 - b. Q.A. Reviewer examines completed spreadsheets for spelling errors, input errors, or missing information, and returns incomplete documents to the Reviewer.
 - c. If the document is complete, the Q.A. Reviewer will send the spreadsheets on to the Project Coordinator in charge of the master spreadsheet.
- IV. Second Level Review**
- a. The Project Coordinator inputs the completed spreadsheets from the Reviewers into the master spreadsheet, tab "Working Master." (**Attachment E: Copy of Master Spreadsheet**).
 - b. The Project Coordinator then prepares the material for second-level review by the two Project Managers by consolidating all recommended approvals and denials.
 - c. The two Project Managers then perform a high-level review of the recommended approvals and denials and prepare the spreadsheet for leadership review, highlighting areas that need to be discussed—particularly the cells that contain the reasons for recommended denials. The Project Managers perform the following tasks:
 - i. Compile and collate completed recommendations; and
 - ii. Flag problems.
- V. Weekly Leadership Sign-off Meeting**
- a. Staff (including Project Coordinators, Reviewers, and Q.A. Reviewer) meets with Division Directors, OCIO Oversight Department Director, and the Senior Policy Advisor weekly to review recommendations and obtain approval regarding recommendations.
 - i. Discuss all recommended denials and obtain approval from Department Director.
 - ii. If Department Director or majority of leadership does not agree with the recommendation, the recommendation is reversed.
 - b. Project Coordinator sends out acceptance and denial letters per leadership meeting-confirmed recommendations (**Attachments F and G: Approval and Denial Letters**).
- VI. Questions**
- a. Problems or policy issues are discussed in a daily team meeting attended by all Annual Limits Waiver staff. The team meeting serves to help staff improve our evaluation strategies, brainstorm, and share common experiences.

[Proposed Effective Date: December 2010]

- b. To address questions of policy that frequently arise, one staff member will compile the issues and send the list to the appropriate parties.
- c. Questions will be sent to one of the following parties:
 - i. Director of Market Compliance and other Senior Leadership; or
 - ii. To Market Compliance for a review through the vetting process (reviewed by the Office of General Counsel and the Director of Oversight).

VII. Appeals Process for Denials

- a. If a company that is denied a waiver wishes to appeal, it should draft a letter to the same e-mail or post-office stop as the original address. The letter should set out supplemental information not included in the original letter explaining why the determination will result in either:
 - i. A significant increase in premiums, or
 - ii. A significant decrease in access to benefits.
- b. Project Managers review the appeal letters and make a recommendation, then pass them on to the leadership team.
- c. The Director of the Market Rules Division and the Director of OCIO Oversight then read the letters and approve or deny project managers' recommendations.
- d. A company may also call the Director of the Market Rules Division or other leaders (Director of Oversight, Director of Enforcement) to discuss their application. This process should be managed by the Reviewer of the company's application as follows:
 - i. The company may contact the Reviewer regarding the negative determination and requesting a further hearing.
 - ii. The Reviewer may set up time for a telephone conference call with the Director of the Market Rules Division, at least one Project Manager, and the Reviewer.
 - iii. The Reviewer should ensure that the company's application number and information is entered into the Reviewer's copy of the master spreadsheet so that it is re-entered into the master spreadsheet by the Project Coordinator for the Weekly Leadership Meeting. This also applies if the appeal is mailed in.

VIII. Flexibility Policy

- a. The Reviewers are flexible in applying standard operating procedures and policies when needed and mandated by the Project Managers and OCIO leadership. The first-level review analysis and leadership sign-off meeting decisions may change to reflect policy changes and decisions made at the Director level, and to make fair decisions for the highly varied plans that submit applications for waivers. Revisions to the section

[Proposed Effective Date: December 2010]

will be made in conjunction with any changes in policy made by the directors of OCIO and Oversight.

ATTACHMENTS

Attachment A: September 3, 2010 Sub-Regulatory Guidance

Attachment B: November 5, 2010 Sub-Regulatory Guidance

Attachment C: Memorandum: Consumer Sensitivity to Premium Price Increases

Attachment D: Sample e-mail from Dedicated Reviewer to applicant (redacted)

Attachment E: Copy of Master Spreadsheet

Attachment F: Approval Letter

Attachment G: Denial Letter

[Proposed Effective Date: December 2010]

**QUESTIONS FROM APPLICANTS, POTENTIAL APPLICANTS, AND THE PUBLIC:
STANDARD OPERATING PROCEDURE**

In the September 3, 2010 Sub-Regulatory Guidance and on the OCIO website, a general OCIO email address is provided for individuals to contact the annual limits waiver program with relevant questions. The process is as follows:

- I. **Intake**
 - a. The Intake Manager collects emails from the OCIOOversight@hhs.gov inbox with the header "waiver" or a header relevant to annual limits waivers, and sends them to the Correspondence Coordinator dedicated to Public Inquiries.

- II. **Correspondence**
 - a. The Correspondence Coordinator logs each question into a spreadsheet in chronological order, and saves the question in a file on the shared (G:) drive (**Attachment A**).
 - b. The Correspondence Coordinator answers the question—if possible using language from the "Waiver Applicant FAQ," Sub-Regulatory Guidance, or the Regulation (**Attachment B**). The response is saved in a folder with the query in the G: drive. The table is hyperlinked to the saved email question and response. The contact information for the requestor is also entered.
 - c. If the question concerns annual limits but the Correspondence Coordinator does not know how to answer it, she forwards it to the Project Managers and the Division Director, who will respond to the Correspondence Coordinator with an answer. The Correspondence Coordinator will then reply to the requestor with that response and log all the information per the above protocol.
 - d. If the question does not concern annual limits and is a consumer question, the Correspondence Coordinator will forward it to our contact with the State Compliance division, who forwards it to the head of the Consumer Information Division, who will respond to the question.
 - i. If there is no response from the party to whom the question was forwarded, the row in which the information is inputted is highlighted to indicate the question has not been answered until it is answered.
 - ii. The Correspondence Coordinator replies to the requestor with a confirmation of receipt and promise to reply pending the answer.

- III. **Policy Issues/Difficult Questions**
 - a. A table of particularly complex questions is compiled each week and brought to a meeting with leadership by the Project Managers.

[Proposed Effective Date: December 2010]

- IV. Any follow-up questions are logged in the same row as "Question 2" (Question 3 and so on...) and in the same folder, which is named for the company the requestor represents (unless it is a consumer, in which case it is the consumer's name).
- V. **Flexibility Policy**
 - a. The Reviewers are flexible in applying standard operating procedures and policies when needed and mandated by the Project Managers and OCIO leadership. Changes to the correspondence section may be made to reflect policy changes and decisions made at the Director level. Revisions to the section will be made in conjunction with any changes in policy made by the Directors of OCIO and Oversight.

ATTACHMENTS

Attachment A: Copy of Public Inquiry Spreadsheet

Attachment B: Annual Limits Waiver FAQs

Mr. GOWDY. I will now recognize the ranking member of the full committee, the gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, to you and to our ranking member.

Next week is the 1-year anniversary of the Patient Protection and Affordable Care Act. This landmark health care reform bill prevents insurance companies from denying children health insurance because of preexisting conditions, prevents insurance companies from dropping beneficiaries simply because they get sick, provides small businesses tax credits to extend coverage to their employees, and provides seniors with a 50 percent discount on brand name drugs through Medicare Part D.

Another significant improvement this law made was to direct the phaseout of so-called mini-med insurance plans that place restrictive limits on coverage. These plans provide meager benefits and often leave patients high and dry when they become ill or are involved in an accident.

For example, a Wall Street Journal article in September 2010 featured a prominent fast food chain that offers its hourly employees a limited benefit plan that caps annual benefits at only \$2,000. This plan covers almost nothing when someone needs serious medical care. A single trip to the hospital could cost tens of thousands of dollars and leave beneficiaries without coverage or with extensive out of pocket costs.

In July 2009, the New York Times featured a story about a man whose limited benefit health plan capped hospital services at \$10,000. When he had to have a heart procedure, his insurance plan covered only a fraction of his \$200,000 hospital bill. As a result, he and his wife were forced into bankruptcy, like many Americans, despite the fact that he was supposedly insured.

Former health care executive Wendell Potter referred to these plans as essentially fake insurance. The reality is that people with mini-med plans often do not realize how terrible their health insurance is until they get sick or hurt and really need it.

The Affordable Care Act directed the phaseout of these deficient plans, but it also gave the Secretary of HHS authority to create a waiver process. This is a temporary fix to help employers that offer mini-med plans whose premiums would increase in the short term with an abrupt transition to high or no annual limit plans. In 2014, waivers will not be necessary because consumers will have access to comprehensive coverage through State health care exchanges that reduce premiums by increasing competition and spreading risk.

There have been allegations on the Republican side that the HHS waiver process has been neither transparent nor fair but the facts do not bear this out. According to Agency data, HHS has approved waiver applications for 1,040 plans and rejected only 65. The overall approval rate is 94 percent. Allegations that unions have received preferential treatment also appear unsubstantiated. According to the same data, HHS approved 85½ percent of waiver applications from union plans or plans serving union members and 97.4 percent of non-union waiver applications.

Unfortunately, today's hearing seems to be little more than a do over of a hearing held last month by the Energy and Commerce

Committee—the same allegations, the same documents, and even the same HHS witness.

At that hearing, Ranking Member Henry Waxman issued a memorandum analyzing 50,000 pages of documents provided by HHS that found no merit to these allegations. I would like to make that memo part of our official hearing record.

The memo also pointed out that various industry applicants were in fact very happy with the waiver process, thanking HHS repeatedly for their prompt and courteous attention.

Mr. Chairman, our committee can play a positive role in making sure the Affordable Care Act is implemented effectively. Rather than using the 1-year anniversary to criticize a process that has been incredibly flexible and favorable to the industry, let us work together to make sure that real health insurance coverage is extended to 32 million Americans who do not have it today.

I am very pleased to see one of our witnesses, Steve Larsen, who played a major role when I was in the State legislature in Maryland for 15 years. He has served in many, many roles. I can say that of all the public servants I have worked with, he is one of the most honorable, honest, efficient, effective public servants I have ever met.

With that, I yield back.

[The prepared statement of Hon. Elijah E. Cummings follows:]

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ONE HUNDRED TWELFTH CONGRESS

Congress of the United States House of Representatives

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Opening Statement Rep. Elijah E. Cummings, Ranking Member Committee on Oversight and Government Reform

Subcommittee on Health Care, District of Columbia, Census and the National Archives Hearing entitled, "Obamacare: Why the Need for Waivers?"

March 15, 2011

Next week is the one year anniversary of the Patient Protection and Affordable Care Act. This landmark healthcare reform bill prevents insurance companies from denying children health insurance because of preexisting conditions, prevents insurance companies from dropping beneficiaries simply because they get sick, provides small businesses tax credits to extend coverage to their employees, and provides seniors with a 50% discount on brand-name drugs through Medicare Part D.

Another significant improvement this law made was to direct the phase out of so-called "mini-med" insurance plans that place restrictive limits on coverage. These plans provide meager benefits and often leave patients high and dry when they become ill or are in accidents.

For example, a *Wall Street Journal* article in September 2010 featured a prominent fast-food chain that offers its hourly employees a limited benefit plan that caps annual benefits at only \$2,000. This plan covers almost nothing when someone needs serious medical care. A single trip to the hospital could cost tens of thousands of dollars and leave beneficiaries without coverage or with extensive out-of-pocket costs.

In July 2009, the *New York Times* featured a story about a man whose limited benefit health plan capped hospital services at \$10,000. When he had to have a heart procedure, his insurance plan covered only a fraction of his \$200,000 hospital bill. As a result, he and his wife were forced into bankruptcy, despite the fact that he was supposedly insured.

Former health care executive Wendell Potter referred to these plans as essentially "fake insurance." The reality is that people with mini-med plans often do not realize how terrible their health insurance is until they get sick or hurt and really need it.

The Affordable Care Act directed the phase-out of these deficient plans. But it also gave the Secretary of HHS authority to create a waiver process. This is a temporary fix to help employers that offer mini-med plans whose premiums would increase in the short term with an

abrupt transition to high or no annual limit plans. In 2014, waivers will not be necessary because consumers will have access to comprehensive coverage through state health care exchanges that reduce premiums by increasing competition and spreading risk.

There have been allegations on the Republican side that the HHS waiver process has been neither transparent nor fair. But the facts do not bear this out. According to agency data, HHS has approved waiver applications for 1,040 plans and rejected only 65. The overall approval rate is 94%. Allegations that unions have received preferential treatment also appear unsubstantiated. According to the same data, HHS approved 85.5% of waiver applications from union plans or plans serving union members and 97.4% of non-union waiver applications.

Unfortunately, today's hearing seems to be little more than a "do-over" of a hearing held last month by the Energy and Commerce Committee—the same allegations, the same documents, even the same HHS witness. At that hearing, Ranking Member Henry Waxman issued a memorandum analyzing 50,000 pages of documents provided by HHS that found no merit to these allegations. I would like to make that memo part of our official hearing record.

The memo also pointed out that various industry applicants were in fact very happy with the waiver process, thanking HHS repeatedly for their prompt and courteous attention.

Mr. Chairman, our Committee can play a positive role in making sure the Affordable Care Act is implemented effectively. Rather than using the one year anniversary to criticize a process that has been incredibly flexible and favorable to industry, let's work together to make sure that real health insurance coverage is extended to 32 million Americans who do not have it today.

Mr. GOWDY. Thank you, Mr. Cummings.

The Chair would now recognize the chairman of the full committee, the gentleman from California, Mr. Issa.

Chairman ISSA. Thank you, Mr. Chairman.

