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CUTTING THE RED TAPE: SAVING JOBS FROM PPACA'S HARMFUL REGULATIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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CUTTING THE RED TAPE: SAVING JOBS FROM PPACA'S HARMFUL REGULATIONS

THURSDAY, SEPTEMBER 15, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.——

The subcommittee met, pursuant to call, at 11:17 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Rogers, Murphy, Gingrey, Latta, Lance, Cassidy, Guthrie, Pallone, Dingell, and Schakowsky.

Staff present: Howard Cohen, Chief Counsel, Health; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Kirby Howard, Legislative Clerk; Debbee Keller, Press Secretary; Ryan Long, Chief Counsel; Carly McWilliams, Legislative Clerk; Andrew Powaleny, Press Assistant; Heidi Stirrup, Health Policy Coordinator; Phil Barnett, Democratic Staff Director; Alli Corr, Democratic Policy Analyst; Tim Gronniger, Democratic Senior Professional Staff Member; Ruth Katz, Democratic Chief Public Health Counsel; and Purvee Kempf, Democratic Senior Counsel.

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

"If you like your current plan, you will be able to keep it." Let me repeat that: "If you like your plan, you will be able to keep it." That was a remark by President Obama at the White House on July 21, 2009. Another quote: "If you like your insurance plan, you will keep it. No one will be able to take that away from you. It hasn't happened yet. It won't happen in the future." President Obama in April of 2010. Despite these claims, repeated claims, it has become abundantly clear that the "if you like it, you can keep it" promise to the American people has been broken.

By the Administration's own estimates, 49 to 80 percent of the small-employer plans, 34 to 64 percent of large-employer plans, and 40 to 67 percent of individual insurance coverage will not be grandfathered by the end of 2013.

A May 2011 PricewaterhouseCoopers survey of employers also echoes the Administration's warnings. Of note, 51 percent of the

employers surveyed did not expect to maintain grandfathered health status, meaning their employees would forfeit their current coverage and pay higher premiums due to the health care law's mandates on their new coverage. Because grandfathered plans are subject to many of PPACA's requirements, employers today are forced to pay more to keep their current grandfathered plans, shop for more expensive plans, or drop coverage for their employees altogether.

The discussion draft before us today simply prevents the Administration from implementing its June 17 interim final rule and it prevents the Administration from imposing any standards or requirements as a result of PPACA on grandfathered health plans. That way, consumers who really do like the coverage they have, really get to keep it.

As for the medical loss ratio, Section 1001 of PPACA requires health plans to spend 80 percent for plans in the individual and group market and 85 percent for large group plans of premium revenue on medical care, beginning this year. Plans that fail to meet these thresholds are required to rebate the difference to their consumers.

Supporters of this section claim the medical loss ratio regulation was designed to protect consumers from unscrupulous insurance companies. However, it actually contains perverse incentives for insurance companies to ignore waste and fraud, which drives up premiums and copayments for consumers. Under the regulation, investments in fraud detection, and even quality improvement and care coordination, fall under administrative expenses, which can only make up 20 percent of a plan's spending. Plans struggling to make the 80 to 85 percent threshold for medical costs often can't risk these activities, which could save consumers money and provide them with a higher quality of care, for fear of being penalized and having to pay rebates. Even worse, if a plan does identify fraud, cutting those fraudulent payments and activities actually reduces their amount of spending on medical costs, making it even harder for them to reach the 80 or 85 percent threshold.

Consumers, not HHS and government bureaucrats, should be deciding what health care spending is appropriate and what health care spending is not appropriate for their plans. Plans should be able to invest in waste, fraud, and abuse detection without worrying if that spending puts them in violation of a government regulation. And consumers should be free to select those plans that share their priorities, not the government's.

Again, while the medical loss ratio has been billed as a tool to protect consumers from insurance companies, many States are clamoring for waivers to exempt their citizens from these protections. The Secretary of HHS is empowered to grant MLR waivers to States that can prove that meeting the 80 to 85 percent thresholds will destabilize its insurance market.

Currently, HHS has granted MLR waivers to five states: Maine, New Hampshire, Nevada, Kentucky and Iowa. With these waivers, consumers in these States are now protected from one of the health care law's key consumer protections. Residents of North Dakota and Delaware are not as lucky. HHS rejected their waivers. Nine more states—Florida, Georgia, Louisiana, Kansas, Indiana, Michi-

gan, Texas, Oklahoma and North Carolina—have determined that their insurance markets will be destabilized by having to comply with the MLR regulation and have applied for waivers. They are still waiting to hear back.

The MLR regulation is also costing jobs at a time when unemployment remains stubbornly above 9 percent. HHS's interim final rule on MLR includes health insurance agent and broker commissions in the administrative costs category. Many plans, desperate to meet the 80 to 85 percent threshold, simply cannot afford to use brokers and agents as they once did. One estimate from the National Association of Health Underwriters suggests that more than 20 percent of agents will have to downsize their businesses as a direct result of this calculation.

I strongly support H.R. 2077, introduced by Dr. Tom Price and Rep. Cathy McMorris Rodgers, which repeals the section of the Public Health Service Act dealing with MLR requirements, which was added by the new health care law, and I would urge my colleagues to support.

Finally, I would like to thank all of our witnesses for being here today and yield back my time.

[The prepared statement of Mr. Pitts follows:]

Rep. Joseph R. Pitts
Opening Statement
Energy and Commerce Subcommittee on Health
Hearing on "Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations." (MLR and Grandfather Regulations)

September 15, 2011

The Subcommittee will come to order.

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"If you like your current plan, you will be able to keep it. Let me repeat that: If you like your plan, you'll be able to keep it." (President Obama, remarks at White House, 7/21/09)

"If you like your insurance plan, you will keep it. No one will be able to take that away from you. It hasn't happened yet. It won't happen in the future." (President Obama, remarks April 2010)

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A May 2011 Price Waterhouse Coopers survey of employers also echoes the Administration's warnings.

Of note, 51% of employers surveyed did not expect to maintain grandfathered health status, meaning their employees would forfeit their current coverage and pay higher premiums due to the health care law's mandates on their new coverage.

Because grandfathered plans are subject to many of PPACA's requirements, employers today are forced to pay more to keep their current grandfathered plans, shop for more expensive plans, or drop coverage for their employees altogether.

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Finally, I would like to thank all of our witnesses for being here today, and I yield back my time.

Mr. PITTS. I now recognize the ranking member of the subcommittee, Mr. Pallone, for 5 minutes.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

I am extremely disappointed in today's hearing topic because for too long, too many hardworking Americans paid the price for policies that handed free rein to insurance companies, and so Democrats did something about it. We passed the health reform law that gives hardworking families the security they deserve. But here we are once again as Congressional Republicans introduce new piecemeal repeal legislation to take these protections away. The result of such legislation is putting insurance companies, not patients, back in control.

The two bills under discussion today support what I have been saying all year long. If the Republicans had their way, insurance companies would have free rein to drop someone's coverage unexpectedly when they are in an accident or become sick because of a simple mistake on an application. If the Republicans had their way, over 1.2 million young adults would lose their insurance coverage through their parents' health plan as their children worked to launch their careers. And if the Republicans had their way, insurance companies would once again be allowed to deny health coverage to a breast cancer patient who was in remission but now needs to restart her chemo and to put an annual cap on the amount of care she will have access to, or even worse, a lifetime limit on her health coverage so in a desperate time of need she has to choose between bankruptcy and getting lifesaving care. If the Republicans had their way, insurance companies would once again have the ability to freely raise patients' premiums, likely by double digits, and have no restraints or accountability on what proportion of these premium dollars are spent on health care services.

Now, I am going to stand silent while the repeal Republicans work to rescind the Patient's Bill of Rights and leave tens of millions of Americans at the mercy of the insurance companies. Enough is enough. Let us move on to the real priorities of the American people, and that is jobs, jobs, jobs, jobs.

I thank you, Mr. Chairman. I would like to yield to time that I have left to the gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. I thank the ranking member very much for yielding to me.

Well, here we are again, and what we are witnessing once again today is an effort by the Republicans to do the bidding of the insurance companies at the expense of ordinary consumers.

The idea of a medical loss ratio says that we are just not going to let the insurance companies charge whatever they want. That legislation, that rule, the medical loss ratio, holds insurance companies accountable and ensures that health care consumers receive

the services for which they are already paying top dollar. By law, insurance companies have to spend at least 80 percent of their premium dollars on medical care and health quality improvement as opposed to administrative costs, marketing, executive salaries and bonuses.

I am so glad that we are going to hear from somebody who has had years of experience in the insurance industry and knows all the games that are played in order to extract as much money as they can from sickness in the United States of America.

This hearing is also going to focus on legislation to repeal the grandfathered health plan regulation, and doing so basic consumer protections like ending lifetime coverage limits and rescission of coverage will be undermined and employer-sponsored health insurance plans, plans that cover 160 million people. So now we are not just talking about public plans, we are going to reach into those private plans and tell these employers what they can do and offer to their consumers.

It is just incredible to me the number of things that the Energy and Commerce Committee has to do in order to make life better for people out there who are really suffering right now under this economy. You know, you lose your job, you lose your health care many times, so people are trying to figure out how their kids are going to get health care. Our legislation said that preexisting conditions for children will not be a reason to exclude children from health care. We said if your child has a terrible life-threatening disease that may cost a lot of money, that those lifetime caps are going to be removed, and here we sit today saying no, no, no, this is not fair to the poor insurance companies, those poor insurance companies who have been making record profits. I think this is utterly outrageous that we should be spending our time doing that when the American people are looking to us at this moment for help.

Thank you. I yield back.

Mr. PITTS. The chair thanks the gentlelady and recognizes the vice chairman of the subcommittee, Dr. Burgess, for 5 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for the recognition and I do thank our panelists for being here today. Director Larsen, you have been kind enough to come talk to me in my office in the time between our last hearing, and I appreciate the information that you have provided. As you will find out today, perhaps there are a few more things that we would like to know, and I know that you will provide them.

Grace-Marie Turner, it is always good to see you again.

I have to say, we talked about doing the bidding of insurance companies. Exhibit A, the Affordable Care Act, why cannot we get the information from the White House from the six groups that met down there in May of 2009 that discussed how we were going to carve up things in health care, insurance companies to be sure, doctors, hospitals, pharma, medical device manufacturers and the unions. So what was up with that? The President came out of that meeting and said we saved $2 trillion for health care. Two trillion

dollars for health care, but there are no minutes, there are no emails. There is not even an envelope with a scratch on the back about what this $2 trillion represented, and we are to believe that?

Now, yesterday in the Subcommittee on Oversight and Investigations, we had a big hearing on Solyndra and how Solyndra was given a loan guarantee from the Department of Energy which had all of the appearances of being something that was a rush job and done improperly. Well, if you want to talk about something that is a rush job and done improperly, see the Affordable Care Act. Insurance companies have prospered since the Affordable Care Act passed. Go back and look at the earnings statements from the big companies from March of 2010 when this thing was passed. The insurance companies got the individual mandate. They got everything they asked for in this bill. Thank you, Democrats, for that. And now we are left to deal with the consequences of this.

We are concerned about jobs. The President came and talked on the House Floor about jobs last week. I am grateful that he came with his ideas. The fact remains that unemployment stands at over 9 percent and doesn't appear to be budging.

Now, is there a reason for this? Is partly the reason because since 2008 the government has spent $54 billion on regulatory agencies and they are growing at 16 percent—the only true growth industry in this country is federal regulation—or that the government regulatory system is the third largest employer in the Nation or because complying with federal rules and regulations costs $1.75 trillion per year? Is it because the Affordable Care Act and the effect that its regulations are having on our Nation's employers?

From over-regulation to burdensome requirements to perverse incentives that will drive up health spending, this thing levies unreasonable demands on employers, manufacturers and providers. Discourage hiring? You bet. Encourages employers to drop their insurance apparently, oh, yes, and in the bargain we are going to punish physicians and tax the industry out of America.

Today we are going to look at two of these requirements in some depth but honestly, the list is much, much longer, and we are going to hear from some of those folks who are on the ground dealing with this, but I am afraid we may be too late. This law has proven to be unworkable and to stifle economic growth. Every day we have got another announcement about another rule going into effect, and far too many are coming out as interim final rules, and what does that mean? That means we have short-circuited the public input part of that process. So if we are serious about getting America back to work, the first step should be to loosen our stranglehold imposed by this law.

Thank you, Mr. Chairman, and——

Mr. SHIMKUS. Would you yield?

Mr. BURGESS. Yes, I would be happy to yield to the gentleman from Illinois.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you from my colleagues, and I am going to take this minute just to do a plug on a bill that we just dropped yesterday, which was the Medicare common access card. We all

know there is Medicare fraud. Part of this debate is, how do you stop fraud in billing. In Medicare, we know there is great fraud. What the Medicare common access card, which I have a copy of one, it is just using an ID card like the military does. It is a double identification system with a chip in the card and then a password. To date, in the DOD, these cards are out. Twenty million of these cards have been out. There has been not a single instance of fraud. And so if you really want to make sure that the person who is supposed to receive the service is identified and properly billed for it, then I would encourage all my colleagues on both sides to look at the bill dropped.

On the Senate side, Senators Kirk, Wyden and Rubio expect bipartisan support, and I would imagine it would have support across the spectrum from both conservatives and liberals if we want to get a national way to make sure we have secure billing.

With that, thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member emeritus, Mr. Dingell, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy and I thank you for recognizing me.

Today's hearing, Mr. Chairman, is yet another unfortunate attempt by my colleagues on the other side of the aisle to roll back the Patient's Bill of Rights, which is included in the Affordable Care Act. There has been continuing opposition to both proposals and attempts to destroy it in every possible way including by delay and outright repeal in whole or in part.

The bills before us today would strip historic reforms that protect consumers and it is going to leave us in a situation where the things that we have done to ensure and protect the rights of the American public are stripped away in a most unfortunate way. The intent of the medical loss requirement is to ensure that consumers know that money coming out of their paychecks each month for health care is going to go for quality care, not to line the pockets of the insurance companies. This provision is going to benefit countless Americans. It is going to, according to HHS estimates, see to it that nearly 75 million people are in health plans that will be subject to new requirements and up to 9 million Americans will be eligible for rebates next year. Costs to the government that we pay for health care will go down because of the things under attack in this committee today. The requirements that we are making are safe, effective and achievable.

The same is true here also of the grandfathered health plan regulation. Preventing enforcement of this regulation allows abhorrent and false claims to be made by the other side for no reason other than political rancor. We cannot allow the public to be misled this way. Even worse, preventing the grandfathered health plan rule to move forward would be to remove a trigger for health plans to lose grandfather status if they cut benefits, increase co-payments or premiums, or make changes in annual limits.

These two bills are a direct and unfortunate assault on the sick, the elderly and the disabled who deserve protection and assurance that they will have the care they need when they are wheeled into an emergency room, and sadly, it will let the insurers spend consumers' hard-earned dollars with no accountability. These things are bad from the standpoint of the public, the consuming public. They are also bad from the standpoint of the taxpayers because the loss of these provisions is going to run up the cost of Medicare, Medicaid, government retirement plans, and it is also going to run up the cost of plans which are held by private industry for the benefit of their employees, and the situation is going to impact on ordinary citizens who buy their own insurance because they have no one to assure their protection against the abuses which the legislation before the committee would strip the consumers of protection in their enactment.

I urge my colleagues to defeat this legislation, to not let it out of the committee, and to have an honest exposition of the abuses we are attacking. This committee will recall that we have worked long and hard to get a national health insurance proposal enacted into law. It isn't what any one of us would want but it is good enough to do the job that we have need of.

It is unfortunate that this legislation is also a part of an ongoing attempt by my Republican colleagues to do away with government regulation. I am not one who is sitting here to tell you that this regulation is all good. That would not be true. But the hard fact of the matter is, what we are striking at today is not just health care but it is part of a pattern which will destroy regulation to protect people from bad foods, bad drugs, to protect people from fraud in the securities industry, to see to it that consumers receive protection through the Consumer Product Safety Commission, and a wide array of other programs that are necessary to protect American consumers.

The idea is not to eliminate regulation but to eliminate bad, unfortunate and wasteful regulation rather than just striking out broadcast to destroy regulation and to strip the American public of the protections that they need for their safety, for their health, for their financial and economic well-being.

I thank you for the time, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman.

That concludes the members' opening statements. We will call panel one to the table. Our first panel is Steve Larsen, Director of the Center for Consumer Information and Insurance Oversight with the Centers for Medicare and Medicaid Services. Welcome, Mr. Larsen. If you can summarize, your written testimony will be made part of the record, and you have 5 minutes.

STATEMENT OF STEVEN B. LARSEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. LARSEN. Thank you, Chairman Pitts, Ranking Member Pallone and members of the subcommittee, and thank you for the

opportunity to discuss the benefits of the medical loss ratio and grandfathering provisions of the Affordable Care Act.

The ACA expands access to affordable, quality health insurance coverage to over 30 million Americans and strengthens consumer protections to ensure that individuals have coverage when they need it most. The ACA addresses many longstanding problems in the private health insurance market for both individuals and for small businesses.

Since enactment of the ACA, HHS with the Departments of Labor and Treasury have already implemented many of the private insurance market reforms including prohibiting insurance companies from imposing lifetime dollar limits on coverage, rescinding coverage absent fraud, and enabling many young people to stay on their parents' health plans up to age 26.

The MLR provision in the Affordable Care Act reforms the health insurance market so that Americans receive value for their premium dollars. This provision requires that spending by health insurance companies on clinical services for members and spending on activities that improve quality for their members account for 80 percent of the premium dollars for the individual and small group market and 85 percent for the large group market. This ensures that premiums that consumers pay are not used for excessive administrative expenses. Because insurance companies whose coverage does not meet the applicable MLR standard will provide rebates to their customers, insurers are incentivized to operate efficiently, provide value pricing and invest in activities that improve the health status of the people they cover. The provision also adds transparency to the marketplace by allowing all consumers to see how their premium dollars are being spent.

Consumers will begin receiving rebates in 2012 from plans that don't meet the standard in 2011. However, we are already seeing indications that the MLR provision is causing insurance companies to more carefully evaluate their need for increases, slowing the rate of premium growth. Insurers that have not met these standards have announced to Wall Street and in many cases advised State regulators that they are now setting prices to meet these new standards. One large insurer will reportedly be dropping rates for nearly 10,000 customers in Connecticut by between 5 and 20 percent. The GAO also found that issuers were moderate rate increases because of this rule. Repealing this provision will be a step backward for consumers.

Regarding grandfathered health plans, while the ACA requires all health plans to provide important new benefits to consumers, under the law, plans that were in existence in March of 2010 are grandfathered and exempt from some of the new requirements in the ACA. For example, grandfathered plans not subject to provisions that require health plans to provide preventive services with no cost sharing are not subject to the new appeals provisions, and premiums for these plans are not subject to the rate review provisions of the ACA. However, grandfathered plans still must eliminate all lifetime benefit limits, extent dependant coverage to most children under age 26, and follow other consumers protections including the MLR provisions.

The grandfathered plans interim final rule is intended to preserve the ability of Americans to keep the coverage that they had when the ACA was passed. However, if the terms of that coverage are changed significantly, the plan could end up as a very different plan than the one that was in effect in March of 2010, perhaps with much higher coinsurance, deductibles or with fewer benefits, but if this modified coverage is still considered to be grandfathered coverage, it also would not provide some of the key consumer protections that we just talked about.

The grandfather rule avoids this undesirable result by balancing the interests of health care consumers with those of employers. It does this by giving employers the feedback the flexibility to modify existing benefits to accommodate changing conditions without the loss of grandfather status while also guaranteeing Americans access to important consumer protections if the coverage changes significantly.

Examples of the flexibility that employers have include the ability to make changes to different types of cost-sharing provisions such as copays and deductibles, to vary premiums, and to make modest changes to the levels of employer contributions. Importantly, health plans and employers have the choice of continuing the coverage that was in place on March 23rd or making changes beyond the areas outlined in the regulation.

Also, based on the feedback we have received through out process and from formal comments in response to the interim final rule, HHS and Departments of Labor and Treasury issued an amendment to the amendment to the grandfathering rule in November of 2010. The amended final rule allows employers to change carriers and keep their grandfathered status, again, providing even more flexibility to businesses and insurance companies in the implementation of this provision.

In conclusion, we are proud of all that we have accomplished over the last year and a half and look forward to 2014 when more Americans will have access to affordable and comprehensive health insurance plans and all of the consumers protections in the ACA will apply.

Thanks for the opportunity to appear before you, and I look forward to answering 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

ON

IMPLEMENTING THE AFFORDABLE CARE ACT

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON HEALTH

SEPTEMBER 15, 2011

House Committee on Energy & Commerce, Subcommittee on Health
Hearing on Implementing the Affordable Care Act

September 15, 2011

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the opportunity to discuss the benefits of the Medical Loss Ratio (MLR) and the grandfathering provisions in the Affordable Care Act.

In March 2010, Congress passed and the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), collectively referred to as the Affordable Care Act. The Affordable Care Act expands access to affordable, quality health insurance coverage to over 30 million Americans and strengthens consumer protections to ensure that 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, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury have already implemented historic private insurance market reforms – including eliminating pre-existing condition exclusions for 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 young adult children to stay on their parent's health plan up to age 26.

As part of these changes, the MLR provision in the Affordable Care Act reforms the health insurance market in a way that allows Americans to ensure they receive value for their premium dollars and allows them to see how their premium dollars are spent, while preserving the stability of the individual insurance market. Additionally, the grandfathering provision in the Affordable Care Act protects the ability of individuals and businesses to keep their current plan. Both of these reforms are designed to provide important consumer protections while keeping the market stable as we transition towards a more competitive marketplace in 2014, when new patient

protections are fully in effect and State-based Affordable Insurance Exchanges make health coverage available to all Americans.

Medical Loss Ratio

On December 1, 2010, HHS published an interim final regulation with 60-day comment period implementing the MLR provisions of the Affordable Care Act (45 CFR 158 [OCIIO-9988-IFC]). This regulation outlines disclosure and reporting requirements, how insurance companies will calculate their MLR and provide rebates, and how adjustments could be made to the MLR standard to guard against individual market destabilization.

Importantly, this interim final regulation certifies and adopts the recommendations submitted to the Secretary on October 27, 2010, by the National Association of Insurance Commissioners (NAIC), and incorporates recommendations from a letter sent to the Secretary by the NAIC on October 13, 2010. The NAIC worked for nearly six months to develop definitions and methodologies for calculating a MLR and the reporting format to be used by the health insurance industry. The process included significant input from the public, States, and other key stakeholders and was widely praised for its openness and transparency. The results of that process were approved unanimously by the NAIC Commissioners. HHS certified and adopted the NAIC recommendations, and the reaction from consumers and insurers has been very positive.

Many insurance companies spend or allocate a substantial portion of consumers' premium dollars on administrative costs and profits (including executive salaries, overhead, and marketing), relative to what they spend on clinical services and quality improvement. To ensure that consumers receive value for their premium dollars, the Affordable Care Act establishes national minimum standards for spending by health insurance issuers on clinical services and activities that improve quality for their members, known as the MLR provisions. The Affordable Care Act establishes MLR standards for issuers of 80 percent for the individual and small group markets and 85 percent for the large group market, which apply beginning in the 2011 reporting year. Insurance companies whose coverage does not meet the applicable MLR standard will provide rebates to their customers.

We are already seeing indications that the MLR provision is causing insurance companies to more carefully evaluate their need for premium increases, slowing the rate of premium growth and, in some cases, decreasing premiums. For example, more than 15,000 Aetna customers in Connecticut will see their health insurance premiums drop by between 5 percent and 19.5 percent due, in part, to the new MLR policy. [1]

Consumers will begin receiving rebates in 2012 from plans that did not meet the standard in 2011. Rebates will be paid by August 1st of each year following the year that the MLR requirement is not satisfied. The MLR provision also ensures that insurance companies publicly report how they spend premium dollars, providing consumers with meaningful information on how much money goes toward actual medical care and activities to improve health care quality versus how much money is dedicated to administrative expenses and profits. Preliminary estimates indicate that up to 9 million Americans could be eligible for rebates starting in 2012 worth up to $1.4 billion.[2]

Recognizing the need for State flexibility, the Affordable Care Act allows for a temporary adjustment to the individual market MLR standard if a State requests it and demonstrates that the 80 percent MLR standard may destabilize its individual insurance market. The rule established the process and criteria for evaluating State requests for adjustments, based on recommendations made by the NAIC. Some States have sought adjustments to the MLR standard in the individual market to put them on a path toward meeting the full standard by 2014.[3]

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[1] Arielle Levin Becker, "As Federal Health Reforms Take Effect, Aetna Proposes Rate Cuts." The Connecticut Mirror. May 11, 2011, link, here.

[2] 75 FR 74863 – Interim Final Rule Regarding Health Insurance Issuers Implementing MLR Requirements Under the Patient Protection and Affordable Care Act (December 1, 2010) link, here.

[3] Through August 17, 2011, five States (Iowa, Kentucky, Maine, Nevada, and New Hampshire) have received an MLR adjustment — and eight States (Florida, Georgia, Indiana, Kansas, Louisiana, Michigan, Texas, and North Carolina) have applied for an MLR adjustment and have their applications currently under review. Delaware and North Dakota's MLR adjustment application did not meet the stated criteria and was denied. Guam requested a MLR adjustment, but all issuers in Guam do not have sufficient life-years to be credible (i.e. fewer than 1,000 life years, based on the criteria in the interim final regulation) and hence are presumed to meet or exceed the statutory MLR standard. As a result, no action was required on Guam's request.

Grandfathered Health Plans

The Affordable Care Act gives American families and businesses more control over their health care by providing greater benefits and protections for employees and their families. It also provides the stability and flexibility that families and businesses need to make the choices that work best for them. The grandfathered health plans interim final rule with sixty-day comment period (45 CFR 147 [OCIIO-9991-IFC]) that HHS and the Labor and Treasury Departments jointly published on June 17, 2010 and amended on November 17, 2010 (45 CFR 147 [OCIIO-9991-IFC2]), is intended to preserve the ability of Americans to keep their current plan, while still allowing employers flexibility in modifying existing plans to accommodate changing conditions, while ensuring Americans access to important consumer protections.

While the Affordable Care Act requires all health plans to provide important new benefits to consumers, under the law, plans that were in existence on March 23, 2010 are "grandfathered" and exempt from some of the new requirements in the Affordable Care Act. However, grandfathered plans still must eliminate all lifetime limits, extend dependent coverage to most children until age 26, and abide by consumer protections such as the ban on rescissions and the medical loss ratio requirements. The regulation gives plans the flexibility to contain costs by ensuring insurers and employers maintain the ability to make some routine changes without losing their plans' grandfathered status, such as cost adjustments to keep pace with medical inflation, adding new benefits, adjusting existing benefits, or voluntarily adopting the new consumer protections under the Affordable Care Act. If plans lose their grandfathered status, then consumers in these plans will gain additional new benefits including the patient protections provided by the Affordable Care Act such as no cost sharing for preventive benefits and review of potentially unreasonable rates in the individual and small group markets.

The three Departments have held meetings with issuers and consumer assistance groups about the rule's standards for grandfathered status. Based on feedback we have received through our inquiry process, and from formal comments in response to the interim final rule, HHS, Labor, and the Treasury issued an amendment to the grandfathering rule in November 2010 as well as

technical guidance[4]. The amended final rule allows employers to change carriers and keep their grandfathered status, providing additional flexibility in the implementation of this provision.

Transparency and Accountability

As we have implemented these new programs and processes, we have pursued them in an open and transparent manner. CMS has published extensive information on our rulemaking and other decisions on the CCIIO website and on the consumer-oriented www.HealthCare.gov to ensure that information is widely available for public input and understanding.