As the ranking member said, another committee has looked into this problem. And it is a problem when over 1,000 waivers need to be granted, whether it is 94 percent, 85 percent, or 100 percent. You ask is the Patient Protection and Affordable Care Act ready for prime time. The answer clearly is it is not. It was ill conceived run through in a manner that Speaker Pelosi “wisely” said let’s pass it so we can find out what’s in it. That, in fact, is the reason that these thousands of pages are only now being analyzed to find out that compliance is not available.

And contrary to what the ranking member said, it is likely that a year from now waivers will continue to be granted, and a year from then and a year from then. Why? Because, as President Obama has admitted, it is hard to bend down the health curve. It is hard to do some of these things. In fact, many of the goals of the Affordable Care Act will not ever come to pass.

Health care continues to spike and spiral up. What was considered to be a Cadillac plan based on dollars just a year ago would now be undoubtedly a Bentley plan today.

As we look at this on every committee of jurisdiction, including ours, let us bear in mind that two million workers out of uniform and another million workers in uniform are part of a Government health care plan that we oversee. Additionally, Indian health care and plenty of other plans continue to have the problem of spikes in cost with no likelihood of abatement.

Our committee has a responsibility to find ways to insure and protect Federal workers through an affordable health care plan. We additionally have an obligation to see that this law passed lives up to its goals or is rescinded.

The committee must look at this in light of its post-passage spike in cost and the admission by the President himself that the cost curve is, in fact, not being bent down. Sixteen million, not 32 million, uninsured Americans will be covered. They will be covered based on Medicare, one of the most inefficient delivery systems that we can find. So this committee is dedicated to being honest about what a law is or is not doing and seeing that, in fact, inefficiency in government goes away.

As most members of this committee are becoming acutely aware, Medicaid is not the right way to provide health care coverage. Yet we continue to see waivers for conventional systems that were vilified during the legislation while we see an expansion of Medicaid, one of the least affordable—from a cost standpoint—ways to provide health care. It is in my State of California well known that Medicaid patients are actually more likely to show up at an emergency room than the uninsured overall.

This and other factors tell us that we need to look at all aspects of this, not just the 1,040 applicants granted waivers. With that, Mr. Chairman, I thank you for doing our committee’s work.

I would reserve a point of order on the ranking member’s request to put the work already in another committee into our record. I believe it is our practice to put in limited amounts. If there is a spe-

cific citing that the ranking member would like to limit to, I would remove mine. But to simply put Mr. Waxman's full activities in I think would be inappropriate. He left this committee. He is in another committee. It is in his record.

With that, I yield back.

Mr. GOWDY. Thank you, Mr. Chairman.

The Chair would now recognize the gentleman from Missouri, Mr. Clay, for his opening statement.

Mr. CLAY. Thank you, Chairman Gowdy.

When a party is in the minority, without the authority and responsibilities of the majority, some nuisance tactics are to be expected. But being in the majority changes things, or at least it should.

Take, for instance, the title of this hearing. The use of the term Obamacare is not helpful in any way. I think it is purposefully provocative. We all know that using a negative catchy term for the President's signature domestic program, a program that affects each and every American in many positive ways and fundamentally reforms health care in this country for the better, is red meat for red States. We all know that.

The Affordable Care Act protects sick people from being dropped by insurance companies because they get sick. If my Republican colleagues believe that insurance companies are to be allowed to drop sick people from coverage once they get sick, they ought to say it. The health care reform legislation protects people from being denied coverage by insurance companies because they have preexisting conditions. If someone really believes that insurance companies ought to be able to deny coverage to people with preexisting conditions, they should say so.

Health care reform, an unfulfilled dream of both Republican and Democratic presidents for decades, means positive changes for virtually all Americans. If you want to roll back the progress that we finally achieved and leave Americans without health insurance, without health care, and without health, you should tell the American people that straight out.

But clearly it is unhelpful to use misleading terms and slogans like death panels and Obamacare. Reducing the President's signature domestic program, one that benefits all Americans, to a misleading term detracts from real oversight. It is also unfair. It would be like Democrats reducing the previous administration's signature domestic program that benefited all Americans. Well, if someone could remind me what that was, it would be unfair to call that program a negative nickname, too.

Mr. Chairman, I yield back.

Mr. GOWDY. Thank you, Mr. Clay.

I would point out that people within this very administration have called this piece of legislation Obamacare. I do not recall any moral outrage at the use of the terms Bush Tax Cuts, Bush Wars, Regonomics, or Carter Malaise.

[Simultaneous conversations.]

Mr. GOWDY. Anyone who doesn't want to use the phrase Obamacare does not have to use it.

Mr. CLAY. But it was paid for or implemented by tax reform. So what does it mean anyway?

Mr. GOWDY. Mr. Clay, are you through?

Mr. CLAY. I am through.

Mr. GOWDY. I would like to welcome the witnesses at this point. Let me also say this: Members may have 7 days to submit opening statements and extraneous material for the record.

We will now welcome our panel of witnesses. We will start with Mr. Steve Larsen, who is the deputy administrator and director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid services. Previously he has served as the Director of Oversight at the Office for Consumer Information and Insurance Oversight when it was within the immediate Office of the Secretary of HHS.

I ask a moment of your indulgence.

[Pause.]

Mr. GOWDY. With your indulgence, I will introduce everyone. Then we will start with you, Mr. Larsen, and go on if that is OK with our witnesses.

I will apologize in advance. My South Carolina upbringing may not allow me to pronounce Haislmaier correctly. I am willing to get it right if you will correct me and tell me what it is.

Mr. HAISLMAIER. It is Haislmaier but I even have relatives who call it Haislmaier.

Mr. GOWDY. Well, Haislmaier. Ed Haislmaier is the senior research fellow at the Center for Health Policy Studies at the Heritage Foundation.

Scott Wold is an attorney at Hitesman and Wolf, an employee benefits law firm located in Minneapolis, MN. Mr. Wold's practice focuses almost exclusively on employee benefits.

Ms. Judy Feder is a professor at Georgetown University where she also served as dean of Georgetown's Public Policy Institute from 2000 to 2008. She is currently a fellow with the Center for American Progress.

Welcome to all of you. Let me swear you first. I thought I was getting away from that when I left the DA's office. [Laughter.]

Let me find the oath. I am going to get you to all rise. Raise your right hands.

[Witnesses sworn.]

Mr. GOWDY. Let the record reflect that all the witnesses answered in the affirmative.

We will start, Mr. Larsen, with you. We will recognize you for your 5 minute opening statement and then we will move from my left to right, your right to left, and finish with Dr. Feder.

STATEMENTS OF STEVEN LARSEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES; EDMUND HAISLMAIER, SENIOR RESEARCH FELLOW, CENTER FOR HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION; SCOTT WOLD, SHAREHOLDER, HITESMAN AND WOLF; AND JUDITH FEDER, PROFESSOR, GEORGETOWN UNIVERSITY AND SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS ACTION FUND

STATEMENT OF STEVEN LARSEN

Mr. LARSEN. Thank you, Chairman Gowdy, Ranking Member Davis, and members of the subcommittee. Thank you for the chance to appear before you this afternoon.

My full testimony has been submitted for the record.

I serve, as was mentioned, as deputy administrator of CMS and director of the Center for Consumer Information and Insurance Oversight [CCIIO], within CMS. Since taking on this role I have been involved in implementing many of the provisions of the Affordable Care Act including overseeing private health insurance reforms, establishing the health insurance exchanges, and ensuring that consumers have access to information about their rights and coverage options.

Prior to becoming director of CCIIO, I served as the director of the Office of Oversight, which worked with the States to implement the new insurance rules.

As director of CCIIO, I am committed to improving the health insurance system so that it works for consumers and businesses, both now and in 2014 when consumers and businesses will have more quality health care options. As part of improving the current health insurance system, the Affordable Care Act ensures that consumers are provided meaningful and reliable coverage for their premium dollars by phasing in restrictions on the annual limits insurance policies between now and 2014, the subject you have asked me to discuss today.

Right now, about 160 million Americans get their health insurance through an employer. However, not all coverage offered by employers is the same. A very small percentage of employees are offered policies with low annual limits—caps on the amount of benefits that are provided under the policy in a given year. Often these policies are provided by employers who hire lower wage, part-time, or seasonal workers.

While having such limited coverage may be better than no coverage at all, this coverage unfortunately can fail those that need it most. These policies can have high deductibles and annual dollar caps as low as \$2,500. Some are better with \$5,000 or even \$25,000 in coverage but in the case of a serious illness or accident, the coverage can be inadequate.

In 2014 consumers will be able to purchase fuller health insurance coverage in State-based exchanges but, in the time between now and 2014, we need to maintain coverage for the small percentage of employees with these limited policies until better options are available for them in 2014. Immediate compliance with the new Af-

fordable Care Act provisions on annual limits could cause disruption of this coverage.

The Affordable Care Act specifically directs the Secretary to implement the restrictions on annual limits in a manner that ensures continued access to coverage. This is accomplished by phasing in the annual limit restrictions for most policies and, for this year, we established a waiver process. All employers and insurers that offer limited benefit plans may apply for a waiver if they demonstrate that there will be a significant increase in premiums or a significant decrease in access to coverage without a waiver. Applying for a waiver is simple and basic with only five elements that CCIIO has clearly published on our Web site.

It is important to note that more than 30 percent of applicants have fewer than 100 enrollees. Small businesses are able to take advantage of this as well as large ones. We administer the process fairly without regard to the type of applicant or size of business.

We have published our standards for reviewing the applications in the regulations implementing the law and again in the bulletins implementing the regulations.

The vast majority of waivers, more than 94 percent, were granted to health plans that are employer-based. Of the waivers approved, 41 percent were to self-insured employer plans, 31 percent to HRAs, 23 percent to Taft-Hartley plans—these are employer plans governed by collective bargaining agreements—and 3 percent to issuers. Only 2 percent of waivers have been granted to union plans.

The limited benefit plans for which waivers are allowed cover an extremely small portion of people who have employer-sponsored coverage. Since setting up this waiver program, CCIIO has granted waivers to plans covering less than 2 percent of all covered people in the private insurance market.

The vast majority of employers who applied for a waiver have also reacted to the application process positively. We have been open to feedback from applicants and, based on their input, we improved the application process so that it is timely and responsive to their needs.

Thank you for the privilege of appearing before you. I would be happy to answer your questions.

[The prepared statement of Mr. Larsen follows:]

STATEMENT OF
STEVEN B. LARSEN

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

BEFORE THE
U. S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM,
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND
THE NATIONAL ARCHIVES

MARCH 15, 2011



**House Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census, and the National Archives**

March 15, 2011

Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the opportunity to discuss the Department of Health and Human Services' work implementing the Affordable Care Act. I serve as Deputy Administrator and Director of the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS). Since taking on this role, I have been involved in CCIIO's implementation of many of the provisions of the Affordable Care Act, including overseeing private health insurance reforms, assisting States to implement Health Insurance Exchanges (Exchanges), and ensuring that consumers have access to information about their rights and coverage options. Prior to becoming the Director of CCIIO, I served as the Director of the Office of Oversight within CCIIO, which is charged with working with the States to ensure compliance with the new insurance market rules, such as the prohibitions on rescissions and pre-existing condition exclusions for children, as well as ensuring consumer value for premium payments through the medical loss ratio standards and the enforcement of the new restrictions on annual dollar limits on benefits.

As a former State Insurance Commissioner, I understand the key role that States play in the regulation of insurance and insurance markets. I have seen first-hand the importance of holding insurance companies accountable, and understand the need to make quality, affordable coverage more accessible to all health care consumers. I have also served as an executive in a for-profit, publicly-traded managed care company, and understand the need for competitive and robust markets as well reasonable regulations. The Affordable Care Act appropriately balances these objectives.

At this time last year, Congress passed and the President signed into law the Affordable Care Act, which expands access to affordable, quality coverage to over 30 million Americans and strengthens consumer protections to ensure individuals have coverage when they need it most. Immediate reforms include a critical foundation of patients' rights in the private health

insurance market that help put Americans in charge of their own health care. Over the past year, we have already implemented historic private market reforms including eliminating pre-existing condition exclusions of children, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and from imposing lifetime dollar limits on coverage, and enabling many dependent young adult children to stay on their parent's insurance plan up to age 26. The Affordable Care Act also established new programs to expand and support coverage options, including the Pre-Existing Condition Insurance Plan (PCIP) and the Early Retiree Reinsurance Program (ERRP).

Beginning in 2014, State-based health insurance Exchanges will improve access to affordable, quality insurance options for Americans who previously had no health insurance coverage or inadequate coverage. The Exchanges will make purchasing private health insurance coverage easier by providing individuals, families, and small businesses with "one-stop shopping" on a single, easy-to-use website. On the website, American consumers, businesses, and other organizations will be able to compare a range of plans. Eligible individuals will also have new premium tax credits and cost-sharing reductions available to them to make coverage more affordable. By increasing competition between insurance companies and allowing individuals and small businesses to band together to purchase insurance, Exchanges will help to lower health care costs for consumers.

Today, millions of Americans are already benefiting from the Affordable Care Act. Many parents across the country are able to protect their dependent young adult children by allowing them to stay on a parent's plan until they are 26 years old. We estimate that, in 2011, more than 1.2 million young adults will be able to maintain insurance coverage through their parent's health plans because of this new policy. This is an important protection for these young adults and a huge relief for their parents.

We estimate that more than 31 million Americans will benefit from the preventive services provision of the Affordable Care Act, which requires that important early detection

services like mammograms and colonoscopies be available to Americans enrolling in new plans without expensive co-pays or deductibles. Furthermore, insurers are no longer permitted to rescind insurance policies simply because a consumer made an inadvertent error on a form. These changes are putting consumers back in charge of their health care and getting insurers out from between patients and their doctors.