CMS has worked to manage different statutory implementation schedules while still seeking, considering, and accommodating public input and comment. For example, CMS received and considered input from consumers, industry, States, and other stakeholders through formal requests for comment as we developed regulations on the medical loss ratio and grandfathered health plans. As a result of these processes and the feedback received by CMS, the regulations that have been issued to implement the Affordable Care Act have been strengthened by the views and opinions expressed by affected stakeholders. As we transition to 2014, when many provisions of the Affordable Care Act will be fully in effect, CCIIO will continue to work closely with all interested stakeholders and to use the transparency of the regulatory process to ensure the new law best serves the American people.

When deadlines in the Affordable Care Act have necessitated that the Departments issue interim final rules, we have solicited comments on those rules and relied on public input in making revisions. Based on comments and questions HHS and the Labor and Treasury Departments have received on regulations issued to date, we have provided additional interpretive guidance to affected parties on regulations relating to grandfathering, medical loss ratio, the Pre-Existing Condition Insurance Plan program, the Early Retiree Reinsurance Program, internal and external appeals, and provisions relating to annual limits on health plan coverage. We continue to work with stakeholders to implement the Affordable Care Act and to provide additional clarity and information when necessary.

[4] CCIIO website: CCIIO.CMS.gov; technical guidance: http://cciio.cms.gov/resources/factsheets/index.html#aca

And the response from stakeholders has been positive. In response to one of our Exchange proposed rules, one business coalition stated: "We appreciate the Obama Administration's efforts to provide stability and certainty regarding employer-sponsored coverage." In response to a potential idea on how to define "full-time workers" for the purpose of the new law, one major trade group wrote that it "hopes this flexibility will be extended to the various other regulations that will make up the employer shared responsibility requirements." We remain committed to working with employers, consumers, providers, insurers, and average Americans on how to implement the reforms, in the near term and the long run, in a balanced way.

Moving Forward

We are proud of all that we have accomplished over the past year and a half and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans. In the meantime, I look forward to continuing to work on our bridge to 2014, which includes the MLR and grandfathered health plan regulations. I plan to continue to strengthen CCIIO's partnership with Congress and participate in our open dialogue with States, consumers, and other stakeholders across the country through our transparent rulemaking process and informative website. Thank you for the opportunity to appear before you to discuss the work that CCIIO has been doing to implement the Affordable Care Act.

Mr. PITTS. The chair thanks the gentleman. We will now begin the questioning and recognize myself for 5 minutes for that purpose.

Mr. Larsen, we have heard testimony from health insurance brokers that the Administration's MLR regulation is already leading to job loss and income reduction for agents. According to a National Association of Health Underwriters survey, agents are seeing income losses of 20 to 50 percent. Additionally, 21 percent of agents have downsized their business in response to the MLR regulation alone. Earlier this summer, with unemployment at a staggering 9.1 percent, you told us HHS would not rescind or suspend the MLR regulation under the President's Executive Order on Regulatory Review. With unemployment still at 9.1 percent, has the Administration reconsidered its decision to continue with the medical loss ratio regulation despite massive job loss among the broker community?

Mr. LARSEN. We have spent a substantial amount of time looking at this impact on agents and brokers. We know, for example, that the National Association of Insurance Commissioners on other issues related to the MLR standard took a pretty close look at the impact on agents and brokers of the MLR provision. Ultimately, as you may know, the NEIC declined to take further action in terms of recommendations or endorsements of changes to the MLR provision whether it is repealing it or other modifications. As I remember, the work that the NEIC did, they found there was really a spectrum of activity, that there was certainly some issuers that had decided to lower commissions. It wasn't always clear whether that was a direct result. Some issuers in fact had increased. There wasn't a clear trend across all markets in all States regarding responses by issuers on the agent and broker issue. So I think it is certainly the case that in some instances insurers have limited their commissions to brokers. We are concerned about that and we will continue look at it. At this point the NEIC declined to take any action on that, and I think we have limited legal ability to do so as well.

Mr. PITTS. Well, you have the ability to review regulations. Are you going to review the regs?

Mr. LARSEN. Well, we have been reviewing them in the context of the data that has been available to us, and we have looked at and certainly spoken with NAHU and looked at their survey, and I think the challenge is balancing the impact of, you know, major changes to the MLR standard, which will deprive a lot of consumers and businesses with rebates with some of the impacts that agents and broker communities have expressed.

Mr. PITTS. Recently, the Administration announced that it would use brokers and agents to help enroll individuals in PPACA's high-risk pools. This action was taken in response to the low enrollment in the program so far. If the Administration believes it is necessary to enlist the help of brokers to enroll Americans in a government program created by PPACA, why is HHS punishing the agent community and their customers in the private insurance space through the MLR rule? Shouldn't we be encouraging rather than hurting jobs in the private sector?

Mr. LARSEN. Well, first of all, we certainly support the role of agents and brokers in connection with the PESA program. We were very pleased to be able to provide payments or commissions to them on the PESA program. We certainly don't view the MLR rule as punishing agents and brokers. Frankly, it is many of the insurance companies that are taking this action. There is a very wide range in commissions that companies pay, and it is very possible that some of the companies are exploiting the MLR provision to lower agents' and brokers' commissions when they may not need to be doing that. I am not sure there is any clear data on that, but we support the role of agents and brokers both now and in 2014 in the exchanges, and we look forward to working with them to see if there is a way to get us through that period between now and then.

Mr. PITTS. Now, if a small business uses a broker to assist it in finding the best health plan for its particular unique circumstances, then the commission paid to the broker will count towards the administrative cost of the plan and thus could lower the plan's medical loss ratio percentage? Yes or no.

Mr. LARSEN. If I understand your question, yes, commissions are considered part of the administrative expense.

Mr. PITTS. If a large company has its own human resource department that researches the type of health plan that it will purchase from an insurer for its employees, will the costs of the work done by the H.R. department be calculated in the administrative costs of the health plan? Yes or no.

Mr. LARSEN. No.

Mr. PITTS. It seems these rules are written in a way to disadvantage small employers. It also seems as if these rules will direct people into these new exchange plans. If a small business wants to use a broker or an agent because their employees don't want to be dumped into the exchange, they should be able to without federal rules that tilt the playing field to government entities.

My time has expired and I yield now to the ranking member for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. Larsen, the Republicans are portraying the discussion draft as a means for Americans who like their health coverage to keep it, and in fact I think this legislation is much broader. The real intention, I think, is to eliminate the insurance reforms enacted by the Affordable Care Act and put insurance companies, not patients, back in control, and I just wanted to point out just a few of the consequences of this legislation becoming law. One is, over 1.2 million young adults would lose their insurance coverage because plans would no longer be required to cover them until age 26. Over 165 million Americans with private insurance coverage would be vulnerable again to having lifetime limits placed on how much insurance companies will spend on their health care. Fifteen point nine million people in the United States would be at risk of losing their insurance because rescissions would once again be legal, and 41 million Americans would lose guaranteed coverage for preventive services like mammograms and flu shots without cost sharing. Up to 43 million people in small business health plans would lose

their medical loss ratio and rate review protections, which would allow insurers to charge them high prices for low-value plans.

Now, Mr. Larsen, would it be accurate to say that this legislation is yet another attempt and way to repeal health reform?

Mr. LARSEN. The discussion draft that I have seen certainly would do more than modify the grandfathering rule but in fact repeals the applicability of all the protections that you just enumerated from any of the plans that were in place at that time.

Mr. PALLONE. And does the Republican legislation allow patients to keep their insurance if they like it as claimed by Republicans or are insurers really in charge allowed to cut benefits, you know, increase cost sharing and make other changes?

Mr. LARSEN. It doesn't, and that is the whole point of the rule. The rule provides employers some flexibility to make changes, but in the absence of the rule, employers and health plans could rewrite the entire plan, cut out benefits, remove protections. The plan would look very different. It would not look like the same coverage.

Mr. PALLONE. Now, the Republicans have repeatedly claimed that the grandfathering rule issued by HHS will result in tens of millions of people losing their health care. Is it accurate to say, as some are, that the grandfathering rule will result in people with employer-sponsored coverage being denied or losing their health insurance coverage because of HHS or because of the Affordable Care Act?

Mr. LARSEN. Yes, because the provisions that now apply to grandfathered plans include options for people to get better coverage, so if you are removing that, you are going to have people that don't have coverage that would have had it if the bill weren't in place.

Mr. PALLONE. And so where would Republicans get the idea that tens of millions of people are losing their health care? Where is this coming from?

Mr. LARSEN. I don't know exactly where that is coming from.

Mr. PALLONE. OK. I mean, it just appears to me as another case where the Republicans are inventing problems allegedly caused by the Affordable Care Act, and even if plans do lose grandfathered status, that doesn't mean a person loses their health insurance. In fact, they gain some consumer protections like rights to external appears and coverage of preventative services, and in any case, these requirements will not be prohibitive for employer plans because they usually already meet the rules. One employer benefits consultant notes, and I quote, that "large companies realize that they already comply with many of the requirements of non-grandfathered plans so the changes they will need to make aren't likely to add a significant cost or administrative burden." I mean, I just—to me, this is just a lot of nonsense. It is just another way to repeal patient protections, and everything that the Republicans are saying is going to happen, in fact, it is just the opposite.

Let me just ask you one more thing. I have got another minute here. Under the Republican legislation, grandfathered health plans would not have to report or openly justify premium increases. Have you seen an impact from rate review on premiums in any States in which it has been implemented so far, and is rate review going

to be an impossibly onerous burden for insurance companies to meet?

Mr. LARSEN. Well, like the MLR provision, we know that the rate review provisions are having impacts now. There are beneficial impacts. They are lowering rates. We know that rate review, the process works to lower rates in States, and I think we have cited in other hearings and our materials where commissioners have looked at rates and concluded that there were improper assumptions or excessive requests that have been scaled back and saved people, you know, millions of dollars in premiums. So that is a very important provision.

Mr. PALLONE. I mean, it just seems to me that, you know, the patient protections, the regulations on insurance companies that are consumer protections, they are all working. They are all having a very positive impact. There is absolutely no reason not to let the insurance companies continue down that path to protect a consumer. It is not that onerous. And now we are just going to say let us throw it all out and let the insurance companies do whatever their please, which makes no sense.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and recognizes the vice chairman of the committee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and again, Dr. Larsen, let me thank you for your willingness to provide our office with information. We have gotten some things answered. There are some things that are still outstanding, and I suspect there will be some new questions that come up as a result of our interaction today, and I would just like to have your commitment to continue to work together to get answers to those questions.

Mr. LARSEN. Yes, sir. I know that we provided an initial response to you since our last meeting, and we are working quickly to get the rest of those to you.

Mr. BURGESS. Let me ask you a quick yes or no question. States have rate review authority and they had that prior to the passage of the Affordable Care Act. Is that correct?

Mr. LARSEN. Some did, some didn't.

Mr. BURGESS. Now, in response to a question that Mr. Pallone asked, you said you didn't know where the figures came from about people who would lose their plans under grandfathered status. So June 17, 2010, Department of Health and Human Services issued an interim final rule imposing additional restrictions that health plans must comply with in order to protect their grandfathered status. The Administration issued an amendment to the interim final rule 17 November 2010. By the Administration's own estimates, 49 to 80 percent of the small employer plans, 34 to 64 percent of large employer plans and 40 to 67 percent of individual insurance coverage will not be grandfathered by the end of 2013, so that is from which those figures come, and we will be glad to provide you the places for those citations so you can familiarize——

Mr. LARSEN. Perhaps I misunderstood. I thought that the question was, was there a claim that people were going to lose their coverage. The answer is no. Those statistics relate to the projected——

Mr. BURGESS. Remember, the big selling point on the Affordable Care Act was, if you like what you have, you can keep it.

Mr. LARSEN. Sure.

Mr. BURGESS. And if people like what they have, they may not able to keep it. I think that is a fair statement. Is that not right?

Mr. LARSEN. Well——

Mr. BURGESS. Yes is the answer to the question. Let us move on.

Are you familiar with the Texas benefit pool?

Mr. LARSEN. Say that again.

Mr. BURGESS. The Texas benefit pool. It is not the high-risk pool, but this is a benefit pool for relatively small jurisdictions like small towns, and there are a number of small towns in Texas, to be able to pool together to purchase health insurance for their municipal employees that otherwise—and these are frequently cities that have significantly less than 50 employees under their jurisdiction. So 40,000 beneficiaries in 750 different political subdivisions and 90 percent of these numbers have 50 or fewer employees. Under the Affordable Care Act as currently written, they will go out of business. They cannot be a grandfathered plan. They cannot survive as a health plan in the exchanges because of the tight definitions, so it looks like they have got nowhere to go, and this is the solution that the State of Texas created to a problem well over 30 years ago. It has worked and it is providing lower-cost health care today but it is going to end up costing the Federal Government more because you will need higher subsidies for low-income workers and higher-priced plans.

So is there a—how do we say we are promoting State flexibility when in my State it will force lower-cost alternative municipal employees to go out of business and drive those employees into a one-size-fits-all exchange structure which will increase federal spending even more?

Mr. LARSEN. Well, I have to confess, I am not familiar with the entity that you just referred to. We would be happy to work with you to determine, you know, how it fits into the exchange structure in 2014.

Mr. BURGESS. All right. We will get you some more information on that, and I have got a number of others, and clearly I am going to run out of time.

As you know, I have been fascinated by your center or office or whatever we are calling it since I first learned of it a little over a year ago, and what began as the Office of Consumer Information and Insurance Oversight last summer is now the Center for Consumer Information and Insurance Oversight and it is now under the direction of the Centers for Medicare and Medicaid Services and not a standalone agency within the agency. Have I basically given a recapitulation of your brief history correctly?

Mr. LARSEN. Yes.

Mr. BURGESS. But also nowhere in here is your agency or center authorized. It was not mentioned specifically in statute in the Affordable Care Act, so it was a mystery to many of us when we first learned about it in August of last year that you were up and running and office space off the Hill and hiring employees, and I remember talking to your predecessor about well, why in the world could you—you know, surely these are functions that are already

being performed at HHS, why not just—you are duplicating abilities, and I was informed that that is not the case because for the first time the federal government is going to regulate the entire private insurance market in the country, which historically has been a function of the States. Is that correct?

Mr. LARSEN. The original office, OCIO, yes, was set up to implement the new provisions relating to the private health insurance market.

Mr. BURGESS. And we have a new agency or a new office or center——

Mr. LARSEN. Center.

Mr. BURGESS [continuing]. Not authorized under statute. You have spent now, according to figures you provided me through the end of August, almost $3 billion, $3.2 billion in implementation funds, correct?

Mr. LARSEN. Well, much of that, as you know, as I think you know, are the reimbursements under various programs but we haven't——

Mr. BURGESS. It is fascinating that this could occur——

Mr. LARSEN. But we haven't spent that money on the operations of——

Mr. BURGESS [continuing]. Under the statute and Congress not be aware of it. I mean, so I welcome your presence here today. I think it is good we are finally having this dialog and this oversight, but it troubles me that it occurred the way it did. It was seemingly something that was under the radar screen.

Thank you, Mr. Chairman, for your indulgence. I will yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the Ranking Member Emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Director Larsen, yes or no questions. Is it true that prior to the Affordable Care Act, MLR standards and/or reporting requirements varied widely from State to State? Yes or no.

Mr. LARSEN. True.

Mr. DINGELL. Is it also true that 34 States prior to ACA had a minimum MLR standard or reporting requirements for certain markets? Yes or no.

Mr. LARSEN. I think that is right, yes.

Mr. DINGELL. As you know, ACA sets a minimum federal MLR standard. As a former State insurance commissioner, do you believe that this will simplify regulatory compliance for insurance companies? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Further, do you believe that minimum MLR requirements will encourage greater transparency and understanding in insurance spending for consumers? Yes or no.

Mr. LARSEN. Yes, I do.

Mr. DINGELL. Under the Affordable Care Act, the National Association of Insurance Commissioners was tasked with coming up with definitions and calculation for MLR requirements. Were the recommendations from the National Association of Insurance Commissioners taken into consideration prior to the interim final vote? Yes or no.

Mr. LARSEN. Yes. In fact we adopted them all.

Mr. DINGELL. As a matter of fact, you adopted them all. That is right, isn't it?

Mr. LARSEN. Yes, sir.

Mr. DINGELL. Is it correct that the NAIC recommendations were unanimously approved by the insurance commissioners from all 50 States and the District of Columbia?

Mr. LARSEN. Yes, that is correct.

Mr. DINGELL. So you had vast unanimity on this matter, did you not?

Mr. LARSEN. Yes.

Mr. DINGELL. Now, did you separately consult with the States, the public and other stakeholders prior to issuing the rule? Yes or no.

Mr. LARSEN. We accepted the public input process that the NAIC conducted and then we have since taken comments and plan to look at further modifications to the MLR standard.

Mr. DINGELL. Now, one item that has gotten much attention recently is the ability of the States to apply for an adjustment under MLR requirements. The Affordable Care Act allows the Secretary to adjust the MLR standard for the individual market in a State if it is found that the standard may destabilize the individual market. Is that correct?

Mr. LARSEN. Yes.

Mr. DINGELL. And have you had applications for this kind of waiver and have you granted such waivers?

Mr. LARSEN. We have had a number of applications. I think that we have granted five of the ones that we have reviewed so far.

Mr. DINGELL. Now, is this adjustment meant to help to transition the State and the insurance plans will have to make to comply with the new federal minimum MLR standards?

Mr. LARSEN. Yes, sir, that is exactly what it does.

Mr. DINGELL. How many States have requested adjustments so far?

Mr. LARSEN. I think it is about 13.

Mr. DINGELL. Of this number, how many States have received adjustments?

Mr. LARSEN. Five of the ones, but we haven't finished reviewing many of them. Their applications are not complete yet from the States.

Mr. DINGELL. Has anybody been turned down?

Mr. LARSEN. Yes, two States.

Mr. DINGELL. In whole or in part?

Mr. LARSEN. In whole.

Mr. DINGELL. This temporary adjustment then maintains the intent of MLR requirements which is to ensure that the majority of premium dollars are spent on medical claims and activities to improve health quality. Is that right or wrong?

Mr. LARSEN. Correct.

Mr. DINGELL. As a former insurance commissioner, do you believe that the MLR requirement will help the American consumer get more value out of their health plans? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Now, under the MLR requirement, we are already starting to see insurance companies either slow or decrease the growth in premiums. Is that right?

Mr. LARSEN. Yes.

Mr. DINGELL. Do you believe that the repealing of the MLR requirements will harm or hamper or impede this progress?

Mr. LARSEN. It is a step backward, yes.

Mr. DINGELL. All right. Now, let us take a little look. Some of the things which will be adversely affected here that we are concerned with are things like insurance for young adults to 26, prohibition of rescission of insurance, prohibition of annual and lifetime limits, prohibition of preexisting-condition discrimination—I want to note particularly that one—no cost sharing for preventive benefits, patient's choice of providers, protecting small businesses, giving them new rights, protecting patients from medical bankruptcy, and right to appeal from insurance company denials. All of those new rights will be adversely affected by this legislation. Is that correct?

Mr. LARSEN. Yes.

Mr. DINGELL. And the rights will be taken away from the consumers. Is that right?

Mr. LARSEN. Yes.

Mr. DINGELL. Thank you, Mr. Chairman. Bad piece of legislation. I hope everybody is noting it.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from New Jersey, Mr. Lance, for 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman.

Good afternoon. Very good to be with you. There obviously remains significant interest in Congress about antifraud efforts in Medicare and Medicaid on a bipartisan basis. In fact, you stated that fighting fraud in Medicare was a key goal of the Administration when you came before the committee in May, and we all agree with you on that.

As I understand the MLR regulation, there is an exclusion of health plan investments and initiatives to prevent fraud from those activities that improve health care quality. It seems to me that this creates a perverse incentive to tackle fraud on the pay-and-chase side rather than the prevention side, and I believe CMS is stepping away from the pay-and-chase model. Could you give us your views on why we may be choosing to penalize measures to combat fraud and abuse in the MLR rule?

Mr. LARSEN. So the way that the MLR rule treats fraud is, it allows certain fraud recovery expenses to be included but not all of them, and that was essentially the middle ground that the NAIC reached when they looked at this issue and balanced the desire to, you know, encourage companies to invest in fraud prevention recovery versus the statutory language. I will say, though, that I don't think that we agree with the conclusion that this creates a disincentive for investment in fraud because to the extent that insurers invest in fraud prevention and fraud recovery and lower their underlying expenses, they are going to be in a position to lower their premiums and have a competitive advantage compared to other companies that don't make those types of investments. So

even though it is not fully recoverable in the MLR formula, we don't agree that that creates a disincentive for plans to engage in activities that they should do that is helpful for their efficiency as well.

Mr. LANCE. Why not go all the way and permit it and not have a middle ground?

Mr. LARSEN. Well, again, the statutory language that we are dealing with talks about two categories, categories related to clinical services like paying doctors and hospitals, and then quality-improving activities, and again, I think the NAIC and we came to kind of a middle ground on this issue but thought that it would be really stretching the envelope to include a wider range of expenditures relating to fraud prevention.

Mr. LANCE. Thank you. I obviously respectfully disagree and I hope that you might examine that again.

HHS has issued interim final rules implementing PPACA without first issuing proposed rules and receiving comment. From my perspective, HHS is acting on an ad hoc basis with no clear standards. What is your protocol for deciding when HHS will issue a rule on an interim final rule without first issuing a proposed rule?

Mr. LARSEN. Well, in the case of implementing the ACA, there were a number of interim final rules, or IFRs, that we issued in June right after the bill passed, and those were largely a function of the pressing time frame that was facing us to get regulations in place so that businesses and individuals had guidance as to how the law would be implementing. In areas where we have had a longer lead time to implement the law, we have done proposed rulemaking. So, for example, on the rate review reg, we did a proposed rule and then we finalized that rule recently, so it has largely in the case of ACA been a function of meeting the statutory deadlines, and of course, after we issue the IFR, we always take comments and some case like the grandfathering reg we went back and have amended them.

Mr. LANCE. When will you be replacing the interim final rules such as final rules such as the grandfathering and MLR rule?

Mr. LARSEN. So we continue to evaluate the comments that we have gotten in. I can't provide you with a specific timeline for that at this point but we continually evaluate the status of the interim rules to determine——

Mr. LANCE. Do you think it might be by the end of the year, Mr. Larsen?

Mr. LARSEN. If I could get back to you on that?

Mr. LANCE. Certainly, through the distinguished chairman.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes for questions.

Mr. CASSIDY. Hello, Mr. Larsen. Now, just to be clear, if somebody has a high-deductible health plan with an HSA, the contribution to the HSA is not included, so they pay out $2,000 out of their HSA, that is not included in terms of the claims payment history of the insurance company, correct?

Mr. LARSEN. I think that is right.

Mr. CASSIDY. That is my understanding. Now, it seems like there is a clear prejudice here because the insurance company has fixed costs. They have rent, they have utilities, they have whatever. So that the high-deductible health care plan, 95 percent of people who have these have less than $5,000 per annum expenses and their deductible may be $5,000. The insurance company has an absolute amount less dollars because of the 15 percent MLR, correct? If you will, this is a clear prejudice against a plan which encourages the person to be most cost-aware and which studies show gives a nice balance of the customer, if you will, the patient, looking for value. Is that easily acknowledged?

Mr. LARSEN. I know that is one of the perceived benefits, yes.

Mr. CASSIDY. That is a perceived benefit of the plan?

Mr. LARSEN. Yes.

Mr. CASSIDY. And studies would show that it is true. Now, that said, this MLR is clearly prejudiced against such plans. They have fewer absolute dollars with which to pay their administrative fixed costs relative to a gold star plan which, you know, my gosh, if you charge $10,000 for a policy versus $2,000, in absolute dollars there is a lot less. Fair statement?

Mr. LARSEN. Right.

Mr. CASSIDY. So why would we have a policy which is prejudicing against the purchase or the delivery of a plan which studies show give you a more cost-effective purchase of health insurance?

Mr. LARSEN. It is a question we can go back, to be honest with you, the issue about the applicability of this to the higher-deductible plans hasn't come on my radar screen, so I would be happy to go back and look at that.

Mr. CASSIDY. I have to say that surprises me, since we see the uptake of HSAs with high-deductible health care plans as increasing dramatically, and again, this is a clear prejudice towards higher-cost plans because a higher-cost plan at a 15 percent MLR has more absolute dollars for the insurance company to play with. Again, that is not disputable, is it?

Mr. LARSEN. So we can go back and look at that, as I said. We have—you know, there is a number of issues that are kind of front and center on MLR and there are some provisions we may have to modify before the end of the year, so I would be happy to look at that.

Mr. CASSIDY. Yes. When you say "look at", I just don't know what that means. Does that mean that you can see that there is a problem here or that well, we will look at it? Do you see what I am saying?

Mr. LARSEN. Yes, I think it means that I would like to, you know, sit down and get a better understanding of how the MLR provision applies. Again, and it may just be me, we haven't heard a lot about this, at least I haven't. You know, I confess, it doesn't mean that my staff has not. So "look at it" means understand it and see if we need to respond to it.

Mr. CASSIDY. The second thing is, so you are at least open to having a different set of rules for high-deductible health care plans?

Mr. LARSEN. Pardon me?

Mr. CASSIDY. Are you open or is it possible to have a different set of rules for catastrophic plans?

Mr. LARSEN. I don't know whether the statute would allow that or not, so——

Mr. CASSIDY. If the statute does not, would you think it would be a reasonable thing to correct that, pass another law, perhaps?

Mr. LARSEN. I hesitate to say without having a better sense of what I am talking about.

Mr. CASSIDY. That is a fair statement.

The other thing that disturbs is that the pattern of usage by the person with the HSA will greatly influence how this applies. If you have a group of people, each with $2,000 HSAs, and each uses $2,000, you never enter into a claim, but if one person has $10,000 and everybody else has zero, you have got five people in the group, everybody else has zero but one has $10,000, and clearly there are going to be claims paid, you are more likely to be able to hit the MLR requirement even though the claims history for the group is no different. Fair statement?

Mr. LARSEN. Sounds like it.

Mr. CASSIDY. Yes. So I have to admit that this kind of bill, which everybody is endorsing over there as sacrosanct gives me great pause just as I think about it.

I have a little bit of time left. My insurance company—clearly a criticism of our system is that it is a sickness treatment system, not a wellness-promoting system. There is an insurance company back home, Baton Rouge, Louisiana, which goes into a small employer and institutes wellness programs, and in so doing, they actually decrease utilization. They have outcomes data that shows this. But apparently this would be included in the MLR. They say they are going to have to eliminate the wellness program because it will—granted, claims history is down, which in and of itself decreases their absolute dollars, but a portion of their administrative costs is getting the folks over 50 to take an aspirin a day. So again, this seems like we are prejudicing against——

Mr. LARSEN. Well, I have to confess that I don't understand because that activity at least that you are describing would sound like it would be a quality-improving activity. We lay out the categories in the—the statute actually lays out the categories for improving health care outcomes, lowering hospital readmissions, prevention, wellness. Those are all part of the permissible types of expenses. So I am not clear why in the situation you are describing there is a disincentive to do that. It sounds like it would be the opposite.

Mr. CASSIDY. I am out of time, so let me pursue that and we will get back to you.

Mr. LARSEN. OK.

Mr. CASSIDY. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes of questions.

Mr. GINGREY. Mr. Chairman, thank you.