Consumers can also use an important new tool to gain access to an unprecedented amount of information about insurance options and public programs available to them by zip code. In eight months, www.HealthCare.gov has had more than 4 million visitors and the number of insurance options listed continues to grow rapidly. Visitors can get information in plain English – and Spanish – about the coverage options available to them, their protections, and their rights as health care consumers.

As mentioned previously, States play a crucial role in the implementation of the Affordable Care Act. Since enactment, we have worked actively with the Governors, insurance commissioners, Medicaid directors, and other stakeholders to implement programs that are helping consumers and businesses with coverage. It has been our priority to work collaboratively with our State partners as the provisions of the Affordable Care Act go into effect.

States were critical to our efforts to write regulations implementing the new medical loss ratio provisions of the Act. The National Association of Insurance Commissioners (NAIC) worked for nearly six months to develop uniform definitions and methodologies for calculating MLR. Their process included significant input from the public, States, and other key stakeholders, and was approved unanimously by the NAIC Commissioners. HHS certified and adopted the NAIC recommendations and the reaction from consumers and insurers has been very positive. Starting this year, insurers must spend at least 80 or 85 percent of premium dollars, depending on the market, on health care and quality improvement efforts instead of CEO bonuses, profits, or marketing. And those that do not meet this standard will be required to reduce their rates or provide rebates to their customers. In addition, the Department recognizes

State flexibility. The law allows for a temporary adjustment to the individual market MLR standard if the State requests it and demonstrates that the 80 percent MLR standard may destabilize their individual insurance market.

This MLR provision ensures consumers receive value for their premium dollars and encourages insurers to invest in the health of their policyholders, while maintaining insurance market stability. There are signs that this provision has already helped to moderate premium increases.

Rising insurance costs have made it difficult for American employers to provide quality, affordable coverage for their workers and retirees while also remaining competitive in the global economy. The Early Retiree Reinsurance Program serves as one bridge to the new Exchanges that will become available in 2014. Many Americans who retire before they are eligible for Medicare and without employer-sponsored insurance see their life savings disappear because of the high cost of insurance in the individual market. Millions more see their insurance disappear, leaving them vulnerable to high costs and poor quality care. The ERRP provides much-needed financial relief for employers so early retirees and their families can continue to have quality, affordable insurance. More than 5,000 employers – including many State and local governments – have been accepted into the program from all 50 States and the District of Columbia.

The Pre-Existing Condition Insurance Plan program is another bridge to 2014, when all Americans, regardless of health status, will have access to affordable coverage. PCIP provides a lifeline to uninsured Americans who private insurers have refused to insure because of a pre-existing condition. These Americans can now receive health coverage without limitation on benefits or higher premiums because of their condition. Thousands of Americans who were locked out of accessible private insurance coverage before the passage of the law now have this valuable and needed coverage. I'm pleased that enrollment has increased by 50 percent in the last few months, and we expect it to grow. The Department is actively working with States, consumer groups, chronic disease organizations, health care providers, social workers, other

Federal agencies, and the insurance industry to promote the program, including holding meetings with State officials, consumer groups, and others.

Finally, for Americans who receive insurance in the individual and small group markets, the Affordable Care Act should result in more protections from unreasonable rate increases. The law provides \$250 million to strengthen States and Territories' ability to review proposals by private health insurance companies to raise their rates for small businesses, individuals, and families. Since enactment, \$45 million has been distributed to 44 States and the District of Columbia, and, in February, \$205 million in additional funding was made available to States, the District of Columbia, and Territories to continue such efforts. We are committed to working with States, the District of Columbia, and Territories, who are the primary regulator of insurance rates and solvency.

The Bridge to 2014

As Director of CCIIO, I am committed to continued improvement of the health insurance system so that it works for consumers both now and with the additional reforms that start in 2014. It is essential that we make sure that Americans who have insurance today – even if that insurance is highly limited – can keep that coverage until reforms take effect that will increase their ability to choose among comprehensive, affordable insurance options in 2014.

As part of our package of consumer protections called the Patient's Bill of Rights, we began implementing the Affordable Care Act's phase-out of limited benefit insurance products – a subject area that you have asked me to discuss. When consumers are covered under health plans with limited benefits, consumers do not always have access to coverage when they need it. In some cases, policies have "lifetime" dollar limits on benefits, and in some cases, insurers have "annual" limits or dollar-amount caps on what the policies will pay during a single year for the benefits that they cover. In 2009, over 100 million Americans were in private health insurance plans with a lifetime limit, and roughly 18 million Americans were enrolled in a plan with an annual limit.

The Affordable Care Act prohibits lifetime limits in all health insurance plans starting in new plan years on or after September 23, 2010. It also provides that, as of January 1, 2014, no group health plan or any individual market plan that is not a “grandfathered” plan may have annual limits on coverage. However, Congress recognized that there should be a transition period between now and 2014, when the Exchanges will be up and running, during which annual limits would be phased out. Section 2711 of the Public Health Service Act provides that group health plans and issuers may continue to impose a “restricted” annual limit with respect to essential health benefits until the consumer protections take effect in 2014. More importantly, the statute directs the Secretary to define “restricted annual limit” during the interim period in a way that will “ensure that access to needed services is made available with a minimal impact on premiums.” This statutory directive recognizes that, for some health plans, an immediate transition to high or no annual limits could significantly raise premiums or reduce coverage with adverse consequences. Therefore, the Secretary must address this concern in implementing the provision during the transition years between passage of the Affordable Care Act and the availability of new quality, affordable options in 2014.

In June of last year, we issued regulations providing that the “restricted annual limit” is \$750,000 for group and non-grandfathered individual plans with plan and policy years starting between September 23, 2010 and September 22, 2011. In other words, plans must provide at least \$750,000 in coverage for essential benefits such as hospital, physician and pharmacy benefits. The limit will be \$1.25 million for plan and policy years starting between September 23, 2011 and September 22, 2012, and \$2 million for plan and policy years starting between September 23, 2012 and December 31, 2013. The rising restricted annual limits will increasingly ensure that consumers have coverage when they really need it.

Most group health plans either already exceeded the new restricted annual limits or could comply with the new restricted annual limits with a negligible or minimal impact on premiums or coverage. However, a very small percentage of the market provides coverage below the new annual limits. It is this small percentage of policies in particular that, without an

accommodation, would sustain more than a “minimal” impact on premiums or coverage if they were required to provide coverage at or above the annual limits provided for in the regulation.

To be sure, limited benefit plans (also known as “mini-med” plans) can leave consumers with unexpected medical bills in the event of hospitalization or chronic disease. Unfortunately they are the only option that some employers offer to their employees and some individuals can afford in some States. In order to protect coverage for these workers, pursuant to the statutory requirement, CCIIO established a process whereby those plans with annual limits below \$750,000 could apply for a one-year waiver from the restricted annual limits. The waiver process, which is grounded in our regulation and fleshed out in subsequent guidance, allows employers and insurers to continue offering limited coverage if they can show that complying with the regulation would cause their enrollees to experience a significant increase in premiums or decrease in access to benefits.

The waiver procedure is administered fairly based on each application’s merits without regard to the type of applicant or size of business, with the goal of minimizing market disruption and maintaining coverage. Guidance on how to apply for a waiver was posted on our website on September 3, 2010. Applicants must submit: 1) the terms of the plan; 2) the number of enrollees; 3) a description of the annual limits; 4) a narrative describing how compliance would lead to a significant increase in premiums or a significant decrease in access to benefits; and 5) an attestation of the facts of the application by the CEO or plan administrator.

We have posted additional guidance detailing the criteria CCIIO uses to determine if the premium increase or access decrease would be significant. Further guidance also lays out specific disclosure requirements that approved applicants must meet. Approved applicants must notify enrollees and potential enrollees of the plan’s annual limits and the fact that the plan does not meet the standards of most plans covered by the Affordable Care Act. This notice is designed to ensure that consumers are aware that their coverage may be inadequate in the event of a catastrophic event or chronic disease.

The annual limit waiver process has been carried out in a way that reflects a commitment to transparency and responsible implementation. CCIIO regularly posts a list of approved annual limit waivers. The list includes the name of the company, the date their application was received, the plan effective date, the number of enrollees covered, the date the application was completed, and the date the waiver was approved.

After we initiated the process in September, applications were received at a relatively steady rate. However, we experienced an expected increase in applications in December, due to the fact that employers and insurers must submit their applications 30 days before the start of their plan year. Many plan years begin on January 1; for that reason we received a large number of applications at the beginning of December. CCIIO worked very hard to ensure that we could process those applications and make timely decisions with respect to these applicants.

As of late February, CCIIO has approved 94 percent of waiver applications received from employers, insurers, and other applicants. The vast majority of waivers, more than 95 percent, were granted to health plans that are job-related. These include self-insured employer health plans, health reimbursement arrangements, collectively-bargained multiemployer plans, and health plans sold by issuers to fully-insured employers.

It is important to note that these limited benefit plans that have received waivers cover an extremely small proportion of the people covered by private health plans in the United States. Since setting up this program, CCIIO has granted waivers to plans covering approximately 2.6 million people, out of the 160 million people who have employer-sponsored health coverage.¹ This figure is less than 2 percent of all covered lives in the private insurance market.

Moving Forward

Until now, very little data were available about these limited benefit plans. We are now analyzing the data we have received through the waiver process and have begun determining what approach we should take for plan years beginning September 23, 2011 and beyond to 2014.

¹ Kaiser Family Foundation - Kaiser's "Employer Health Benefits 2010 Annual Survey," September 2010.

We will continue to work in a manner that minimizes market disruption and ensures Americans have health coverage. The overriding purpose of this waiver program is to ensure that Americans do not lose their health coverage before better health insurance options become available in 2014.

As we lay the groundwork for 2014, it is our intention to continue implementing vital consumer protections while offering enough flexibility to ensure that the market is not disrupted. We are proud of all that we have accomplished over the past year and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans without annual limits that cap their benefits. When the insurance market reforms in the Affordable Care Act are fully implemented, limited benefit plans will be a thing of the past.

In the meantime, I look forward to continuing to work on our bridge toward 2014, year after year, strengthening CCIIO's partnership with Congress, the States, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CCIIO has been doing to implement the Affordable Care Act.

Mr. GOWDY. Thank you, Mr. Larsen.
Mr. Haislmaier.

STATEMENT OF EDMUND HAISLMAIER

Mr. HAISLMAIER. Thank you, Mr. Chairman.

In keeping with your opening remarks that the policy issues are for other committees, in particular the Energy and Commerce Committee, which would have jurisdiction, I am not going to address that. I will note that in my prepared remarks I did give a brief overview of the policy issues just to give the members of the committee some background.

There has been some discussion of the policy issue here. In that connection, I would simply like to make one point that came up in some of the Members' statements. I think it is somewhat relevant here as a policy background.

When you look at the statute, Congress' intent in this is unclear. To say that Congress intended to phaseout these plans is actually not true. There is no evidence that Congress intended to do that. This was not in the House bill. There were no hearings on this provision that I am aware of in the Senate bill. That may have been the intention, but there is no evidence. One can also say that there is no evidence of the other, too, that there was any intention to exempt or preserve these things. So Congress has presented a piece of statute here that is unclear. That is the first point.

The second point is with regards to Mr. Larsen and others who discussed a phase out, it is important to understand that the phaseout that Mr. Larsen and others are discussing is, again, a construct that HHS comes up with. There is no requirement, suggestion, or any other element in the statute with respect to a phaseout.

Now, what we get to in the end of my testimony and what is really at the heart of the question this committee, I think, is dealing with is whether this whole process is actually appropriate. I think that is a valid question.

In looking through the statute and the regulation, I was able to find, in my view, no actual explicit justification for HHS taking the actions that they have in doing the waiver. So regardless of what one thinks about these particular plans or what one thinks about whether Congress intended to get rid of them, intended to keep them, intended to do it quickly or later, the question relevant to this committee is, does HHS have the authority to do it? It does not appear to me that they do, but I am open to hearing the arguments of people who maybe have more expertise in regulatory law than I do.

The other question that occurred to me is, could a reasonable case be made by HHS that, whether it had authority or not, Congress had put it in an impossible situation in the statute and that the Agency or the Department could only resolve the statute through the waiver process. As I indicate in my testimony, again, I do not find that to be the case either.

Congress seems to have simply asked HHS for one very simple thing: Fill in a number. Congress decided that instead of setting a dollar limit in the statute for the interim years, it would delegate that to HHS to come up with a number. That is what the statute

plainly says. So, interestingly enough, HHS came up with three numbers.

When I read the regulation, and I was just looking over it again here while I was waiting, I don't see in the regulation, maybe Mr. Larsen could point to me if I missed something, any explanation of how they arrived at the numbers \$750,000 or \$1.2 million or \$2 million. Indeed, in the table of data that they present, and I am not questioning the data, the breakouts aren't according to that. The breakout is half a million dollars to a million dollars. Well, how did you get \$750,000, which is in the middle? There is nothing that tells me. There is no idea in here as to where these numbers came from or why they did a 3-year phaseout.

All Congress asked them to do was set an interim—an, one interim—number. So clearly, in my view, the statute doesn't require this. HHS could have responded to the requirements of the statute by simply taking the analysis in the regulation and saying that, based on the foregoing analysis, the number prior to 2014 shall be, and set the number. Everyone would then have known what it was and could determine on their own whether they needed to comply or not.

Finally, the question is a public policy question of whether this kind of waiver process is appropriate or desirable in public policy. I would argue for several grounds that it is not desirable for this particular kind of a waiver process in public policy. While there is no evidence I am aware of of corrupt practices, it certainly invites the temptation or the opportunity for favoritism. It certainly does provide for unequal application of the law. It furthermore creates the perception, and possibly the fact, that the regulatory process is being used or subordinated to political ends as opposed to simply enforcing the law that Congress wrote.

So I think there are many reasons to question the suitability of the entire process.