I am going to shift gears just a little bit. I want to talk about the CLASS Act. According to an article that ran in the Atlanta Journal Constitution yesterday, "Even as leading Democrats offered assurances to the contrary, government experts repeatedly

warned that a new long-term care insurance plan could go belly up, saddling taxpayers with another unfunded benefit program, according to emails disclosed by Congressional investigators," and that is a quote. Mr. Larsen, that quote was based on a joint report produced in part by Energy and Commerce Committee Republicans that sheds a bright light on the suspicious inner workings of Congressional Democrats and the White House as a push for Obamacare. The report finds that after repeated warnings from the CMS Chief Actuary and others about the insolvency of the CLASS program. HHS and Senate Democrats effectively cut the actuary out of the process and turned to CBO to give them the numbers they needed, only those numbers were wrong. Eighteen months after CBO pronounced the CLASS Act solvent, Secretary Sebelius finally admitted to the world what we all knew, that the CLASS Act was in fact insolvent. As of today, CBO has failed to make public the economic model cited in the report that deemed this program solvent. Even worse, CBO staff now says they do not have the capacity to analyze the CLASS Act's long-term solvency.

Mr. Larsen, I believe that the economic modeling used to sell PPACA, the Patient Protection and Affordable Care Act, to the American people needs to be thoroughly reviewed from top to bottom.

Further, I would once again call on this Congress to pass H.R. 1173. That is a simple bill that my good friend, Dr. Charles Bustani from Louisiana, and I have introduced to repeal the CLASS Act. The CLASS Act is just another example of how bad policy can threaten the financial health of this great Nation. What say you, Director Larsen?

Mr. LARSEN. Well, I will have to say that I will take your comments back to HHS. The CLASS Act does not fall under the area that I have responsibility for, and I have to confess, I have not kept up with the current situation with the CLASS act, so I would be happy to share your concerns, but I can't respond——

Mr. GINGREY. Fair enough. Fair enough, and I do appreciate the fact that you will take that back and continue to discuss because clearly it is insolvent and it is a real cost driver.

Let me follow up on Dr. Burgess's question for a minute. The President promised the American people that if you are among the hundreds of millions of Americans who already have health insurance through your job, Medicare, Medicaid or the VA, nothing in this plan will require you or your employer to change the coverage or the doctor you have. Let me repeat, nothing in our plan requires you to change what you have. Now, that is pretty much a direct quote from the President. Do you agree with the President that nothing in the Patient Protection and Affordable Care Act will make the hundreds of millions of Americans who already have health insurance through their job to change the insurance that they have today?

Mr. LARSEN. That is the point of the grandfathering provision, and I think that is what our regulation permits, which is for people to continue to keep the coverage that they have.

Mr. GINGREY. Well, you know, let me express a concern, Mr. Larsen, that I have and maybe turn it into a question, and it is not just me as a physician member of the committee and of the

Congress, having too many, 26 years, 31 years clinical practice of medicine. But, you know, it just seems to me that the way this bill was set up with expansion of Medicaid up to 133 percent of the federal poverty level, so you force more and more of the uninsured on to the States that have to balance their budgets and costs them additional billions of dollars. You at the same time—not, you, but the bill—even though you are talking about the grandfathered provision and all that, it really concerns us as you have heard from committee members on this side of the aisle and MLR and why we feel like that that was just another reason why so many of these employers that cover American workers are going to drop their health coverage unless of course it is provided through a union contract. So you basically force a bigger volume of people onto the exchanges and you avoid a lot of the premium support because you push the nearly poor into Medicaid and therefore you make this program work by virtue of volume. Health insurers like that, of course, and require individuals to purchase health insurance even if they don't want it is all part of that scheme, and you ultimately end up with Medicare from cradle to grave, and that is a legitimate concern.

I know I have run out of time, but if the chairman will indulge me, what say you in regard to those concerns?

Mr. LARSEN. Well, you covered a lot of ground, but a couple comments. One, the ACA expands coverage through a number of different mechanisms, certainly through a Medicaid expansion, which by the way the newly eligibles are covered at 100 percent match through, I think——

Mr. GINGREY. For 2 years, yes.

Mr. LARSEN. For I think longer than that. And then, yes, we rely on private market solutions in order to expand coverage for those that are not eligible for Medicaid. There is a premium subsidy for folks between the 100 and 400 percent of poverty but those policies are provided in the exchanges through private issuers, and I think all the studies show that that is going to resolve in a significant expansion of coverage for non-Medicaid individuals as well.

Mr. GINGREY. Mr. Chairman, thank you, and Mr. Larsen, thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the ranking member.

Mr. PALLONE. Mr. Chairman, I would just ask unanimous consent to enter four letters into the record: a group letter from nearly 50 organizations, HIV Health Care Access Working Group letter, American Diabetes Association letter, and a Main Street Alliance letter, and these are in opposition to the draft, and I believe you have them.

Mr. PITTS. We have them. Without objection, so ordered.

[The information follows:]

The Honorable Joe Pitts
Chairman, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

September 15, 2011

Dear Chairman Pitts and Ranking Member Pallone:

The undersigned organizations write to express serious concerns with the legislation to be discussed by your subcommittee that would repeal the medical loss ratio provision of the Affordable Care Act (ACA) and prohibit, in perpetuity, the enforcement of other important consumer insurance protections.

The Medical Loss Ratio is An Essential Consumer Protection
The minimum medical loss ratio (MLR) requires that insurers in the individual and small-group markets spend 80% of premium dollars on medical care and quality improvement activities instead of administrative expenses, like underwriting, marketing and profits; for large groups, medical spending must be at least 85%. Insurers that fail to meet these standards will owe consumers a rebate of the difference. HHS estimates consumers and employers stand to gain rebates worth $1.4 billion for premiums paid in 2011. More importantly, a recent GAO report shows that the MLR requirement is already putting downward pressure on insurance premiums as insurers with high administrative costs work to become more efficient and competitive. For example, Aetna announced in May 2011 that it would decrease premiums in Connecticut by an average of 10% in response to the MLR requirement. H.R. 2077 would repeal this important cost-saving provision for consumers and small businesses, and we strongly oppose it.

Some argue the MLR has led to reductions in agent and broker commissions, causing hardship for the industry and for consumers seeking insurance through a broker. In fact, data submitted to the National Association of Insurance Commissioners (NAIC) Professional Health Insurance Advisors taskforce was inconclusive on this point. To the extent that some reductions in commissions have occurred, it generally appears that very high first-year commissions in some states have been reduced to levels typically found in lower-commission states and high-paying insurers have cut commissions to levels paid by their competitors. Data from California demonstrated that producer commissions have increased very dramatically in recent years and suggested that recent changes in compensation may represent a market correction rather than an unreasonable reduction in fees. There is also little evidence that consumers are losing access to agents and brokers as a result of these trends. In addition, as noted above, insurers have other options for meeting the MLR requirement, including by reducing premiums, becoming more efficient, or lowering profits, which have reached record levels in 2011.

Insured Families Should Not Be Barred from the Benefits of Insurance Reforms
The ACA expands access to new consumer protections while preserving the insurance that consumers currently have. Specifically, there are some protections that all plans must comply

with in plan years beginning on or after September 23, 2010. These include the elimination of lifetime coverage limits, a prohibition on rescissions, and extension of parents' coverage to adults under age 26. Additional protections will be phased in over time for plans that were in effect on March 23, 2010. Those plans are "grandfathered" until substantial changes in benefits or costs are made, and then they must be updated to comply with the new ACA protections. Benefits that are phased in include preventive benefits at no additional cost, greater appeals protections, premium rate review, and in 2014, out-of-pocket spending caps.

This draft legislation wipes out these safeguards, taking away the new protections consumers have recently earned and those they stand to gain in the future. This would impose higher costs for preventive care and reinstate lifetime limits on benefits. It would allow exclusions of coverage for pre-existing conditions in perpetuity, locking in disparate treatment of millions of people. It would increase the number of uninsured by taking away the coverage of many young adults who are newly insured through their parents' health plans. Just this week, the Census reported insurance gains for about 500,000 young adults, due in large part to this provision.

We oppose rolling back essential consumer health insurance protections and urge the subcommittee not to advance this legislation.

Health Care for America Now
Consumers Union
American Cancer Society Cancer Action Network
American Federation of State, County and Municipal Employees (AFSCME)
National Education Association
Service Employees International Union (SEIU)
National Partnership for Women & Families
American Heart Association
Families USA
International Union, United Automobile, Aerospace and Agricultural Implement Workers of America (UAW)
Alliance for a Just Society
Main Street Alliance
Community Organizations in Action
USAction
Raising Women's Voices for the Health Care We Need
United Transportation Union
National Health Law Program
United Steelworkers
National Women's Law Center
Community Catalyst
United Food & Commercial Workers International Union

State Groups:
Health Access California
New Jersey Citizen Action
Citizen Action of New York

Consumers for Affordable Health Care (Maine)
Action NC
Montana Small Business Alliance
Montana Organizing Project
ACTION United (PA)
Iowa Citizen Action Network
Iowa Main Street Alliance
Georgia Rural Urban Summit
WV Citizen Action Group
Toledo Area Jobs with Justice and Interfaith Worker Justice Coalition
OLÉ
Colorado Progressive Action
Progressive Maryland
Missouri Progressive Vote Coalition
Penn Action
Citizen Action/IL
Ohio Communities United
Progressive Leadership Alliance of Nevada
Progress Ohio
Organize Now (Florida)
United Action Connecticut (UACT)
Arkansas Community Organizations
Virginia Organizing
Washington CAN!

HIV Health Care Access Working Group

September 14, 2011

The Honorable Joe Pitts
Chairman, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member, Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone:

We the undersigned organizations strongly urge you to reject H.R. 2077, a bill to repeal the medical loss ratio (MLR), as well as a proposed measure to repeal the grandfathering provisions of the Patient Protection and Affordable Care Act of 2010 (ACA). As a coalition of more than 100 national and community-based AIDS service organizations representing HIV medical providers, public health professionals, advocates and people living with HIV/AIDS, we urge you to consider the effect of repealing these important consumer protections on people living with HIV/AIDS and those at risk for infection.

The minimum medical loss ratio (MLR) requires that insurers in the individual and small-group markets spend 80% of premiums on medical care and quality improvement activities instead of administrative expenses, like underwriting, marketing and profits (for large groups, medical spending must be at least 85%). This provision of the ACA is critical to making the insurance marketplace more transparent and making it easier for consumers to purchase plans that provide better value for their money.

We also oppose proposals to prevent enforcement of the "grandfathered plan" regulation that over time will allow more consumers to benefit from the provisions of the ACA that do not apply to grandfathered plans, particularly the full range of health benefits that the law requires plans to offer in the exchanges and in the individual and small group markets beginning in 2014.

The proposed legislation to repeal the "grandfathered plan" provisions would gut new protections consumers have recently received and those they stand to gain in the future. It would mean higher costs for preventive care and the reinstatement of lifetime limits on benefits. It would take away the ability of 1.2 million young adults to secure coverage through a parent's health plan. It also would hurt consumers by allowing insurance companies to continue to charge discriminatory premiums for the sick, essentially locking in disparate treatment of tens of millions of people, including those living with HIV and other chronic diseases.

We have seen firsthand the need for much stronger consumer protections in the private insurance market to prevent discrimination against Americans living with HIV disease. We oppose rolling back essential consumer health insurance protections and urge the subcommittee not to advance this legislation.

Thank you for your consideration of our views. If you have further questions, please contact Robert Greenwald of the Treatment Access Expansion Project at Harvard University (rgreenwa@law.harvard.edu) or Andrea Weddle of the HIV Medicine Association (aweddle@hivma.org)

Sincerely,

AIDS Foundation of Chicago
AIDS Institute
AIDS Project Los Angeles
AIDS United
CANN - Community Access National Network
HIV Medicine Association
National Association of People with AIDS
National Alliance of State and Territorial AIDS Directors
National Minority AIDS Council
San Francisco AIDS Foundation
Treatment Access Expansion Project
Village Care

September 14, 2011

The Honorable Joe Pitts
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone:

On behalf of the nearly 26 million Americans with diabetes and the 79 million with prediabetes, the American Diabetes Association (Association) is writing to express our opposition to the discussion draft under consideration by the House Energy and Commerce Committee which prevents enforcement of the grandfathered plan regulation required under the Patient Protection and Affordable Care Act (ACA).

Under the ACA, a grandfathered health plan is defined as an existing group health plan or health insurance coverage from the individual health insurance market in which a person was enrolled on the date of enactment. The grandfathering of existing health insurance plans under the ACA provides stability and flexibility to individuals, families and businesses and protects their ability to keep their current health insurance plan. As a result, grandfathered health plans are exempt from the vast majority of the new insurance reforms. However, several important provisions in the ACA do apply to grandfathered plans and these protections are critically important for people with diabetes. It is also essential to maintain the grandfathered health plan regulation so plans are not free to make major changes or cuts to their existing coverage.

Repeal of the grandfathered plan regulation would be extremely harmful to people with diabetes and those at high-risk of developing diabetes because health plans would not have to comply with provisions in the ACA that prohibit pre-existing condition exclusions, prohibition of lifetime and annual limits, extension of dependent coverage for children up to age 26, and restrictions on out-of-pocket maximums. These protections are critical to consumers with and at risk for diabetes and will help improve the coverage for enrollees as well as make private coverage more accessible and affordable. Diabetes has become America's most pressing epidemic and if current trends continue the number of Americans with diabetes will double by 2050. But this tragedy doesn't have to happen and appropriate implementation of the Affordable Care Act will result in improved benefits at an affordable cost for all Americans with or at risk for diabetes.

The Association encourages you to support implementation of the grandfathered health plan regulation which includes valuable protections for people with diabetes. Should you have any questions or need further information, please contact Tekisha Dwan Everette, Managing Director, Federal Government Affairs at teverette@diabetes.org.

Sincerely,

Shereen Arent

Shereen Arent
Executive Vice President
Government Affairs and Advocacy

National Office
1701 North Beauregard Street
Alexandria, VA 22311
Tel: 703-549-1500 • Fax: 703-549-1715

Diabetes Information
Call 1-800-DIABETES (1-800-342-2383)
Online: www.diabetes.org
The Association gratefully accepts gifts through your will.

The Mission of the American Diabetes Association is to prevent and cure diabetes and to improve the lives of all people affected by diabetes.

Small business owners. Small business values.

September 14, 2011

To: House Energy & Commerce Committee Subcommittee on Health

Re: Urging committee members to stand with small businesses, not the insurance industry, and protect medical loss ratio rebates

Dear Chairman Pitts, Ranking Member Pallone, and members of the Subcommittee on Health,

On behalf of the Main Street Alliance, we write to express our opposition to the proposal to eliminate the minimum medical loss ratio (MLR) standards enacted in the Patient Protection and Affordable Care Act.

The Main Street Alliance is a national network of small business coalitions. We create opportunities for everyday small business owners to have a seat at the table and voice in the debate on issues that impact our businesses and our local economies. Health care costs have been a core concern for small businesses for years, and stemming the tide of skyrocketing rate increases continues to be a top priority for our membership.

The minimum medical loss ratio requirements included in the ACA will finally give small businesses a guarantee of a basic standard of value for our premium dollars, and provide rebates to business owners whose insurers fail to meet that basic standard.

As business owners, we recognize the importance of providing real value to our customers, and we want the same commitment to value from our health insurers. We believe the new MLR standards must be protected and implemented as written in current law. If anything, they should be strengthened to raise the MLR thresholds to 85 percent in the small group and individual markets and 90 percent in the large group market, targets that some insurers have demonstrated are realistic.

We have already expressed our opposition to proposals to remove agent and broker commissions and fees from the MLR calculation. If these fees were removed, it would wipe out a major portion of the rebates small businesses are expected to receive (the change could wipe out two-thirds of rebates in the small group market and over half of rebates in the individual market).

Overturning the MLR requirement would do even more harm to small businesses, completely eliminating rebates to small businesses estimated to be on the order of $300 million on premiums paid this year, according to the Department of Health & Human Services. In addition to eliminating the rebates themselves, overturning the MLR requirement would eliminate the incentive for insurers to hold premiums down, giving them back the power to rates at their whim, at our expense.

The Main Street Alliance – 3518 S. Edmunds St. – Seattle, WA 98118 – (603) 831-1835
www.mainstreetalliance.org – info@mainstreetalliance.org

Small businesses need all the help we can get to level the playing field and make decent health coverage affordable. The new MLR requirements throw a lifeline to small businesses struggling to stay afloat with health coverage. We urge you not to take that lifeline away.

If you vote to eliminate the MLR requirement, the rollback of these rebates and the cost containment incentive they represent will be a direct blow to small businesses and a giveaway to the insurance industry. If you want to stand with small businesses, not with the health insurance industry, you should vote to protect the MLR requirements and keep those rebates coming to small businesses who stand to benefit.

Sincerely, on behalf of the Main Street Alliance network,

Kelly Conklin
Foley-Waite Associates, Inc.
Bloomfield, NJ
Main Street Alliance Steering Committee

Jim Houser
Hawthorne Auto Clinic
Portland, OR
Main Street Alliance Steering Committee

Mr. PITTS. The chair now recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

I just wanted to correct one item that I think was mistaken that was mentioned in questioning. Between July of 2010 and July of 2011, a number of insurance agents and brokers actually went up by 5,500 people. So we were hearing about the growing unemployment. In fact, that number is actually increased. This is according to the Insurance Information Institute, and so we are seeing about a .9 percent increase in employment, and given the facts today, not bad, not great, but not bad and going in the right direction.

In 2010, Mr. Larsen, United Health, WellPoint, Humana, Cigna and Aetna made combined profits of $11.7 billion by reducing the share of premiums being spent on the shrinking membership in private health plans. Through the recession and its aftermath from 2008 to 2010, their combined profits increased 51 percent. In 2009, the total private membership to these five companies was reduced by 2.7 million people and another 839,000 in 2010. That was just 2009. In 2010, another 839,000 at a time when 50.7 million people were already uninsured. So profits went up. The number of people that they actually served went down. Despite this decrease in membership, in 2010 the five insurers collected $7.7 billion more in premiums than in 2009. However, the medical loss ratio for four of the five companies decreased from 2009 to 2010.

So clearly, the money generated by rising premiums was not being used for medical or patient care, my point. Health insurers are making enormous profits at the expense of their customers, and this is not an isolated example. Insurers claim that these profits are not large relative to the size of their business, but what I see is nearly $12 billion in profits while hardworking families have been asked to pay more and more in premiums.

So where does profit fit into the medical loss ratio and does a lower medical loss ratio allow insurers to still make a decent profit?

Mr. LARSEN. The answer is yes, that they do still. These standards still clearly allow issuers and insurance companies to make a very fair, reasonable rate of return in profit. The profit is part of the broad administrative expense, so everything that isn't paying doctors' bills or investing in quality is part of the administrative expense. So it is profits, salaries, commissions, overhead, you know, rent all of that is part of the administrative expense.

Ms. SCHAKOWSKY. And when insurance companies talk about their profits, they have already subtracted those things, have they not?

Mr. LARSEN. Well, I think they are part of the other mix. I guess the point I am trying to make is that there is a lot of latitude for the insurers, say, in the individual and small group market. They still have 20 percent of the premiums to devote to all of the things that I just enumerated including profits and so they have the flexibility to modify their business model to lower rates in order to hit the MLR standard, and it still leaves a lot of room for them to make reasonable profits.

Ms. SCHAKOWSKY. So what I have taken from this panel is that a number of insurance companies actually are meeting this medical

loss ratio standard that you have set. Some have actually lowered premiums, making it easier for consumers, that the number of insurance agents and brokers, which I just learned, has actually gone up, and that insurance companies are doing great and that they can well afford to meet this sensible and modest standard. That is my summary. Am I wrong on any of those points?

Mr. LARSEN. I agree.

Ms. SCHAKOWSKY. Thank you.

I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman, and welcome, Mr. Larsen. Sorry about being in and out of the hearing room. They brought meetings down into the side room so I have kind of been in the area but I hope I don't ask questions that have already been asked. I was going to follow up on what the chairman initially asked but he stole my great questions, so I will move to a couple other things, and some of this is kind of like Dr. Gingrey and just maybe messages to send back to HHS and the like.

This is a great committee, especially on our side. We have got practitioners, so I like sitting in. I am not one. I am a receiver of their benefits but you have got Dr. Cassidy, you have got Dr. Burgess, you have Dr. Gingrey, and no one really debates their compassion and concern for the health care system because that is their livelihood, so I do enjoy sitting in and listening to them as they try to make sense of how we can best care for our citizens.

Is there any internal memos going around HHS as to different agencies as far as if the Select Joint Committee does not meet their goal? You know, the defense budget is number one in discretionary budget. Number two and the biggest cost of the national government is HHS. Have you received word as to your office as if there is a sequestration, what that might do, and is there some analysis going on as to how that may affect the rollout of the Patient Protection and Affordable Care Act?

Mr. LARSEN. I suspect there are but, you know, I am really focused on the day-to-day implementation of the provisions like the things that we are talking about today, so——

Mr. SHIMKUS. So they haven't talked to you about that?

Mr. LARSEN. They have not come and talked to me about it.

Mr. SHIMKUS. And obviously, you know, that is my concern. I did support the legislation but my really concern was for the committee that the savings is on provider payments and the hospital payments, physician payments. As we know, Medicare pays 70 cents on the dollar. Medicaid spends 60 cents on the dollar. I have great concerns.

The other direction I would like to go is on the medical loss ratio. We are not a good arbiter on fighting waste, fraud and abuse, and do you not believe there is any credible support that the ability of the insurance companies to fight waste, fraud and abuse should be part of the medical loss ratio? Obviously, that is why we passed this legislation on the Medicare card. We are terrible.

Mr. LARSEN. A component of it is, up to—they can include the amount of expenditures of recovery based on what they recover, and again, that was the balancing that the NAIC achieved when

they looked at this issue. They spent a lot of time looking at this, getting input from different groups. We adopted that balance. So there a component there but I previously testified, we don't agree with the idea that not including everything is a disincentive to those expenditures. We just don't——

Mr. SHIMKUS. Let me go quickly. I am going to run out of time. And to my friend from Illinois, I just had the insurance and financial brokers in yesterday. They weren't there telling me that times are good. They were in the office telling me times are bad, and part of it is because of this piece of legislation that is now the land of the land.

And finally, a question on—we did delegate policymaking responsibilities to the National Association of Insurance Commissioners, but HHS said the association followed a thorough and transparent process in which the views of regulators and stakeholders were discussed, analyzed, addressed and documented in numerous open forums. Were HHS comments documented, posted on the Internet with everyone else's?

Mr. LARSEN. You mean the comments that we provided to NAIC during their process?

Mr. SHIMKUS. Right.

Mr. LARSEN. Well, I don't know that we actually provided kind of formal. We monitored their process so we were aware of what they were doing.

Mr. SHIMKUS. Did you attempt to influence their work product in any way?

Mr. LARSEN. I don't recall providing written comments to them on any of their issues, so we would listen in to their phone calls, but that was largely a delegation to the NAIC, and we would talk to their staff from to time.

Mr. SHIMKUS. And I will finish with this. In October 2010, at the NAIC meeting, over a dozen commissioners proposed that NAIC's official MLR submission to HHS remove agent commissions from the MLR calculation. The votes were there to pass an amendment but it was never called. I understand you were in that room that day. Could you tell us exactly what discussions you and anyone else at HHS had with the NAIC members and staff regarding agent commissions and MLR at the meeting in October 2010?

Mr. LARSEN. Yes. We went down as members of our staff have been to all the NAIC meetings. They are a close partner of ours in the process, so were there to observe the process. We were not there to lobby——

Mr. SHIMKUS. So your testimony would be, you didn't influence it?

Mr. LARSEN. No.

Mr. SHIMKUS. OK. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Kentucky, Mr. Guthrie, for 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Larsen, for coming. I do appreciate it.

I just want to kind of go a little different path about the rebates. Now the rebates are sent back to the employers. And my line of questioning with this, the other day I was back in our work period,

and everywhere we go it seems like we walk in—I know the President says there is a headwind on the economy but I am telling you, I went to one of the smallest banks in Kentucky, the smallest in my district, for sure. They said let me introduce you to my new employee, that is our new compliance officer, he doesn't make any loans, doesn't create anything, all he does is make sure we comply with the new law that came down. And so in this, we do things here in Washington that sound simple. For instance, we are going to rebate back to the employer if the MLR is breached. And so then I can see myself walking into a company, wanting to talk about how we are going to compete with China, Brazil, whatever, and they say let me talk to my HR person that just got back from a briefing and asking questions like if the breach moves forward and an employer-sponsored plan isn't corrected, the plan can either pay the employer or the employee. They can pay either employer or employee, correct?

Mr. LARSEN. They can do what, sir?

Mr. GUTHRIE. If the health insurance company, if they breach the MLR, can rebate, the rebate can go to the employer or employee?

Mr. LARSEN. Well, right, but this is a tricky issue. What we said in the reg, and we are looking at possibly changing this——

Mr. GUTHRIE. But if it goes to the employee, then the employee is responsible for writing a check back to the employer for the——

Mr. LARSEN. The scenario is, so the employee contributes to the health care premium.

Mr. GUTHRIE. Like 20 percent. Right.

Mr. LARSEN. So you have got basically two people paying combined the premium to the company, and so if there is rebate, yes, we have to figure out, how does the rebate get back to the people that paid it, and we understand that concern. In fact, in the proposed rule, we proposed that the insurance company have the obligation to make sure that everyone got the right money and——

Mr. GUTHRIE. So the employer is going to have to send it to the insurance company?

Mr. LARSEN. And we said you can enter into an agreement with an employer to kind of discharge your obligation. The insurance companies have said that is tricky, we are not sure how that is going to work.

Mr. GUTHRIE. Yes, that is a problem. They are out here trying to make it work when it sounds simple.

Mr. LARSEN. So we——

Mr. GUTHRIE. But then so the money comes back to the employer or the employee, it is now taxable income, correct?

Mr. LARSEN. That I am not sure about.

Mr. GUTHRIE. I think it would have to be, because your premium dollars are pre-tax income, so they would have to go back and fix the payroll taxes, correct? If that is true. I know that is not your area of expertise.

Mr. LARSEN. Assuming that is true.

Mr. GUTHRIE. Assuming that is true. Assuming that is also true, then at the end of the year the employer is going to have to update W–2 forms and redistribute them out to all their employees. So, I mean, it sounds simple, but we hear it everywhere everything that

is going on in this town. You go to an employer in Kentucky—I haven't had this one yet because it is not implemented but that is what they are saying. It is reminiscent of the 1099, which created an uproar. And that is the problem that we are seeing is, we can design something that sounds simple on paper, and all of a sudden who does the check go to. That is what they will be asking us. Do I have to take out payroll taxes, if have to pay payroll taxes, I have to update the W–2 forms. Does the income go on this year or does it go on next year?

Mr. LARSEN. Well, we will work with folks as we are in the middle of discussions now to try and figure out how we can make it work. We don't want to lose sight of the purpose, which is, if folks are in the position to get a rebate, it means that they overpaid.

Mr. GUTHRIE. Well, I agree.

Mr. LARSEN. They are entitled to get money back, so——

Mr. GUTHRIE. And then you have to say, do I have to pay—do I have to do an amended tax forms. I mean, it just continues.

Mr. LARSEN. So we want to keep it simple but we don't want to lose sight of the fact that we want them to get the value for their premium dollar, and if they overpaid, we want to make sure that they get the money back in their pocket.

Mr. GUTHRIE. We do hope it is simple. It needs to be simple.

I want to yield to my friend from Louisiana the rest of my time.

Mr. CASSIDY. Thank you.

Mr. Larsen, briefly reflecting on your remarks, I am struck that you all have not considered HSAs. And so I just pulled some statistics. I think I have heard in the past that all new hires in GM's executive corps have HSAs. I just pulled up something. In Lynchburg, Virginia, all the county all has HSAs. I then just pulled up something which from American Health Insurance Plans which speaks about how 11.4 million Americans now have HSAs, which increased 14 percent in the last year, 26 percent of the growth in the large groups but 15 percent in the individual market. I have to ask you, why have not you considered HSAs? Because it seems that that is the emerging market.

Mr. LARSEN. Well, when you say "consider it", meaning consider it as a problem in the context of the medical loss ratio regulation, correct?