Thank you for your patience and your time, Mr. Chairman. I will be happy to answer questions from the committee.

[The prepared statement of Mr. Haislmaier follows:]



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CONGRESSIONAL TESTIMONY

**HHS Waivers of Regulations on
Health Plan Annual Benefit Limits**

**Testimony before
Committee on Oversight and Government
Reform
Subcommittee on Health Care, District of
Columbia, Census and the National Archives**

United States House of Representative

March 15, 2011

**Edmund F. Haislmaier
Senior Research Fellow
Center for Health Policy Studies
The Heritage Foundation**

Mr. Chairman and members of the Committee, thank you for inviting me to testify before you today.

My name is Edmund F. Haislmaier. I am Senior Research Fellow in Health Policy at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

I have over twenty years experience as an analyst specializing in health care policy and markets. Relevant to the topic of today's hearing I would note that my career experience includes numerous instances in which I have assisted, at their request, lawmakers in Congress and various states with designing and drafting health care legislation, particularly with respect to insurance market regulation.

I will begin my testimony with an overview of the relevant law, follow that with a discussion of the underlying health policy issues, and finally proceed to the principal focus of this hearing -- namely, the appropriateness of the waiver process HHS has promulgated and applied in implementing a new statutory provision that regulates annual benefit limits set by health plans.

Background

Section 1001 of the Patient Protection and Affordable Care Act (Public Law 111-148) made a number of amendments to Title 27 of the Public Health Service Act (42 U.S.C. 300gg et seq.). One of those amendment was the addition of a new Section 2711 prohibiting "a group health plan and a health insurance issuer offering group or individual health insurance coverage" from imposing any lifetime or annual "limits on the dollar value of benefits for any participant or beneficiary," effective for plan years beginning on or after January 1, 2014.¹

The statutory language of Section 2711 further stipulates in subsection (a)(2) that:

With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act, as determined by the Secretary. In defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums.

Thus, prior to 2014 the statute permits plans to impose annual coverage limits that are equal to or higher than a minimum dollar amount, grants the Secretary of HHS the discretion to define that minimum dollar amount, and further instructs the

¹ PL 111-148 § 1001.

Secretary to define the minimum dollar amount in a manner that ensures that "access to needed services is made available with a minimal impact on premiums."

Last summer, HHS published interim final regulations implementing this provision of PPACA.² In those regulations, HHS set the "restricted annual limit" as follows:³

For a plan or policy year	Minimum annual limit
Beginning on or after September 23, 2010, but before September 23, 2011	\$750,000
Beginning on or after September 23, 2011, but before September 23, 2012	\$1,250,000
Beginning on or after September 23, 2012, but before January 1, 2014	\$2,000,000

Thus, HHS has implemented this provision by defining the 'restricted annual limit' as three separate limits for each of the three years prior to 2014. However, in the regulations HHS further provided that:

For plan years (in the individual market, policy years) beginning before January 1, 2014, the Secretary may establish a program under which the requirements of paragraph (d)(1) of this section relating to annual limits may be waived (for such period as is specified by the Secretary) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits provided under paragraph (d)(1) of this section if compliance with paragraph (d)(1) of this section would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage.⁴

HHS justified its addition of this waiver process as follows:

The restricted annual limits provided in these interim final regulations are designed to ensure, in the vast majority of cases, that individuals would have access to needed services with a minimal impact on premiums. So that individuals with certain coverage, including coverage under a limited benefit plan or so-called "mini-med" plans, would not be denied access to needed services or experience more than a minimal impact on premiums, these interim final regulations provide for the Secretary of Health and Human Services to establish a program under which the requirements

² "Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," *Federal Register*, Vol. 75, No. 123, pp. 37188-37241, Monday, June 28, 2010.

³ 45 CFR § 147.126(d)(1).

⁴ 45 CFR § 147.126(d)(3).

relating to restricted annual limits may be waived if compliance with these interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums.⁵

As of the end of February 2011, HHS has so far granted one-year waivers to 1,040 health plans with a total of 2.62 million enrollees.⁶

The underlying health policy issue

As data cited by HHS shows, only a relatively small portion of health plans currently have annual benefit limits.⁷ Furthermore, the practice of setting annual benefit limits in health plans has steadily declined over time. The reason is that insurers and employee benefit managers have come to view better "case management" of high-cost cases as a more effective cost-control strategy than simply setting a fixed annual dollar limit on plan benefits.

The principal exception to that general trend is a subset of plans that are commonly called "mini-med" plans. Indeed, as noted in the quote above, HHS cites as justification for its waiver process the adverse effects that imposing higher annual coverage limits will have on mini-med plans.

A mini-med plan has a benefit design that is essentially the mirror image of that of a high-deductible plan. Under a high-deductible plan the enrollee is responsible for paying routine medical expense, with the plan only paying benefits when medical expenses exceed the deductible. In contrast, the design of a mini-med plan reverses this arrangement. A mini-med plan typically pays for routine medical care with little or no patient co-pays, but does not cover major medical expenses.

Employers typically offered mini-med plans in settings characterized by low-wage workers, high employee turnover, and part-time or seasonal employment. In such circumstances it is uneconomical or impractical to offer those workers traditional, full-benefit plans. What mini-med plans provide is an employee benefit that is at least of some immediate, practical value to workers -- even if doesn't offer adequate protection against major medical expenses. In some ways, the situation is analogous to that of a car owner who purchases auto insurance that only covers the cost of damage or injury to others, but doesn't pay to repair or replace his own car.

No one would contend that mini-med plans are ideal, or are even an adequate alternative to full-benefit medical coverage. Rather, they exist as a kind of "better than nothing" solution for certain, limited circumstances.

⁵ *Federal Register*, page 37191.

⁶ "Helping Americans Keep the Coverage They Have and Promoting Transparency," The Center for Consumer Information & Insurance Oversight, U.S. Department of Health and Human Services, at: http://ccio.cms.gov/resources/files/approved_applications_for_waiver.html

⁷ *Federal Register*, tables 3.2 and 3.3 on page 37204.

The problem

The problem is that in drafting this particular provision of PPACA, Congress did not account for its effects on mini-med plans. However, Congress could have instead opted for any one of three alternative approaches that would have avoided creating the problem.

One option would have been to simply delay the effective date of the provision until after 2014, when the legislation's new subsidies for more comprehensive coverage would become available to workers losing their current mini-med coverage. Congress did, in fact, delay the effective dates of a number of other provisions in PPACA until 2014 to avoid similar disruptions.

A second option would have been to exempt mini-med plans from the new coverage requirement by defining them in the statute as a form of "supplemental coverage." This second approach even has statutory precedent. Specifically, this provision of PPACA is an amendment to the section of the Public Health Service Act that was created by the 1996 Health Insurance Portability and Accountability Act (HIPAA) and which includes a list of "supplemental" coverages that are exempted from the requirements imposed on comprehensive medical insurance.⁸ Such exempted insurance products include; dental-only, vision-only, workman's compensation, long-term care, etc. PPACA did nothing to alter those existing statutory exemptions, but Congress could easily have avoided this issue by adding mini-med plans to that list.

Yet a third option would have been for Congress to provide transitional assistance for individuals losing mini-med coverage until the new subsidies become available in 2014. For example, Congress established in Section 1102 of PPACA a transitional reinsurance program for early retirees, which terminates on January 1, 2014.⁹

In fact, however, Congress did none of the above.

HHS' response in its regulation was to impose on plans a set of increasing mandatory minimum annual coverage limits between now and 2014, but then attempt to preserve existing coverage by selectively waiving those requirements for certain plans.

What is wrong with HHS' waiver "solution"

The first problem is that it appears HHS has exceeded its statutory authority in creating this waiver process.

The statute does not explicitly grant HHS authority to waive the application of this provision. In contrast, I count twenty-one other sections of PPACA in which Congress

⁸ 42 U.S.C. 300gg-91(c).

⁹ PL 111-148 § 1102.

did grant HHS explicit, *new* waiver authority with respect to specific provisions.¹⁰ Thus, it is reasonable to presume that if Congress had intended the Department to institute a waiver process as part of its implementation of this particular provision, Congress would have said so in the statute.

Furthermore, this provision does not present HHS with inherently conflicting instructions from Congress that can only be resolved through the creation of a waiver process. The waiver process established by HHS is not the only way that the Department could have fulfilled Congress' requirement that, "In defining the term 'restricted annual limit' for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums." Indeed as the forgoing sentence in the statute indicates, HHS could have "defined" the "restricted annual limit" as an amount sufficiently low enough that "access to needed services is made available with a minimal impact on premiums," even in the case of mini-med plans.

In other words, the Department could have avoided adversely effecting mini-med plans by simply setting a lower amount for the transitional limit. The wording of the statute certainly seems to indicate that Congress' intent was to forego writing a figure into the statute, and instead delegate to HHS the task of determining an appropriate amount -- nothing more.

Beyond the question of whether the establishment of this waiver program exceeds the discretionary authority granted by Congress to the Department in the statute, there is also the larger question of whether this action by the Department constitutes appropriate or desirable public policy.

I believe that the waiver process established by HHS in this instance is inappropriate and undesirable on three public policy grounds:

First, it results in unequal application of the law to affected parties and creates unequal burdens. Some applicants may get waivers while others may not. Furthermore, affected employers that are larger, and thus have more resources for responding to regulatory interventions, are more likely to be aware of, and apply for, the waivers than smaller firms with fewer resources.

Second, it creates at least the perception -- and possibly the fact -- that regulatory enforcement is being subordinated to Administration political priorities or concerns. The combination of HHS establishing interim dollar limits in the regulation, but then also instituting a process for waiving those limits on a case-by-case basis, appears deliberately designed to convey the perception that the new law is having a positive effect, while selectively avoiding any enforcement actions that might create the opposite public perception that the law is resulting in adverse, unintended consequences.

¹⁰ Instances of Congress granting HHS new, explicit waiver authority in PL 111-148 can be found in § 1332, 2704, 2707, 3001, 3021, 3022, 3023, 3024, 3026, 3110, 3303, 4101, 4108, 5311, 5403, 5509, 6112, 6401, 6402, 10323, and 10326.

Third, it creates the opportunity, and the temptation, for Administration officials to apply the law corruptly or to engage in political favoritism when making enforcement decisions. Even if actual enforcement is not in fact tainted, the existence of a regulatory process that appears to invite such a possibility needlessly raises suspicions and undermines public confidence in the rule of law.

What Congress should do now

Based on the foregoing I recommend that Congress now take two actions.

First, Congress should instruct HHS to rewrite the regulation so as to eliminate this waiver program and limit its exercise of discretionary authority to only those matters in this provision over which Congress explicitly granted the Department discretionary authority. In particular, HHS should confine itself to the statutory requirement that the Department define the "restricted annual limit" to be applied prior to 2014. HHS could either retain the limits it has already defined in regulation, or replace them with a new, lower limit.

Second, Congress should consider whether or not it will change or further clarify the statutory language of this provision of PPACA, in the context of its broader debates over the future of this legislation in general and its numerous specific provisions.

Mr. Chairman, this concludes my prepared testimony. I thank you and the rest of the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

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Mr. GOWDY. Thank you.

Mr. Wold, we will recognize you for your 5 minute opening statement.

STATEMENT OF SCOTT WOLD

Mr. WOLD. Thank you, Mr. Chairman and members of the committee.

As you mentioned, I am an employee benefits attorney. On a daily basis I work with employers both large and small with respect to their employee benefits plans. So in the last year since the Patient Protection and Affordable Care Act was passed, as you can imagine, we have spent a large amount of time working with this particular law as it applies to our clients and their plans. I am here today to talk about one particular aspect of that experience over the last year, that is with respect to the waivers from the annual limit restrictions.

First I would like to note how as an attorney I became aware of this program or this process. We did review the legislation, at least the parts of the legislation that applied to employer benefit plans. And we did very closely monitor regulatory implementation. When the regulations came out, we took a close look at those. So the first time I learned of the possibility of a waiver program was in June when the regulations on the annual and lifetime limit restrictions were published.

I noted in reviewing those regulations that there was authority given to the Department to issue or create a program providing waivers for certain types of plans.

The regulations didn't contain a lot of detail and so we didn't really learn much about the program itself until later in September when the first piece of guidance was issued regarding the program itself.

As an attorney we subscribe to a number of different benefits news publications, I guess I would call them. Typically they are on-line. So either daily or weekly we get informed of different developments that are occurring in the employee benefit area. It was through those processes that we learned about the guidance being issued with respect to the waiver program, and of course we went out and reviewed it. I am not aware whether it was publicized in any other way, but that is how I became aware of it and as an attorney we certainly monitor those types of things.

One of the things that we then did was we worked with a number of employers in applying for the waivers. Most of our experience was not in the context of mini-med plans. There has been discussion of mini-med plans and how the waivers are applicable to them. We do have clients with mini-med plans and have applied for waivers for those plans. But a number of our clients and most of our experience in this area has to do with health reimbursement arrangements.

Health reimbursement arrangements are not traditionally thought of as mini-med plans. They are typically used to supplement other group health plan coverage. They are an account-based, defined contribution health plan. The employers will make those available so that employees can have dollars to use to reimburse out of pocket expenses.

HRAs have really been, I would say, largely ignored in this whole process. They are group health plans and they are subject to these rules in general. In the preamble to the interim regulations there was a specific exemption provided to certain health reimbursement arrangements, something called integrated HRAs. The problem was that there was no definition or any guidance provided as to what an integrated HRA is. So there has been a lack of clarity in the benefits community about which HRAs are subject to these annual limit restrictions and which are not.

In addition, it was never clear, at least from the published guidance, whether HRAs could apply for waivers. The guidance talked about mini-med plans or limited benefit plans but there was no mention of HRAs. We did some investigation. We called the Department and informally got an answer that, yes, HRAs could apply for these. That is how we were able to go through that process with our clients who sponsor HRAs.