Mr. CASSIDY. Correct.

Mr. LARSEN. And all I am saying to you is, that that has not come on our radar screen, at least mine, maybe other folks in the agency, as an issue that we need to address in terms of the imbalance.

Mr. CASSIDY. Now, to me, that reflects either—and no offense, but since to me it just seems so apparent that if you have plan which is more parsimonious or at least in terms of how much do I have to pay for it, not as much, and this in absolute dollars which we are on opposite sides of the issue on this bill but we can both agree——

Mr. LARSEN. I mean, I am not sure the NAIC flagged this for us either, so I am not at all adverse to looking at it. You know, we have got a lot to do to implement this law and when issues are brought to our attention, we take them seriously and we will look at it and, you know, we have looked at other issues. We amended

the grandfathering rule based on comments we got. We are looking at possible other tweaks to the MLR rule that we have announced previously—I am not making news here—you know, how we are going to deal with the mini meds going forward and things like that. So we will certainly put this on the list.

Mr. CASSIDY. Thank you.

Mr. PITTS. The chair thanks the gentleman, and that concludes the questioning for Mr. Larsen. Thank you very much, Mr. Larsen, for your testimony and your willingness to answer questions and to work with us.

Mr. LARSEN. Thank you.

Mr. PITTS. We will call now panel two, and our second panel consists of five witnesses. Our first witness is Mr. Edmund Haislmaier, Senior Research Fellow in Health Policy at the Heritage Foundation. Next is Ms. Grace-Marie Turner, the President of the Galen Institute. Our third witness is Ms. Janet Trautwein, who is the CEO of the National Association of Health Underwriters. Our fourth witness is Mr. Wendell Potter, Senior Analyst at the Center for Public Integrity. And finally, Ms. Lynn Quincy, Senior Policy Analyst for the Consumers Union.

So we will begin at my left and go down the line. Mr. Haislmaier, you may begin your testimony. We ask you to summarize your written testimony in 5 minutes and your written testimony will be made a matter of the record.

STATEMENTS OF EDMUND F. HAISLMAIER, SENIOR RESEARCH FELLOW, CENTER FOR HEALTH POLICY STUDIES, THE HERITAGE FOUNDATION; GRACE–MARIE TURNER, PRESIDENT, GALEN INSTITUTE; JANET TRAUTWEIN, CHIEF EXECUTIVE OFFICER, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS; WENDELL BLAINE POTTER, SENIOR POLICY ANALYST, THE CENTER FOR PUBLIC INTEGRITY; AND LYNN BATES QUINCY, SENIOR POLICY ANALYST, CONSUMERS UNION

STATEMENT OF EDMUND F. HAISLMAIER

Mr. HAISLMAIER. Thank you, Mr. Chairman and members of the committee for inviting me to testify today. A few points that I will make out of my written testimony.

I have pointed out in that testimony that there are a number of problems, some of which have already been discussed, with the medical loss ratio regulations. The discussion has already addressed in the previous panel what I see as one of the biggest problems, which is the disincentive for insurers to spend money on preventing fraud and abuse. Mr. Larsen pointed out that there are some provisions that allow insurers to get some credit for that. That is true. I cover that in my testimony.

The problem that I would point out here is really one of statute. It is not the fault or the NAIC or Mr. Larsen's office. The problem is the statute was badly written and this was not accounted for when they wrote the statute. It is one of many problems. What Mr. Cassidy was pointing about HSAs is another problem, and the problem with rebates and how they are paid is another problem. These are things that Congress simply did not consider when they

drafted the statute, and in my reading of the statute, I am afraid that NAIC and Mr. Larsen and HHS really have limited ability because of the constraints of the statute to actually fix what are very real problems, and that is why, Mr. Chairman, I am encouraged that you are having a hearing on this because it really is Congress that needs to fix the problems that they have created here.

Mr. Larsen made the observation, and it is a correct one, in my view, and I didn't touch on it in my testimony so I would like to expound on it for a minute, that even though the MLR provisions disincentivize insurers to pay attention to fraud and abuse, he doesn't think that that will be a problem because an insurer that neglects those activities will result in having higher claims costs and higher premiums and thus be competitively disadvantaged, and I would say that he is economically correct if you assume—and this is the big "if"—that you still have a robust competitive insurance market.

Unfortunately, as I outline in my testimony and have in other things that I have written, this provision in combination with a number of other provisions such as the rate review and some of the benefit mandates will lead to a dramatic reduction in the number of carriers and thus when you move toward an oligopolistic market, if you have only got two or three big carriers, then everybody has an incentive to just say well, we will ignore it and we will just, you know, pass through the costs and pad our profits, particularly since they will be operating in a market where many of their customers will be subsidized by the government under other provisions of PPACA. So while in the short term I think Mr. Larsen's economic analysis is correct, in the long term I think this is a very serious problem.

Let me make two other—let me make an observation about the effects of the medical loss ratio that has not been brought up this morning in my oral remarks, and it is covered in the testimony that I submitted for the record. One of the big problems with this medical loss ratio or minimum loss ratio standard is it effectively constrains the amount of capital that an insurer can accumulate from their premium after paying claims and administrative expenses, and that is going to lead, in my view, to a number of insurers simply exiting the market, particularly smaller ones. I discussed that in the testimony. It will very dramatically prevent or hinder new insurers from being created because it is not possible for an insurer to run a loss and then recoup it in the initial startup phase anymore. So the first thing that this does is kill off any new insurers entering the market.

Parenthetically, I would say—I didn't cover this in my written testimony—but on another subject we have another provision of PPACA that is trying to create new co-op insurers. This actually works against doing that. There are a lot of things that work against doing that.

And then finally, and I think most perversely from the perspective of proponents of this legislation, it severely disadvantages nonprofit insurers relative to for-profit insurers because nonprofit insurers, if you look at a market where you want to consolidate to the point that you are too big to fail, which is I think where insurers are going to go in with PPACA, nonprofit insurers don't have

the wherewithal to do it. They can't raise the capital other than what they retain from premiums whereas for-profit insurers can go into the equity market, issue shares and buy up the nonprofits.

So when I look down the road and say well, what does the world look like in 15 years or 10 years, if you stay on this course, it looks like maybe three national insurance companies, all for profit, doing everything, and they are really going to function like Medicare fiscal intermediaries where they just pay the claims and don't care and leave it to the government to worry about the legitimacy and the cost of it. That I think is very debilitating, and I think is the single biggest reason why Congress should repeal this set of provisions.

Thank you for your time. I will be happy to answer questions.

[The prepared statement of Mr. Haislmaier follows:]

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CONGRESSIONAL TESTIMONY

Effects of the PPACA's Minimum Loss Ratio Regulations

Testimony before
Committee On Energy and Commerce
Subcommittee on Health
United States House of Representatives

September 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.

Background

The Patient Protection and Affordable Care Act (PPACA) established new federal rules governing how health insurers spend premium dollars.[1] These rules are commonly referred to as "minimum loss ratio" regulations—meaning that they specify the minimum share of premium income that an insurer must spend on claims costs and "activities that improve health care quality."

The minimum levels are set in PPACA at 85 percent for large group plans and 80 percent for small group and individual plans. The statute explicitly excludes insurer payments of "Federal and State taxes and licensing or regulatory fees" from the calculation of minimum loss ratios.

PPACA further stipulates that if an insurer spends less than the required minimum in a given year, then the insurer must refund the difference to policyholders. Thus, for example, if an insurer is required to spend 80 percent of premium income on claims costs for a particular product but only spends 75 percent, the insurer is required to rebate five percent of the premium collected to policyholders.

The Department of Health and Human Services (HHS) issued regulations last fall implementing this new requirement, which took effect on January 1, of this year.[2]

Consequences of PPACA's Minimum Loss Ratio Regulations

The "loss ratio" for an insurance plan is a common actuarial and accounting metric that may be of interest to some consumers when comparing coverage options. It should be noted that there is nothing inherently problematic about government requiring the disclosure of this information to consumers and that basic loss ratio data can already be derived from standard insurer filings with state regulators.

Reporting or publicizing insurer loss ratios does not, in and of itself, create problems. The problems only occur when governments use a comparative measure, such as this one, as the basis for setting and enforcing a required minimum standard. A useful way to understand this important distinction is by considering analogous examples.

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[1] New § 2718 of the Public Health Service Act (42 U.S. Code § 300gg–18) as added by PL 111-148 § 1001(5) and then amended by §10101(f).
[2] 45 CFR 158.

When government requires manufacturers to disclose product information -- such as the fuel efficiency of cars -- consumers can use that information as another point of comparison when making purchasing decisions. The consumer can then decide, say, whether the higher operating costs of a less fuel-efficient car are compensated for by a lower purchase price or other desirable product features, or to opt instead for a more fuel-efficient car that cost less to operate, but has a higher purchase price or lacks other features the consumer might want.

It is only when government takes the additional step of using such comparative information to impose minimum standards that it distorts the market in ways that can disadvantage some consumers. Thus, what killed-off the family station wagon was not government requiring manufacturers to disclose the fuel-efficiency of automobiles, but rather the additional imposition of a minimum "Corporate Average Fuel Economy" (CAFE) standard that manufactures could only meet by no longer producing larger cars.

In the same fashion, the PPACA's requirement that health insurance plans meet new minimum loss ratio requirements will produce negative effects for consumers -- most notably, reduced insurer competition, higher premiums, and more erroneous or fraudulent claim payments.

Killing Start-Ups

The first to go will be new, start-up health insurers. As with many start-up companies, a substantial initial capital investment is required to create a new insurer. That investment is needed to fund initial marketing and sales efforts to attract paying customers, and to build-out the operational and administrative infrastructure for billing customers, paying claims, etc. Similar to other new businesses, a new insurer initially operates at a loss until it achieves enough "scale" -- that is, it acquires enough customers -- that revenues exceed expenses, and it become profitable.

The MLR regulations effectively constrain the amount, and delay the timing, of any excess premium revenues that a start-up health insurer could plan to either reinvest in growing its business (say, through additional marketing) or repaying its initial investors. Thus, the MLR regulations push further into the future a new company's projected "break-even" point, and may also necessitate additional start-up capital beyond what was previously projected.

Of course, it is uncertain whether a particular start-up insurer would succeed, even without having to deal with the constraints imposed by the MLR regulations. However, what is certain is that imposing the new MLR regulations raises the bar for an "in-process" start-up, and increases the risk and initial capital requirements for an "in-planning" start-up venture.

In at least one reported case investors decided to terminate an "in-process" start-up health insurer, at least in part, due to the effects of the new MLR regulations on its business

plan. As a result, 128 Virginia small businesses and their 1,488 workers and dependents were forced to look for new coverage this year.[3] What is unknowable are how many attempts to create new health insurers that are still in the planning stage are simply being abandoned once investors determine that the added burden of complying with the new minimum loss ratio regulations make it too expensive or too risky to go forward.

Exiting the Market

A number of established companies that currently provide health insurance can also be expected to exit the market over the next several years. The ones most likely to leave are those with multiple lines of coverage, for which offering health insurance is just part of their larger business. In general, the minimum loss ratio regulations will make offering health insurance less profitable, while other regulations, such as the PPACA's new benefit standards and coverage rules, will make health insurance more expensive for customers and more costly for insurers to administer. Thus, companies with multiple lines of business will likely discontinue or sell to competitors their, soon-to-be less profitable, health plans and focus instead on the other lines of insurance that they offer -- such as life, auto, property, or liability coverage -- or on non-insurance business opportunities.

The smaller the company, or the smaller the share of a company's total business represented by health insurance, the more likely it is that the company will exit the post-PPACA health insurance market. Of course, smart managers aren't going to wait for corporate assets to decline further in value, so it is likely that many of those sales and divestitures will occur sooner rather than later.

For example, on September 30, 2010, Principal Financial Group, Inc. announced that it was exiting the major medical health insurance market and transferring its existing book of business to UnitedHealth Group.[4] Principal will instead focus on its other lines of business, which include managing retirement and investment plans, and offering life, disability, dental and vision insurance products (none of which are subject to the PPACA's new federal insurance regulations).

To be sure, such business decisions are often the product of multiple considerations, but the fact that the MLR provisions in the PPACA constrain health insurance administrative spending and profitability while its other new insurance regulations increase benefit and administrative costs, will certainly discourage companies with other options from continuing to offer health plans.

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[3] Michael Schwartz, "Startup health insurer shutting," *Richmond BizSense*, June 4, 2010, at: http://www.richmondbizsense.com/2010/06/04/startup-health-insurer-shutting and Michael Schwartz, "With healthcare reform looming, nHealth was losing millions," *Richmond BizSense*, June 11, 2010, at: http://www.richmondbizsense.com/2010/06/11/with-healthcare-reform-looming-nhealth-was-losing-millions/

[4] Principal Financial Group, "The Principal Financial Group to Exit Medical Insurance Business," press release, September 30, 2010, at: http://phx.corporate-ir.net/phoenix.zhtml?c=125598&p=irol-newsArticle&ID=1477633&highlight=

An Invitation For Fraud

Even more troubling than its tendency to reduce competition by driving some insurers out of the market, is that the PPACA's minimum loss ratio regulations also create a disincentive for insurers to control payment errors and fraud. Under the statute and regulations, money spent on preventing or recovering erroneous or fraudulent claims, counts as "administrative" expenses, and not "medical" costs, while erroneous or fraudulent payments count the same as appropriate and legitimate ones in determining whether a plan has paid out a sufficient share of premium income on "medical care."

As part of this provision, Congress asked the National Association of Insurance Commissioners (NAIC) to advise HHS on how to account for various insurer expenses in administering the MLR standards. In its recommendations, NAIC attempted to partially remedy this defect in the legislation by recommending that the amount of premium income used to calculate the MLR be reduced by the lesser of either what an insurer spends on "Fraud and Abuse Detection/Recovery Expenses," or the amount of erroneous payments the insurer recovers. HHS incorporated that recommendation into its regulations.