The difficulties we experienced, especially with our clients who sponsor health reimbursement arrangements, suggest to me that the waiver process was not the best method to go about providing this relief. I won't take a position on whether the relief was actually needed or a good idea, but I think once it was decided that some of these plans would have time to continue to be maintained as they were, the waiver process created a number of challenges to employers. There may have been a better way to do that.

Thank you.

[The prepared statement of Mr. Wold follows:]

Written Testimony
of
Scott A. Wold

Subcommittee on Health Care, District of Columbia, Census
and the National Archives of the Committee on Oversight and Government Reform

“Obamacare: Why the need for waivers?”

March 15, 2011

I am an attorney and a shareholder of Hitesman & Wold, P.A., an employee benefits law firm located in Minneapolis, Minnesota. My law practice focuses almost exclusively on employee benefits. Over the past year, much of my work has related to the Patient Protection and Affordable Care Act (“PPACA”).

After passage of PPACA, Darcy Hitesman (the other shareholder of Hitesman & Wold, P.A.) and I devoted a significant amount of time reviewing and studying the legislation to determine its impact on our clients. Those clients include employers that sponsor group health plans, insurance companies that issue group health insurance, and service providers that provide insurance brokerage, consulting, and claims administration services to employers and their group health plans. Much of our efforts to become knowledgeable regarding PPACA’s requirements focused on reviewing the regulatory guidance issued pursuant to the legislation. Accordingly, after PPACA was enacted, we closely monitored the issuance of regulations and other guidance by the respective agencies.

In addition to studying the legislation, much of my firm’s work in the last year has involved advising clients regarding the requirements of PPACA and assisting them with compliance. As part of that work, I have had experience assisting group health plans (including a group health plan sponsored by the City of Cottage Grove, Minnesota) request waivers from the annual limit restrictions contained in Section 1001 of PPACA. I am presenting testimony regarding these waivers, including the process for obtaining them.

Shortly after their issuance on June 28, 2010, I became aware of and reviewed the interim final regulations issued by the Internal Revenue Service (IRS), Department of Labor (DOL), and Department of Health and Human Services (HHS) under PPACA’s provisions relating to preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections. At the time, I noted that the regulations gave authority to the Secretary of HHS to establish a program to provide waivers from PPACA’s annual limit restrictions. This provision was noteworthy because I work with several employers that sponsor limited benefit plans. PPACA’s annual limit restrictions were of special concern to employers that sponsor limited benefit plans because typically a key feature of a limited benefit plan is a fairly low (in comparison to traditional major medical plans) annual limit on benefits.¹ The possibility of a waiver program was welcome news to these employers because it would allow them to continue to sponsor these plans at least on a temporary basis.

Another significant aspect of the regulations was the treatment of health reimbursement arrangements (HRAs). HRAs are defined contribution, account-based group health plans that reimburse medical expenses incurred by

¹ This feature allows plan sponsors to keep the cost of coverage under the limited benefit plan low in comparison to the cost of traditional major medical coverage.

employees and their dependents.² HRAs include a variety of plan designs – they may be used to supplement other group health coverage by reimbursing out-of-pocket medical expenses not reimbursed by the other plan, to provide funds for post-employment health expenses, to provide benefits in lieu of traditional group health plan coverage, etc. In general, HRAs are group health plans subject to PPACA although, depending on the plan design, some HRAs are exempt from most of PPACA's requirements.³ A significant number of our clients sponsor, or work with employers who sponsor, HRAs.

The annual and lifetime limit restrictions were of special interest to me due to their impact on HRAs. By definition, the benefits provided by an HRA are limited by the contributions made to the plan by the employer (that is the reason HRAs are considered defined contribution plans). Accordingly, the amount of benefits or reimbursements an HRA participant may receive during a year is generally limited by the amount in the participant's account at the beginning of the year plus the additional contributions allocated to the account throughout the year. It appeared, therefore, that all HRAs impose an annual limit on benefits that would be subject to the new annual limit restrictions. Because an HRA could not comply with the annual limit restrictions, my clients and I were interested to learn whether the agencies had exempted HRAs from them.

The agencies did, in fact, provide an exemption for two categories of HRAs (that were not already exempt): (1) those "integrated" with another group health plan and (2) those that constitute flexible spending arrangements under Section 106 of the Internal Revenue Code. With respect to other HRAs (such as "stand-alone" HRAs that are not retiree-only), the agencies requested comments regarding application of the annual and lifetime limit restrictions. Although the regulations created the possibility that the annual limit restrictions would apply to some HRAs, my expectation was that, before the annual limit restrictions became effective, the agencies would issue additional guidance regarding the application of the rules to these other HRAs.

I subscribe to several services that provide daily or weekly updates regarding developments in employee benefit law. In addition, Darcy Hitesman is an author and speaker for the Employee Benefits Institute of America. From these sources, I became aware in September, 2010, that HHS had established the waiver program and issued guidance regarding applying for waivers.

In late October, my firm began to focus on the need for some of our clients to apply for waivers because the lack of additional guidance from HHS regarding HRAs.⁴ There was an initial question of whether waivers were available for HRAs. The HHS guidance from September did not address this issue. The guidance referred to limited benefit plans and mini-med plans, but was silent regarding HRAs. To seek some clarification, my firm contacted HHS and inquired whether HRAs were eligible for the waivers. We were informed that HRAs were eligible.⁵ We then distributed a communication to all of our clients recommending they should consider seeking a waiver from the annual limit restrictions for their HRAs.

I and my firm have assisted (directly or indirectly)⁶ numerous HRAs seek and obtain waivers (including an HRA sponsored by the City of Cottage Grove, Minnesota). At this time, we have also assisted one limited benefit plan

² A participant's HRA account balance may carry over from year to year.

³ Exempt HRAs include HRAs that are exempt from HIPAA, including retiree-only HRAs and HRAs that constitute HIPAA excepted benefits.

⁴ The annual limit restrictions were/are applicable as of the first plan year beginning on or after September 23, 2010.

⁵ To the extent there was still a question whether HRAs were considered to be subject to the annual limit restrictions, HHS's response to our inquiry confirmed that HRAs are subject to the restrictions.

⁶ In some cases, we prepared and submitted the application on behalf of the employer sponsoring in the plan. In other cases, we prepared a template application for use by our clients who provide services to employers (e.g., brokers/consultants and third party administrators) who in turn made the template application available for use by their

obtain a waiver and expect to assist several more with their applications for the waiver. To my knowledge, none of the applications with which I provided assistance (directly or indirectly) have been formally denied. However, they have not all been issued. Furthermore, I have encountered several issues or difficulties with the process.

As mentioned above, it was not clear whether HRAs were even eligible for waivers. Neither the regulations nor the HHS guidance regarding the waiver program mentioned HRAs. As a result, many employers were surprised to learn that they could (and should) apply for a waiver. HHS's failure to clearly address the availability of waivers for HRAs likely resulted in many sponsors of HRAs not requesting a waiver.

A significant issue faced by many employers who sponsor HRAs was whether a waiver is needed for their particular HRA. The interim final regulations provided an exemption from the annual limit restrictions for HRAs that were "integrated" with other group health plan coverage. However, the regulations did not define the term "integrated" or otherwise describe the concept of an integrated HRA. Although many HRAs are provided in conjunction with other coverage (e.g., the expenses that are reimbursable under the HRA are expenses that would be covered under the medical plan but for the cost-sharing requirements), without any guidance from the agencies regarding what constitutes an integrated HRA, in many cases employers had to guess whether their HRAs are integrated. We took a conservative position on this issue, recommending a waiver be obtained unless the HRA was part of the other group health plan and all participants of the HRA were also covered under the other group plan.

Even after applications were filed for HRAs, HHS did not provide any assistance with this issue. In many cases, upon receiving a waiver application for an HRA, HHS would send a form response reminding the applicant that no application was needed if the HRA was integrated. However, this response provided no further guidance regarding what HHS considered to be an integrated HRA and HHS would not comment further when asked for additional guidance.

Another issue arose with respect to the content of the application. The HHS guidance released in September regarding the waiver program contained few details regarding the information that was required as part of the application and no application form was provided. Although we were able to put together an application that we thought satisfied the requirements of the program, in most cases HHS requested additional information before it considered the application to be complete.

In some cases, HHS responded by requesting an entirely new application be completed. For most of the applications with which we provided assistance, the filing deadline was December 1, 2010. HHS released an application form on or about December 8, 2010. Even though no such application form was available at the time they filed their applications, many employers were asked to complete the new application form.⁷ This requirement added to the time and expense incurred by employers to obtain the necessary waiver.

Another issue that some of our clients encountered was that HHS allowed another party to withdraw their applications. In Minnesota, the state retirement system (Minnesota State Retirement System or MSRS) has established an HRA called the Health Care Savings Plan. The Health Care Savings Plan is administered by MSRS and funded through a trust established by MSRS. However, governmental employers in the state (e.g., cities, counties, school districts) decide on an individual basis whether to participate in the plan and choose or

clients. In the latter case, I was typically consulted with respect to any questions or requests made by HHS with respect to an application submitted by the employer.

⁷ I assisted with the completion of this form in several cases.

establish some of the particular terms of their plan.⁸ We recommended that employers participating in the Health Care Savings Plan should obtain a waiver with respect to their participation in the plan. In several (but not all) of these cases, HHS appeared to take the position that MSRS was the proper party to submit the application and contacted MSRS. MSRS informed HHS that the Health Care Savings Plan did not need a waiver because it was exempt.⁹ As a result, it is my understanding that HHS treated the employer's application to have been withdrawn based solely upon the request of MSRS (i.e., without the employer's consent).¹⁰

Some type of relief from the annual limit restrictions is needed. Because the agencies did not delay the effective date of the rules as they did for another PPACA requirements (e.g., the nondiscrimination requirements for fully insured plans), if a plan is subject to the annual limit restrictions and did not obtain a waiver, the plan is out of compliance and the employer is subject to penalties.

For HRAs, relief should be provided in the form of non-enforcement pending further guidance. Although some employers requested waivers, many employers likely did not request a waiver either because they were unaware of the need to obtain a waiver for an HRA or because they took an aggressive approach and treated their HRAs as integrated HRAs, despite the lack of a definition of "integrated." Other employers sought the waiver, but had their application withdrawn for them. The waiver process is inefficient and, in some cases, inconsistent. A uniform non-enforcement position pending guidance would put all HRA sponsors in the same position while we await additional guidance regarding whether all HRAs are exempt from the annual and lifetime limit restrictions. If no such exemption is provided by the agencies, legislation should be passed providing the exemption.

For employers that sponsor limited benefit plans or mini-med plans, ongoing relief from the annual limit restrictions is needed, whether in the form of waivers or a non-enforcement position. Under PPACA, the limited benefit plan or mini-med plan will eventually need to be eliminated. Employers need time to determine whether to replace those benefits with PPACA-compliant benefits or to not provide benefits to the employees who in the past have been offered the limited benefit or mini-med plan.

I recognize that the agencies, including HHS, have a difficult task implementing PPACA. Employers that must comply with the law also have a difficult task ensuring they are in compliance. My hope is that my testimony about our experience with respect to waivers from the annual limit restrictions will lead to a better process so that all employers are treated fairly and are able to be in compliance.

Respectfully submitted,



Scott A. Wold

⁸ For example, individual employers decide who will participate and the levels of contribution. In addition, each employer is responsible for many of the plan sponsor responsibilities including nondiscrimination testing, application of COBRA, calculation and reflection of GASB liabilities, etc.

⁹ MSRS reportedly informed HHS that the Health Care Savings Plan is a retiree-only plan and, therefore, exempt. However, the terms of the Health Care Savings Plan allow current employees to receive benefits from the plan in certain cases. See <http://www.msrs.state.mn.us/hcsp/reimb.html>.

¹⁰ It is also our understanding that the employer was not informed of the withdrawal or the basis for it. Only upon follow up with respect to the status of the requested waiver was the employer informed by HHS of this information.

Mr. GOWDY. Thank you, Mr. Wold.
Dr. Feder.

STATEMENT OF JUDITH FEDER

Ms. FEDER. Thank you, Chairman Gowdy, Ranking Member Davis, and members of the subcommittee and committee. I am glad to be with you today. I am happy to testify on the Affordable Care Act and its implementation.

Because of its importance, an ever growing body of research tells us that assuring Americans affordable health care and affordable insurance matters enormously to their health and well-being. As you noted in the outset, almost exactly a year ago the Affordable Care Act [ACA], was enacted to provide that assurance. The law assures most, if not all, Americans essential health insurance coverage by building upon, not replacing, the current health insurance system, securing what works and fixing what doesn't.

Today, about 170 million Americans get health insurance through employment. The Affordable Care Act strengthens job-based health insurance through consumer protections like the prohibitions on annual or lifetime limits on benefits and through penalties on employers with more than 50 employees who use newly available tax credits to purchase insurance directly because their employers do not offer affordable coverage. According to the Congressional Budget Office, under the ACA, job-based coverage will remain in the future the primary source of health insurance coverage for working Americans that it is today.

At the same time that the Affordable Care Act secures what works in providing health insurance, it fixes what is generally recognized as broken—the non-group health insurance market. Although in theory people who do not get coverage through their employers can buy it on their own, in practice the non-group market is not a safety net. On the contrary, insurers survive in this market by attracting and ensuring that they attract consumers when they are healthy and avoiding us when we are sick.

To address this problem, the Affordable Care Act takes what is often referred to as a three-legged stool approach. You need all three legs to make the stool work. Unless we require health insurers to take us all, regardless of our health needs and without extra charges for preexisting conditions, people will be denied coverage they need. Insurers can only accept all comers if they can expect all of us to buy insurance when we are healthy and not to wait until we are sick. We can only expect everybody to buy health insurance if they get help to pay premiums if they can't afford them, help the ACA provides in the form of tax credits.

The Congressional Budget Office estimates that with arrangements under the ACA, about 19 million people will be covered through health care exchanges and receive tax credits by 2019. Another 16 million people on top of coverage projected under pre-ACA law will be covered through Medicaid.

This Medicaid expansion reflects another fix in the ACA. Today, the same low wage workers whose employers don't offer coverage have been denied Medicaid benefits as well, no matter how low their incomes. Fortunately, the ACA brings an end to this discrimination by extending Medicaid at full Federal expense to all individ-

uals whose incomes fall below 133 percent of the Federal poverty level.

Though sorely needed, changes in our health insurance system can't take place overnight. The ACA is designed to strengthen and extend the health insurance coverage Americans count on, not to disrupt it. The law recognizes that building new marketplaces will take time. Until the full set of new insurance rules and subsidies are in place, people who have inadequate coverage may want to hold onto it despite its limitations. Therefore, the administration has been willing to grant waivers from some of the law's early requirements which, if fully imposed, might leave some people with nothing.

The aim of the law's early requirements and benefits is to make matters better without making them worse until the full law goes into effect in 2014. Far from indicating weaknesses in the Affordable Care Act, these waivers reflect its strength in matching requirements with capacity. It behooves administrators of the ACA to be sensitive to disruptions alongside improvements and to assure a balance that enhances people's protections as the law intends. It behooves overseers of the law's implementation to recognize the big picture, the enormous problems the Affordable Care Act was enacted to address.

It is designed to strengthen what works, fix what is broken, and avoid unnecessary disruption. Its potential, when fully implemented, is to end discrimination based on preexisting conditions and assure most, if not all, Americans access to affordable health insurance coverage. All of us should be working to make sure that we move as quickly and as smoothly as possible to get us from here to there.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Feder follows:]

STATEMENT OF

JUDITH FEDER, Ph.D

**PROFESSOR OF PUBLIC POLICY, GEORGETOWN UNIVERSITY
SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS ACTION FUND**

BEFORE

**HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS
AND THE NATIONAL ARCHIVES**

MARCH 15, 2011

Mr. Chairman, members of the subcommittee, I appreciate the opportunity to testify before you today on the Affordable Care Act. My testimony reflects more than 30 years of experience—primarily at Georgetown University—exploring how best to address the widely recognized shortcomings of our health insurance system. Over that period, health insurance has become increasingly unaffordable; today an estimated 50 million people are uninsured and unable to afford health care when they need it. An ever-growing body of literature demonstrates that, without health insurance, people get care later, get less care, and are at greater risk of death than people who have health insurance. In short, assuring Americans affordable health insurance matters enormously to the health and well-being of Americans.

Almost exactly a year ago, the Affordable Care Act, or ACA, was enacted to provide that assurance. The law assures most, if not all, Americans essential health insurance coverage by building upon, not replacing, the current health insurance system—securing what works and fixing what doesn't. Put simply, the ACA strengthens the employer-sponsored health insurance that most Americans count on and will cover over 30 million more Americans by making insurance available and affordable to people that today's system leaves uninsured (most of whom are low-wage workers whose employers don't offer health insurance).

Today, about 170 million Americans get health insurance through employment. The Affordable Care Act strengthens job-based health insurance through a combination of consumer protections. The law prohibits annual or lifetime limits on benefits and allows

children up to age 26 to be covered on their parents' policies. It also imposes penalties on employers with more than 50 employees whose employees use newly available tax credits to purchase insurance directly because their employers do not offer affordable coverage. Although the ACA creates new coverage opportunities outside the workplace, estimates of the law's impact by the Congressional Budget Office indicate that in the future, job-based coverage will remain the primary source of health insurance coverage for working Americans, just as it is today.

At the same time the Affordable Care Act secures what works in providing health insurance, it fixes what is generally recognized as broken: the nongroup health insurance market. The overwhelming majority of Americans without health insurance are workers, or in families of workers, whose employers do not offer coverage. Although, in theory, these people can obtain the coverage they need by purchasing health insurance on their own, the nongroup market is not a safety net. On the contrary, insurers survive in this market by assuring they attract consumers when they're healthy and avoid them when they get sick. People with "pre-existing conditions," broadly defined, face enormous difficulties in obtaining coverage in this marketplace—as insurers can deny them coverage, charge exorbitant rates, exclude coverage for specified body parts or systems, and rescind coverage even after it's been awarded.

To address this problem, the Affordable Care Act establishes new rules for private insurance outside the workplace, largely (though not solely) through the states' creation of a new marketplace called an exchange. The rules require insurers to accept all

applicants and provide essential coverage without regard to—or extra charge based on—health status. The law provides tax credits to individuals and some small businesses to make that coverage affordable. And, to assure that health insurance is able to spread risk, the law also requires that everyone able to afford insurance actually buys it.

This set of conditions is often referred to as a “three-legged stool”—without any one leg, the health insurance marketplace simply can’t stand. Unless we require health insurers to sell us health insurance, regardless of our health needs, people will be denied coverage for pre-existing conditions. And insurers can only accept all comers if they can count on us to pay premiums when we’re healthy, not to wait until we get sick. And, given the high cost of insurance, many of us can only afford to pay these premiums if we get some help, which the ACA provides in the form of tax credits. Requirements on insurers and responsibility—with assistance—for consumers work together in the ACA to fix the broken nongroup health insurance market. The ACA also extend these “fixes”—a new marketplace with new rules and new tax credits—to small businesses, who, like individuals, are currently disadvantaged in the health insurance marketplace.

The Congressional Budget Office estimates that under the ACA, about 19 million people will be covered through exchanges and receive tax credits by 2019. The CBO estimates an increase of roughly 16 million people—on top of coverage projected under pre-ACA law—through Medicaid, with support from another ACA “fix”—a change to federal Medicaid law that currently excludes from coverage low income people who are not aged, blind, disabled, children, or parents of dependent children. The same low-wage

workers whose employers don't offer coverage have been denied public benefits as well, no matter how low their incomes. Fortunately, the ACA brings an end to this discrimination by extending Medicaid—at full federal expense—to all individuals whose incomes fall below 133 percent of the federal poverty level.

Though sorely needed, changes in our health insurance system cannot take place overnight. The ACA is designed to strengthen and extend the health insurance coverage Americans count on, not to disrupt it. The law recognizes that building new marketplaces will take time—and until the full set of new insurance rules and subsidies are in place, people who have inadequate coverage may want to hold on to it, despite its limitations. Therefore, the administration has been willing to grant waivers from some of the law's early requirements, which, if fully imposed, might leave people with nothing. The aim of the law's early requirements and benefits is to make matters better, without making them worse, until the full law goes into effect in 2014. Far from indicating weaknesses in the ACA, these waivers reflect its strength in matching requirements with capacity. It behooves administrators of the ACA to be sensitive to disruptions alongside improvements and to assure a balance that enhances people's protections, as the law intends.

And it behooves overseers of the law's implementation to recognize the "big picture"—the enormous problems that the ACA was enacted to address; its design to strengthen what works, fix what's broken, and avoid unnecessary disruption; and its potential when fully implemented to end discrimination based on pre-existing conditions and assure

most, if not all Americans, access to affordable health insurance coverage. All of us should be working to make sure that we move as quickly and as smoothly as possible to get us from here to there.

Mr. GOWDY. Thank you, Dr. Feder.

Let me say this to our witnesses and to our guests in the audience: One thing that you will find total unanimity on in this subcommittee is our desire to be good stewards of your time as well as the time of the people who are gracious enough to be with us. I am informed that votes are imminent. What I would propose to Mr. Davis and to my colleagues is that we continue on until votes are called, that we adjourn long enough to go cast our votes, and then that we come back and that we do it as quickly as we can to be good stewards of your time.

I will recognize myself for 5 minutes at this point.

Mr. Larsen, I am not going to spend any time quarreling about the statutory authority for waivers. I am not even going to discuss the substantive aspects of the health care law. What I want to focus on is the waiver process.

Can you tell me when the waiver process was first made public?

Mr. LARSEN. Yes, thank you, Congressman. I think, as was mentioned, the regulations that identified the phase in of the annual limits, as well as the waiver process were published, the interim final rules, in June. Within 90 days of that, I think on September 3rd, we published the first bulletin that laid out the waiver process and what we think were very simple and straightforward provisions of the application process for the public.

I think it was mentioned that there wasn't an application initially. In fact, in order to make the process very simple, we just laid out the types of information that an applicant could provide. Later on as we got more applications, to improve the process we did develop a form that people were to use online, a spreadsheet if you will.

Mr. GOWDY. Let us assume it is September 3rd. Were there applications for waivers that were made prior to September 3rd?

Mr. LARSEN. Not to my knowledge.

Mr. GOWDY. Were there waivers granted prior to September 3rd?

Mr. LARSEN. Not to my knowledge. We didn't have the application process set up.

Mr. GOWDY. That is my point.

Mr. LARSEN. Right.

Mr. GOWDY. Are you sure there were no requests for waivers prior to September 3, 2010.

Mr. LARSEN. Requests for waivers?

Mr. GOWDY. Requests. Applications or requests.

Mr. LARSEN. I have been advised that there were three.

Mr. GOWDY. What process did you use, given the fact that there was no public process that had been promulgated at that point for those three?

Mr. LARSEN. I assume that they were held until we set the process up. That is my assumption.

Mr. GOWDY. When you say process, are you referring to the regulation that used the words large and significant?

Mr. LARSEN. No, when I say we set up the process, I am referring to the bulletin that we issued in September. That was when we identified that there was a process in place. We issued the regulation and then we established the process through what we re-

ferred to as sub-regulatory guidance, which is the bulletin that we put out in September.

Mr. GOWDY. So your testimony is that there were three applications, whether that is formal or informal, for waivers prior to September 2010?

Mr. LARSEN. That is my understanding, but I would like to confirm that for the committee.

Mr. GOWDY. OK. So how did the companies know the process before you promulgated the regulations?

Mr. LARSEN. Well, again, the regulations were issued in June. I would say the regulations did two things among many others. This was part of a broader regulation. But with respect to the annual limits provisions, we established the tiered phase in for annual limits.

After looking at what was happening in the marketplace and what types of annual limits were out there, we established for the first year the \$750,000 restricted annual limit.

Again, it is very important to note that the statute specifically contemplates that there will be no annual limits in 2014 but what it refers to as restricted annual limits—

Mr. GOWDY. Well, I wasn't going to go to the statute but if you are going to bring it up, you will also have to concede nowhere does it grant the Secretary the express power to grant waivers.

Mr. LARSEN. I am not sure I would agree with that because the clear reading of what is there is that there will be a phase in of the annual limits provisions.

Mr. GOWDY. Well, the word waiver does not appear anywhere in the statute. Would you agree with me there?

Mr. LARSEN. Well, I will agree that the word waiver does not appear in that particular section.

Mr. GOWDY. OK, that is the one we are talking about.

Mr. LARSEN. But I don't think that is, as a lawyer at least, the normal test for whether it is reasonable to interpret a statute—

Mr. GOWDY. Speaking like a lawyer, let me ask you—

Mr. LARSEN. I know you are a lawyer, sir.

Mr. GOWDY. Not much of one, I was just a prosecutor. [Laughter.]

Let me ask you this: If there is a denial, is there an appeals process. What burden of proof does an applicant have to make to be considered, rejected, and then considered again?

Mr. LARSEN. Actually, we do have a reconsideration process. Again, it is a very simple process. We consistently were guided by the principle of making this as easy and as simple as possible. We advise applicants that if they are denied, they can ask for reconsideration. We will work with them to collect whatever additional information we need to look at the application again.

So there isn't a hard and fast burden of proof because our goal in implementing this provision was to ensure that employees could continue the coverage they had. We didn't want to make it burdensome. In fact, if we had to make a choice, our objective would be to err on the side of making sure that people could continue their coverage. We weren't out to deny people. We wanted to make sure that people could continue their coverage.

Mr. GOWDY. I have run into the red light so I will now recognize my colleague from the State of Illinois, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman.

You know, I was just thinking I know people who swear at lawyers and I know others who swear by lawyers. So it just depends on who you are looking at.

Mr. Larsen, the new health care law is intended to phase out what we call mini-med plans. These plans provide low benefits and often leave consumers high and dry when it comes to actually using them to access medical care. We have heard many horror stories about people who rely on these plans thinking that they are insured, only to get sick or have an accident and be left with nothing.

In July 2009, for example, the New York Times featured a story about a man whose limited benefit health plan capped hospital services at \$10,000. He had to undergo a heart procedure and his hospital bill was \$200,000. When it came time to pay, his plan provided next to nothing. He and his wife were forced to declare bankruptcy despite the fact that he was supposedly insured.

Mr. Larsen, some might conclude that these plans should be prohibited immediately. Can you tell us, simply, why do we need these waivers at all? Why not just prohibit these horrible plans outright?

Mr. LARSEN. Yes, sir. What you describe, I think, is the dilemma with these plans. They provide some coverage for the employees that can purchase them but in too many cases they don't provide sufficient coverage or people don't understand that, in fact, they don't have coverage. So with a day or two in the hospital, they have reached their limits.

These really are a bridge to 2014 when fuller, more comprehensive, and affordable coverage will be available. Although this is not great coverage, or good coverage in some cases, it is some coverage. We want to make sure that people can maintain access to that coverage through this process. So the waiver process permits individuals to continue that type of coverage until better coverage is available in 2014.

Mr. DAVIS. Now let us take a look at the other side of this argument. There are those who have argued that since you are approving 94 percent of the waiver applications, that means the underlying health care law must be flawed. For example, my good friend, Representative Cliff Stearns, Chairman of the House Energy and Commerce Subcommittee on Oversight and Investigation puts it this way, "If the law," that is the Affordable Care Act, "is so good, why are so many waivers to the law being granted?"

How do you answer or respond to that?

Mr. LARSEN. I would respond that the waiver provision that was contemplated in the statute shows that the law is, in fact, working because it allows employees to continue this coverage. Remember that it is a small percentage of employees, less than 2 percent. Most people who have coverage have much more comprehensive coverage. This allows them to continue it.

So I would argue or submit that it shows that the law is working. The majority of policies that can meet the annual limits with minimal impact on premiums will do so. And the statutory goal is to ensure that we are phasing out the annual limits in 2014.

Mr. DAVIS. Then why won't the same employers that are seeking waivers today seek them in 2014?

Mr. LARSEN. At that point, we will be much farther along in the reform of this very broken health care system. It is important to keep in mind that these fixes are a result of a broken system where people are denied coverage for being sick, are having their policies rescinded, or have limited benefits. In 2014, more comprehensive, affordable coverage is available for employees of small businesses and individuals.

Mr. DAVIS. Thank you very much, Mr. Larsen.

It reminds me of when my father was explaining the differences between how people see things. If you ask is it fair for birds to eat worms, you get a different answer depending on who you ask. If you ask the bird, you get one answer. If you ask the worm, you get another answer. I guess they both feel that they are right.

Mr. LARSEN. I hope I am the bird. [Laughter.]

Mr. GOWDY. Thank you, Mr. Davis.

The Chair would recognize the gentleman from Arizona, Dr. Gosar.

Mr. GOSAR. Mr. Larsen, when did Health and Human Services first know about the two million Americans, when they would lose their health care coverage even if they liked it? When did you first know that two million Americans would lose their health care based upon this provision?

Mr. LARSEN. I am not sure I am following your question.

Mr. GOSAR. Well, let us go further. President Obama clearly said, "If you like your health care plan, you can keep it."

While limited, mini-med plans provide some coverage to about two million people. True?

[No response.]

Mr. GOSAR. About 1.8 million, to be exact. But the law as written and as understood, and we are talking about attorneys—I am not an attorney, I am a dentist—of 7-11, Lowes, National Restaurant Association, National Retail Federation, and the US Chamber of Commerce, the bill as written eliminated this health care coverage, period. Is that true or not true?

Mr. LARSEN. Not true. As I described earlier, it does two things. It sets up a phase in of restricted annual limits leading to no annual limits in policies but preserves the ability for this small part of the market that has very, very low annual limits to continue until we get to 2014.

Mr. GOSAR. Did you know those groups met with the Secretary for Health and Human Services in June of last year about that very issue?

Mr. LARSEN. I don't think I did. We had meetings with groups as well to talk about the development of the waiver process. I don't know who met with the Secretary, specifically.

Mr. GOSAR. Who was involved in developing the waiver process?

Mr. LARSEN. We developed the waiver process, HHS.

Mr. GOSAR. On your own with no outside inference at all?

Mr. LARSEN. No, our staff developed it. We looked at the regulation. We met with stakeholders who had an interest in the process. We took their suggestions to heart, which were to keep it simple,

to make it easy to apply, to make it prompt so that it didn't take too long.

I think we did all of those things. We have a 30 day turnaround time. Again, we think it is simple to use. We have gotten a lot of positive feedback from a number of groups that, in fact, it is very straightforward.

Mr. GOSAR. Mr. Wold, the whole process of this waiver, would you call it cumbersome or straightforward?

Mr. WOLD. I would say somewhere in between, probably. In some cases, it worked very well for our clients. In other cases, it didn't.

There were certainly issues with respect to identifying what information needed to be provided, at least for the early applications that we submitted before the application form was released. We developed our own template form that we used based on the guidance that was in existence. In some cases, that worked. In other cases our clients heard back that no, they need to provide some additional information or no, we have this form now and they need to provide that. So there were some cumbersome aspects to it.

Mr. GOSAR. If you were trying to help people along and trying to work with them, would you put the waiver form on the sixth page, hidden away in your Web-based application?

Mr. WOLD. No, I wouldn't. When we worked with our clients, we issued what we call a client alert to all of our clients notifying them of this waiver process. We had found the link, obviously, by that time and included the link. I would have made it more prominent, yes.

Mr. GOSAR. OK. So if you were from outside Washington, DC—God forbid—and maybe back out in Arizona or California or whatever, this is an arduous process, is it not?

Mr. WOLD. I think it is for the average employer, yes. In part, that is why they come to benefits attorneys to help them with that process. But I think that if you didn't have the means to hire a benefits attorney or didn't have a third party who is an expert in the benefits field, for the average employer it would be arduous.

Mr. GOSAR. So Mr. Larsen, we spent some considerable effort upon this Web design. We spent a lot of time and energy trying to incorporate the waiver process, did we not? It came at quite an expense in time.

Mr. LARSEN. I am sorry?

Mr. GOSAR. To develop the waiver process and to put it on a Web-based system took some time?

Mr. LARSEN. You mean for HHS?

Mr. GOSAR. Yes.

Mr. LARSEN. No, I would not describe it as a large expense. We had a number of staff working on it. Again, we tried to keep it simple. We put it on the Web site. We put out a press release.

Most small businesses even and larger businesses have their benefits administered by these third party administrators who, by all indications we got, were very familiar with this process and were aware of the process. I am not aware of feedback that we got that people were not aware of this or troubled by it. Even Mr. Wold found it. He spoke with HHS people. He got his questions answered, I think. I don't want to speak for him but I have read his testimony.

Mr. GOSAR. Thank you, Mr. Chairman.

Mr. GOWDY. Thank you, Dr. Gosar.

The Chair would recognize the gentleman from Maryland, Mr. Cummings, for his 5 minutes of questions.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. Larsen, some of your critics have raised questions about the Secretary's authority to issue waivers that allow limited benefit plans to be extended and gradually phased out by 2014. For example, in a February 10, 2010 letter to you, Chairman Issa said that it was unclear which section of the Patient Protection and Affordable Care Act grants authority for HHS to waive the statutory provisions that end limited benefit plans.

As I understand it, the Affordable Care Act added section 2711 to the Public Health Service Act. There is a clear language in that section that states, "The Secretary shall ensure that access to needed services is made available with a minimal impact on premiums." Is that right?

Mr. LARSEN. That is correct, sir.

Mr. CUMMINGS. That is where you get your authority?

Mr. LARSEN. We think that authority is clear in that provision.

Mr. CUMMINGS. As I understand it, this section gives the Secretary the authority to pursue a mechanism to phaseout limited benefit plans by 2014, but to do it in a way that has minimal impact on those plans.

Under this provision, the Secretary issued an interim final rule that explains in detail that issuing short term waivers would help phaseout these plans with minimal impact. Is that right?

Mr. LARSEN. We did both phaseout annual limits and reference the waiver process for mini-meds, yes.

Mr. CUMMINGS. I thought about this a bit. You seem like you would be damned if you do and damned if you don't. If you don't give some people some leeway for these mini-med plans to continue, people will say you threw people out of their insurance. On the other hand, when you provide a waiver for them to continue it, they say that the program doesn't work, although it isn't supposed to be fully functioning until 2014. That is a bit of a dilemma there.

Would you agree? You don't have to agree with what I just said. I am just wondering.

Mr. LARSEN. I think I have said previously that I think that had we not been granting waivers for this small number of low limit policies, people would be arguing that the law was ineffective. So we are, as the President suggested, allowing people to keep their coverage through 2014. It is not specifically contemplated in the statute and so it is being suggested that we are not following the law.

Mr. CUMMINGS. Your office was given responsibility to issue this guidance, address applicant questions, and review applications for suitability. Is that right? Is that part of your job?

Mr. LARSEN. Yes, sir.

Mr. CUMMINGS. The committee staff reviewed hundreds of pages of comments submitted by interested parties regarding the waiver process. They had trouble finding any submissions that indicated

concern with the Secretary's authority to issue the waivers under this provision. Did you know that?

Mr. LARSEN. I am aware that, in fact, most if not all the comments are supportive of the waiver process.

Mr. CUMMINGS. Generally, I would assume that the industry supports the waiver process?

Mr. LARSEN. It does.

Mr. CUMMINGS. How do you know that? You haven't had any complaints from the industry? I am sure they didn't come running into your office saying, hallelujah, we love this.

Mr. LARSEN. Well, we have gotten comments on the interim final rule which were supportive of the waiver process. And in the course of administering the process as well, we have received positive feedback both from individual applicants and trade groups associated with businesses that need waivers.

Mr. CUMMINGS. Some critics have suggested that the process by which annual limit waivers have been issued is biased in favor of certain groups such as unions. For example, in the February 10, 2010 letter to the Secretary, Chairman Issa made this statement: "The current process gives credence to the perception that bureaucrats are picking winners and losers in a politicized environment where the winners are favored constituencies of the administration."

Is that accurate?

Mr. LARSEN. That is not true. We do not favor any particular type of applicant or any applicant from a particular sector. We have applied the standards that we set out fairly across all the applicants.

Mr. CUMMINGS. Is political support for the Obama administration or health care reform a factor your Office uses in evaluating applications for annual limit waivers?

Mr. LARSEN. It is not.

Mr. CUMMINGS. You understand you are under oath?

Mr. LARSEN. I do, sir.

Mr. CUMMINGS. I think that will be it. I yield back.

Mr. GOWDY. Thank you, Mr. Cummings.

The Chair would recognize Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Dr. Feder, I guess we will start with you. I was listening to your testimony and you seemed pretty confident about the upcoming success of the Obamacare, or ACA as you call it. How would you rate the Government's management of the Medicare system right now?

Ms. FEDER. Of the Medicare system?

Mr. DESJARLAIS. Yes.

Ms. FEDER. I know that the Medicare system is extraordinarily effective in assuring access to affordable health care for the Nation's seniors and those people with disabilities that it covers. It has been so for some years. That does not mean that it does everything right.

One of the advantages of the Affordable Care Act is the new mechanisms it creates to reform payment mechanisms in Medicare to make it much more efficient.

Mr. DESJARLAIS. Do you think Medicare is efficient and financially stable right now?

Ms. FEDER. I think that health costs are rising. Medicare's rate of growth in health care cost per capita has actually over the last multitude of years been slower than growth in the private sector.

Mr. DESJARLAIS. Do you think health care costs are going to stop rising?

Ms. FEDER. I think we are going to have to do everything we can to make us get better value for the dollar in the system.

Medicare has in the past been a leader in that effort. The private sector has followed when Medicare has been a leader and I think that is what we need again.

Mr. DESJARLAIS. Do you think Medicaid is a good system and that it is financially stable?

Ms. FEDER. When you talk about payment, Medicaid is paying a very low rate.

Mr. DESJARLAIS. Is it a broken system?

Ms. FEDER. No, it is not a broken system. It is the Nation's long term care safety net and enormously valued for covering those that it protects.

Mr. DESJARLAIS. OK. So you think that the Federal-run programs right now, Medicare and Medicaid, are doing pretty good?

Ms. FEDER. What I said was I think that they are enormously valuable in terms of protecting people. Relative to the private sector, they are doing, if anything, better in terms of efficiency. But I think we need to improve everybody.

Mr. DESJARLAIS. OK, that is a good point. You think it is doing better than the private sector.

Ms. FEDER. In terms of its per capita rates of health.

Mr. DESJARLAIS. Do you know, prior to the implementation of Obamacare, approximately what percentage of Americans rated their health care as good or excellent?

Ms. FEDER. I would have to check.

Mr. DESJARLAIS. It is about 75 percent.

How many people was the Affordable Care Act or Obamacare supposed to cover? What was uncovered?

Ms. FEDER. The Congressional Budget Office says that it will expand coverage by over 30 million people.

Mr. DESJARLAIS. OK. You said that 19 million would go in the exchange?

Ms. FEDER. Nineteen million in the exchanges receiving credit.

Mr. DESJARLAIS. And another 16 million would go on Medicaid?

Ms. FEDER. Yes.

Mr. DESJARLAIS. If you break that down, I guess my math is correct, that is about 35 million people that you are saying are uncovered right now?

Ms. FEDER. I am saying that the Congressional Budget Office says these will be additional people who will receive coverage, the expansion of coverage.

Mr. DESJARLAIS. Well, the fact that we are having this hearing today about waivers makes me feel that maybe the health care act itself was flawed and now we are trying to find a way to make it look better.

I guess I have grave concerns about the systems right now. In fact, we are about to go vote on a way to keep the country running because, as we all know, we are broke and our deficits are increasing at remarkable rates. Yet somehow we think that we are going to add people to a health care system, decrease cost, and increase quality.

Do you really believe that with increasing health care costs?

Ms. FEDER. What I would say—only reiterating what the Congressional Budget Office found—is that the law is fully paid for, that it actually slows the growth in Medicare spending, and that it covers people at the same time. I think that is the right thing to do.

Mr. DESJARLAIS. Mr. Haislmaier, you haven't had a chance to talk much here. Do you have an opinion on any of that?

Mr. HAISLMAIER. All of the foregoing is not true, I suppose. Look, the hearing really is not about health policy but about this waiver process. I could debate with Dr. Feder some of her comments all day.

I just want to make it really clear for the committee that there is no mention of a waiver in that portion of the law as Congressman Cummings cited. In fact, the preamble to the sentence, Congressman, is "In defining the term restricted annual limit for purposes of the preceding sentence, the Secretary shall ensure that access to needed services is made available with a minimal impact on premiums." So the instruction to the Secretary in the statute is purely to define the term restricted annual limit. It doesn't even contemplate a phase-in.

Mr. Larsen, Mr. Davis, and some of the other Members had made the comment that this was intended to phaseout. It may have been. If it was, we don't know. The reason we don't know is that there is nothing beyond the statute to give any indication of congressional intent. This was added later in the Senate version of the bill. There were no hearings on this. Whether it was or wasn't intended, there is no phaseout in here. There is no waiver.

Finally, Mr. DesJarlais, I could direct your attention to one of my footnotes in my paper. I cited that, in contrast, I found 21 subsections of this legislation, PPACA, where there is explicit new, not existing, waiver authority. There are many more that refer to existing waiver authority, but explicit new waiver authority was deliberately granted by Congress to the Secretary of HHS. That is in 21 separate other sections. And there are more instances because in some sections waiver authority was granted in more than one place and there were also examples where waiver authority was granted to other departments outside HHS.

My point is simply that if Congress had intended for this to be a phase in, it should have said so. If they intended for it to be a waiver, they should have said so. They did neither. HHS has exceeded its authority, regardless of what one thinks of the policy. I have offered how you could either abolish mini-meds tomorrow or you could wait until 2014. I point in my testimony that there are three different ways to do it.

Thank you.

Mr. GOWDY. Thank you.

Given the fact that the bell is sounding, we will recess for votes and we will reconvene as quickly as we can all reassemble. Thank you.

[Recess.]

Mr. GOWDY. The committee will come to order.

I thank everyone for their indulgence as we went to vote.

At this point, the Chair will recognize the gentlelady from the District of Columbia, Ms. Holmes Norton, for her 5 minutes.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Larsen, ladies and gentlemen, this hearing might have been called Damned if You Do and Damned if You Don't.

I want to congratulate you on the 30-day turnaround period for the waivers.

I was interested in the 94 percent acceptance of waivers. That seemed a high number. How can you explain that number?

Mr. LARSEN. We have a number of criteria by which we review the applications that come in. The vast majority of the applicants are able to satisfy the criteria that we have laid out in our regulations and our guidance.

Again, I think it reflects a point I made earlier that the goal of the waiver process is to ensure that employees that have this type of coverage are able to maintain it.

So the high approval rate reflects the criteria that we apply and the desire to maintain coverage.

Ms. NORTON. So we don't have people left without coverage as we convert from one system, or non-system, to another?

Mr. LARSEN. That is correct.

Ms. NORTON. The notion of transparency is a serious charge. So far, from what I have heard in this hearing, it strikes me that it is a bogus charge. But the way to show that would be to have you walk me through the process, so let us start when this bill was passed. We are coming upon the anniversary; I think it was March 23rd or something of that time.

Now, under the APA, of course, there has to be notice and comment. So the test of transparency is what does the public know. What does the general public, including those who are most affected on either side, what does the general public know?

You had to go into the Federal Register. When did you go into the Federal Register?

Mr. LARSEN. We issued an interim final rule with a request for comments in June 2010.

Ms. NORTON. So this bill is passed in March and within 3 months you are in the Federal Register?

Mr. LARSEN. That is correct.

Ms. NORTON. So people have almost immediate notice that they can avoid gaps in coverage.

Now, let us go further to test the charge of lack of transparency. Did you publish any guidance documents that would inform someone who wanted to apply of how to apply?

Mr. LARSEN. We did. We issued the first guidance in September. I think it was September 3rd or 4th, 2010, within 90 days of the issuance of the interim final rule. Subsequent to that we issued guidance in November further clarifying the criteria that we had been applying. Then in December, we issued two additional guid-

ance documents on issues relating to disclosure, the new sales of mini-meds, and the like.

Ms. NORTON. Did all interested parties have the opportunity to submit comments? Were there any complaints that you didn't keep the comment period open long enough?

Mr. LARSEN. In fact, the guidance that we issued were in many cases in response to comments and concerns that we received. We reacted to those and would issue guidance in response to the feedback we got from the public or employers.

Ms. NORTON. Did you make adjustments based upon the feedback? How would you characterize what effect the comments from the public had on the final regulation?

Mr. LARSEN. One example of that is that there is concern over whether people know for example, that their mini-med policies have annual limits when we grant a waiver. So, for example, some of the consumer groups wanted to make sure that people who had these policies were given notice that their policies had limited benefits. So, for example, in the guidance that we issued in the fall, we indicated that people who receive waivers should make sure that they are providing disclosure to people who are covered under these policies.

That is a good example of how we got input about public disclosure of these and then we put guidance out reflecting that input.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. Chairman, I just want to say as I open my round of questioning I think that what the witness has just carried us through indicates that, whatever problems you have with the health care bill, it is a completely bogus charge to allege that there was no transparency in this process.

I thank you.

Mr. GOWDY. I thank the gentlelady.

The Chair would now recognize the gentleman from Illinois, Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman.

Mr. Haislmaier, I know I butchered your name and I apologize.

Let me have at what my colleague on the other side just mentioned. This issue of transparency, is that a bogus charge as far as you are concerned?

Mr. Haislmaier. I really can't speak as much to that issue. I think maybe some of the others on the panel, maybe Mr. Wold, could because I am not an applicant for a waiver. I haven't been through the process.

Mr. WALSH. Thank you.

Let me quickly go to you, Mr. Wold. Just opine. Is that a bogus charge, the transparency?

Mr. WOLD. That is a tough question. I think as a benefits attorney the transparency means something different to me than to maybe an employer who sponsors one of these plans, given the fact that I have access to information and have resources that aren't generally used by employers. So, from my perspective, we were able to follow the different pieces of guidance. Some of our clients had not heard anything about it until we informed them about it.

Mr. WALSH. Mr. Larsen, according to the HHS Annual Limits Review and Evaluation Standard Operating Procedures, HHS em-

ployees must specifically look for whether applicants are unions. No similar consideration is made for small businesses. In fact, unions are provided two special criteria for flexibility, criteria not given to other hourly wage employer groups such as restaurants, the retail industry, or seasonal workers.

Does Obamacare provide special consideration for unions and not for small businesses?

Mr. LARSEN. We, in implementing the waiver process, do not provide any special treatment for any particular type of applicant or applicants from a particular sector in administering the program.

Mr. WALSH. Why were HHS employees instructed to specifically look for whether applicants are unions?

Mr. LARSEN. I don't recall that the standard operating procedures describe it in that way. It may just be because we categorize whether they are Taft-Hartley plans or whether they are self-insured plans.

We categorize the type of applicant but if someone is categorized as Taft-Hartley, self-insured, or a union plan, they don't get any different treatment. There are no different criteria applied to them.

Mr. WALSH. Mr. Haislmaier, do you have a thought on that issue?

Mr. HAISLMAIER. Yes, it is a little far afield but it is an interesting question. Well, it is not far afield. It is tangential but it is an interesting question.

This particular statute is part of what is known as Title 27 of the Public Health Service Act, which was originally put in as part of the Health Insurance Portability and Accountability Act of 1996.

There is the question of regulating insurers and the question of regulating employer plans. What is interesting about this is that under prior law, HIPAA, ERISA, COBRA, etc., this regulation of whether an employer plan passes muster would have been the Department of Labor. In fact, if you look at these regulations, they are jointly issued, as were the HIPAA regulations. Any of these Title 27s are because of the joint jurisdiction by HHS, Labor, and Treasury.

The interesting question to me is how in that process the administration suddenly decides that now HHS is going to regulate employee benefit plans.

Mr. WALSH. How do you think that—

Mr. HAISLMAIER. I don't know, but it is an interesting kind of jurisdictional question that you might want to look into.

I mean, I know the people at the Employee Benefits Security Administration over at Labor. I have worked with them in the past. That is traditionally where this kind of thing would go. Mr. Larsen's answer that you have these different kinds of plans—there is the multi-employer, Taft-Hartley, union, trust—these are things that agency at Labor deals with all the time.

Somehow in this jointly issued regulation several things happened that are to me quite surprising. One, they took what was Congress' instruction to define a term, meaning to set a number, and they turned it into three numbers over 3 years, an escalation. Suddenly we are talking about a phaseout, which isn't in the statute. They then instituted a waiver process from that phaseout, which again, as I pointed out, is not authorized in the statute in

spite of Congress' explicitly authorizing a waiver process in 21 other places in the statute. Now they have put the enforcement of the regulation not just on insurers but on employer plans with Mr. Larsen and HHS, which is just contrary to the normal practice that we have had in the past in this area of law.

So I don't know why.

Mr. WALSH. Thank you.

Mr. Chairman, I yield back.

Mr. GOWDY. Thank you, Mr. Walsh.

The Chair would now recognize the chairman of the full committee, the gentleman from California, Mr. Issa.

Chairman ISSA. Thank you, Mr. Chairman.

Mr. Larsen, I am still a little baffled about this question. If it doesn't matter if somebody is unionized or not, why would you put out an SOP to recognize whether they are covered under a union contract? What is the purpose?

Mr. LARSEN. The purpose in setting out the categories is that depending on the applicant, for example, if an insured plan applies, you have premiums that are associated with the coverage. If you have, for example, a self-insured plan or in some cases a collectively bargained plan, you will have premium equivalents.

Chairman ISSA. In Obamacare, as a matter of law, is that specified?

Mr. LARSEN. I am sorry, what is your question?

Chairman ISSA. Well, I hear all of that. But the fact is that if you put into a waiver authority the information, then we have to presume the information was seen. If the information was seen, it can have an effect on granting or not granting, right?

Mr. LARSEN. I wouldn't say that is true. In the case of unions—

Chairman ISSA. But the people who are approving waivers know who they are approving and they know what their category is, right?

Mr. LARSEN. They are aware of how the plans are categorized but it doesn't impact how they review the applications.

Chairman ISSA. Let me ask a broader question. With all due respect, aren't we disenfranchising smaller businesses by granting waivers, which inherently are to those who are smart enough and can afford to come and do it?

Mr. Haislmaier, don't we inherently have in this very application process not only things which are extra or outside the legislation and therefore not lawful to be done by the administration, and if they need to do it they need to come back for the authority, which they haven't sought, but don't we also have a situation in which we are inherently disenfranchising the vast majority who do not have a financial capability of coming and asking for waivers because the cost of going through the waiver process would be greater than the savings?

Mr. Haislmaier. Mr. Chairman, I did in my prepared testimony address that at the end. There is a legal question, as we both talked about, as to whether the Department actually has the authority.

But yes, there is this policy question of this kind of a waiver process in this or other circumstances. Rather than drawing a line that anybody can look up to see which side of the line they are on,

you are saying come ask us and maybe we will let you know. Yes, that will have at least the perception, if not the reality, of tending to favor those who are larger and better resourced than those who are smaller, less aware, and less resourced.

Chairman ISSA. Doesn't this committee and the Congress have an obligation under equal protection to find out who the disenfranchised are and see that they are given equal opportunity? That is what public service announcements are all about, trying to inform the public.

Do any of you know of any effort by the administration to inform the employer public or the insurance public that they can receive these waivers and to make the cost of doing it de minimis? Is there any program of that sort?

Mr. LARSEN. As I testified earlier, we put out the bulletins.—

Chairman ISSA. A bulletin? I am an employer, where would I have read that bulletin?

Mr. LARSEN. What we found is that 30 percent of the applicants that we processed were small businesses. They had 100 enrollees.

Chairman ISSA. Where did they find out about this?

Mr. LARSEN. We didn't ask them how. I would guess the point is that they were able—

Chairman ISSA. Oh, come on. You advertise and then you didn't ask how? I have never seen anyone come in that didn't ask how people found out about their program.

So how do you gauge the effectiveness of your advertising? Put in another way, how do you gauge the effectiveness of spending the taxpayers' money?

Mr. LARSEN. We are always open to suggestions for getting the word out.

Chairman ISSA. No, no. I am asking how do you do it.

Mr. LARSEN. How do we do what, sir?

Chairman ISSA. Look, Obamacare is an abysmal failure and people are being hurt out there by rising health costs. Then there is a waiver program that seems to select winners and losers fairly arbitrarily. How do you defend that process? More importantly, how do you know you are effectively reaching out to all of those who could be entitled to the lottery of opting out or not?

Mr. LARSEN. Well, it is a good process. We have 30 percent in small businesses that are approved. We are able to maintain coverage for over two million people.

Chairman ISSA. What percentage of the American public has been approved? These waivers, what do they represent in the percentage of insured America that is not waived out?

Mr. LARSEN. I do know that these waivers account for about 2 percent, a very small percentage, of those who have employer-based coverage.

Chairman ISSA. OK, so is there anybody else here who sees a problem with 2 percent opting out on a program that, in fact, is not ready for prime time?

[Speaker off mic.]

Chairman ISSA. That is a rhetorical question.

I am astounded that we are having a hearing and every answer is we don't know, we will check into it, we think the process was fair, we don't have answers to that, or we don't think that is true.

I simply have one closing question. If only 2 percent have it and if there is no affirmative plan to enable small businesses, of which I have some, to avail themselves of it, then how can we feel that it is being done fairly for the 2 percent that are getting to opt out, a great many of which are, if you will, the already advantaged groups of society?

Mr. HAISLMAIER. I would say that is exactly the kind of problem that this sort of situation creates. It is difficult for anyone, Mr. Larsen or anyone else enforcing this, to counter the perception that this is not the rule of law but that this is actually the rule of who you know. That is why the whole mechanism, no matter how fairly or how generously one attempts to administer it, the entire mechanism is suspect in my view because of that.

Chairman ISSA. Thank you.

Mr. Chairman, thank you for shedding light on this problem of the 2 percent versus the rest of America.

Mr. GOWDY. Thank you, Mr. Chairman.

Members will have 5 legislative days to insert comments for the record.

On behalf of everyone on the subcommittee and those who are not on the subcommittee but on the full committee that were gracious enough to join us, I want thank you for your time and your collegiality and professionalism in answering the questions.

The committee stands adjourned.

[Whereupon, at 4:05 p.m., the subcommittee was adjourned.]