However, even that tweak does not fix the problem. Under these rules an insurer that simply pays claims without first checking whether they are legitimate or accurate will still be financially better off than one that spends money trying prevent or recover erroneous or fraudulent payments. The reason is that, under any possible scenario of administrative expenses and recoveries, an insurer that spends nothing on preventing or collecting erroneous payments will still retain more funds -- which it can use to cover other administrative costs, or to pad its profits -- than an insurer that spends money on preventing or recovering improper claims payments. Indeed, an insurer that doesn't spend anything trying to prevent or recover errors or fraud, will actually report a higher (i.e., "better") medical loss ratio than its competitors, since any overpayments or fraudulent claim payments will count as expenditures "on reimbursement for clinical services" under the MLR provisions of the PPACA.

Bias Toward Higher Premiums

Yet another unintended consequence of the minimum loss ratio regulations is that it creates an inherent bias for insurers to charge *higher* premiums than they otherwise would absent the MLR requirement. This is because if an insurer overestimates expected spending on medical care, it must refund excess premiums to policyholders, but if it underestimates expected claims costs, it cannot keep more revenue the next year to recoup that loss.

There is an inherent tension in any insurance company between the actuaries who want a "margin of safety" built into premiums (which increases rates) and sales and marketing which wants to charge the lowest practical rates in order to attract or retain customers. The MLR regulations will tip that balance in favor of the actuaries. They will argue that underestimating medical costs can now produce losses that cannot be recovered, while

charging premiums that might be higher than necessary will protect the insurer's profitability, at the cost of sending rebate checks to policyholders next year if it turns out that the extra funds were not needed after all.

Favoring For Profit Insurers

Still another unintended consequence of the minimum loss ratio regulations is that they will increase the competitive advantage of for-profit insurers over their non-profit rivals. Because the MLR requirement constrains the share of premium income that an insurer can "retain," it limits an insurer's ability to accumulate the capital needed to expand, either by increasing marketing and sales efforts or by purchasing business from other insurers. Non-profit insurers have no other source of investment capital beyond whatever excess premium income they can accumulate after paying claims costs and administrative expenses. However, for-profit insurers can finance their capital needs by issuing equity shares. Since the proceeds of a share offering are not premium income, the MLR restrictions do not apply.

Thus, the minimum loss ratio regulations will not only spur increased consolidation in the health insurance industry, but will also further drive that consolidation toward a market dominated by a few, very large, for-profit, insurers. It is easy to envision large, for profit health insurers applying the same "roll-up" strategy of raising capital through equity offerings and then using the proceeds to buy smaller competitors that has been successfully applied in other sectors. Such an outcome is probably not something that the authors of the PPACA either intended or envisioned.

Recommendation

These undesirable and unintended consequences of the PPACA's minimum loss ratio regulations offer an object lesson in how greater information transparency is often a better public policy solution than new regulations.

State insurance departments already gather data from insurer regulatory filings on how health insurers spend their premium revenues. Thus, states can, and probably should, publish that data in an easily comparable format so that consumers can use it when shopping for coverage. Such an information transparency approach provides consumers with another useful tool for comparing plans, while also encouraging insurers to offer better value to their customers. More importantly, it achieves those goals without creating the perverse incentives and undesirable side effects of the PPACA's minimum loss ratio regulations.

The best course of action now would be for Congress to simply repeal the PPACA's misguided and badly design minimum loss ratio regulations.

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. PITTS. The chair thanks the gentleman.

We are voting on the floor at this time, so we will try to get through another presentation, and if it is all right with the ranking member, we will break and come back. Is that OK?

Mr. PALLONE. Yes.

Mr. PITTS. We have two votes, unfortunately, so we are going to have to go.

Ms. Turner, you are recognized for 5 minutes.

STATEMENT OF GRACE–MARIE TURNER

Ms. TURNER. I will be quick. Thank you, Mr. Chairman. Thank you, Mr. Pallone and members of the committee.

Many employers said that the assurances that their health plans would be grandfathered was a key reason that they supported the legislation, yet independent surveys and the Administration's own estimates, as we have heard today, indicate that most employers will not be able to maintain their grandfathered status and therefore I would argue that the rules that were designed to do that therefore are failing and are not achieving their goal. The grandfathering rules really boxed employers into a corner. They can't make changes other than minor modifications to their health plans to keep costs down without being forced to comply with expensive regulations that increase their health care costs.

Health costs are directly related to creation of jobs, as we have talked about a lot today. Higher health care costs put additional pressure on the employer's bottom line and increase the cost of hiring new workers. This is bad for the economy and bad for unemployed workers. Employers do work very hard to find the balance between keeping of cost of health insurance down and also offering benefits that employees want and need. Part of the way that they are able to do that is by seeking bids from competing insurers and adjusting benefits structures on the margin.

But under the grandfathering rules, employers are now very limited in what they can do to change benefits. That also means they are limited in what they can do to keep costs down. Many people argue that the ACA's restrictions are needed to keep employers from cutting benefits or imposing higher health costs on their employees, and also providing these additional consumer protections. But employers or really employees are really the ones who are ultimately paying the price for these higher health care costs since coverage is part of their compensation.

A recent Rand study found that most of the pay increases that employees have received over the last 10 years have been consumed by health costs. The study found that the typical family had just $95 a month in real dollars more for non-health spending in 2009 than it did in 1999. In contrast, the authors say that the growth rate of health insurance has simply kept pace with the regular cost increase general inflation. The family would have had an additional $5,400 a year to spend. So employees are really the ones paying the price for higher health care costs. Therefore, it is in the interest of both to keep health care costs down, and the grandfathering regulations issued by HHS restrict their ability to do that.

There are many problems that need to be solved in our health sector but it is important to follow the medical dictum to first do no harm in making changes.

The chairman mentioned that legislation is being drafted to reverse the interim final rule, and the Administration itself recognizes that companies need relief from burdensome and expensive regulations that impact their competitiveness and their ability to generate revenues to create new jobs, and withdrawing the grandfathering regulations would be a very good place to start to achieve those goals.

Thank you, Mr. Chairman. I look forward to questions.

[The prepared statement of Ms. Turner follows:]

A not-for-profit health and tax policy research organization

Testimony before the U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Rep. Joe Pitts, Chairman
Rep. Frank Pallone, Jr., Ranking Member

Hearing on

Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations

September 15, 2011

Testimony presented by
Grace-Marie Turner
President, Galen Institute

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Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations

Committee on Energy and Commerce
Subcommittee on Health
Testimony by
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Executive summary

- While most companies initially hoped they would be able to preserve much of their existing group health plans under the new grandfather provisions, a survey by Aon Hewitt Consulting found almost all will not. The administration's own estimates indicate most employers will not be able to maintain grandfathered status.

- The grandfathering rules box employers into a corner. They cannot make changes, other than minor modifications, to their health plans to keep costs down without being forced to comply with expensive PPACA regulations that increase their health costs.

- Health costs are directly related to creation of new jobs. Higher health costs put additional pressures on the employer's bottom line and increase the cost of hiring new workers, in turn discouraging job creation. This is not good news for the economy or for unemployed workers.

- Many people argue that the ACA's restrictions are necessary to keep employers from cutting benefits or imposing higher health costs onto their employees. But employees actually pay the price for higher health costs since health coverage is part of employee compensation.

- A recent RAND study found that most of the pay increases that employees have received over the last ten years have been consumed by health costs. The study found that the typical family had just $95 a month more to devote to non-health spending in 2009 than they had a decade earlier. By contrast, the authors say that if the rate of health care cost growth had not exceeded general inflation, the family would have had $545 more per month in spendable income instead of $95 — a difference of $5,400 per year.

- It is in the interest of both employers and employees to keep health costs down, and the grandfathering regulations issued by HHS restrict their ability to do that.

- Health costs are a jobs issue. The administration recognizes that companies need relief from burdensome and expensive regulations that impact their competitiveness and their ability to generate the revenues they need to hire more workers. Withdrawing the grandfathering regulation would be a good place to start to give them that relief.

Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations

Committee on Energy and Commerce
Subcommittee on Health
September 15, 2011
By Grace-Marie Turner, Galen Institute

Thank you Chairman Pitts, Ranking Member Pallone, and members of the Committee for the opportunity to testify today about the rules that govern the ability of employers to protect health insurance policies under the "grandfathering" provisions of the Patient Protection and Affordable Care Act (PPACA).

"If you like your health insurance, you can keep your health insurance." That was the promise made to millions of Americans by President Obama and leaders in Congress many times in assuring them that the new health law would not disrupt the coverage they have now. In fact, many employers said assurances that their health plans would be "grandfathered" was a key reason that led to their support or to their taking a neutral stance on passage of the legislation. People who have and value their health coverage were also reassured. Surveys have shown that 88% of Americans are satisfied with their health coverage.[1] While most companies initially hoped they would be able to preserve much of their existing group health plans under the new grandfather provisions, a survey by Aon Hewitt Consulting found almost all will not.[2]

Even the administration now admits that this promise will not be kept. It expects that by 2013, between one-third and two-thirds of the 133 million people with coverage through large employers will lose their grandfathered status. And up to 80 percent of the 43 million people in small employer plans will lose their grandfathered protection. Up to 70 percent of those with

coverage in the individual market would be forced to comply with expensive new federal rules within a year.[3] Few of them are likely to lose coverage in the short term, but most will lose the coverage they have now.

The grandfathering rules box employers into a corner. They cannot make changes, other than minor modifications, to their health plans to keep costs down without being forced to comply with expensive PPACA regulations that increase their health costs.

Health costs are the issue

The human resources consulting firm Towers Watson released a survey of large employers regarding health costs.[4] Seven out of ten of the employers surveyed expect to lose grandfathered health status in 2012 — subjecting them to all of the new regulations and mandates under the new health law. Of even greater concern, nearly three in ten employers (29%) are unsure whether or not they will continue offering coverage to their current workers after all of the provisions of the new health law take effect.

Towers Watson reports that overall health plan costs are projected to rise at a 5.9% rate in 2012, continuing to rise faster than the rate of overall inflation. Because of rising health insurance costs and the other cost pressures that employers face, a majority of firms say they will be forced to increase the employee share of premiums in 2012. Only one percent of firms say they will be able to decrease the employee share of premium contributions next year.

Health costs are directly related to creation of new jobs. Employers continue to face a fragile economy. Higher health costs put additional pressures on their bottom line and increase the cost of hiring new workers, in turn discouraging job creation. This is bad news for the economy or for unemployed workers.

What all employers must cover

Under the Affordable Care Act, all health plans — whether or not they are grandfathered plans — were required to provide certain benefits for plan years starting after September 23, 2010, including:[5]

- Restrictions on lifetime limits on coverage for all plans. Starting in 2014, insurance plans must provide coverage without imposing any annual or lifetime limits on the amount paid to individual beneficiaries. During the transition years between now and 2014, however, insurance firms can impose annual limits, subject to HHS rules. The HHS regulations issued last June dictated how high these limits must be. In 2011, insurance companies can continue to impose an annual limit, but it must be at least $750,000 per enrollee. In 2012, the limit will have to be at least $1.25 million, and in 2013, $2 million. In 2014 there can be no limit on payouts for any individual's care.[6] This is the particular regulation that has led to 1,578 waivers being issued by HHS, primarily covering limited benefit plans offered by employers who said the higher cost could force them to drop the coverage altogether.[7]
- No rescissions. Plans may not rescind coverage after enrolling a participant, except in the case of fraud or limited circumstances.

- No coverage exclusions for children under age 19 with pre-existing conditions, and no pre-existing condition exclusions for anyone starting in 2014.[8]
- Group health plans that provide dependent coverage are required to extend coverage to adult children up to age 26 with no conditions on dependency.

A recent employer survey said that 28% percent of employers believe that compliance with PPACA rules already is increasing their health cost.[9]

Restrictions on plans hoping to keep grandfathered status

What do plans have to do in order to maintain their grandfathered status? A Health and Human Services Department fact sheet describes the restrictions.[10]

Compared to policies in effect on March 23, 2010, employers:

- cannot significantly cut or reduce benefits
- cannot raise co-insurance charges
- cannot significantly raise co-payment charges
- cannot significantly raise deductibles
- cannot significantly lower employer contributions
- cannot add or tighten an annual limit on what the insurer pays
- cannot change insurance companies. (This rule was later amended to allow employers to switch insurance carriers as long as the overall structure of the coverage does not violate other rules for maintaining grandfathered plan status. The amended rule specifically

directs that the new insurance carrier must precisely match the same terms of coverage that were previously in place.)

These rules mean, for example, that health plans and employers with plans in effect on March 23, 2010, lose their exempt — or grandfathered — status if they were to raise co-payments by the greater of $5 or a medical inflation rate plus 15 percent. Deductibles couldn't go up more than medical inflation plus 15 percent. In addition, employers couldn't cut the amount of the premium that they contribute by more than 5 percent.

Plans that lose their grandfathered status become subject to all of the reforms in the Act, including first-dollar coverage for preventive care, required coverage for certain clinical trials, quality reporting requirements, and implementation of internal and external appeals processes.

While most companies initially hoped they would be able to preserve much of their existing group health plans under the new grandfather provisions, a survey by Aon Hewitt Consulting found almost all will not. Ninety percent of companies said they anticipate losing grandfathered status by 2014, with the majority expecting to do so in the next two years. The same study found that among those companies with self-insured plans, 51 percent expect to first lose grandfathered status in 2011 and another 21 percent expect to lose it in 2012. The survey found that "Most employers would rather have the flexibility to change their benefit programs than be restricted to the limited modifications allowed under the new law."[11]

Why employers need flexibility

The employment-based health system in the United States has evolved from decisions made during World War II that gave favored status to health insurance offered through the workplace. Our system of employer-based health insurance is underpinned by generous tax incentives that allow employers to deduct the cost of health insurance as a part of their employee compensation costs and through a separate tax provision that shields the value of the policy from being taxed as income to the worker. These dual tax incentives have provided strong incentives for people to get their health insurance at work and have led to the system in which 158 million Americans get health insurance through the workplace.

Employers work very hard to find the balance in keeping the cost of health insurance as low as possible while offering the benefits that employees want and need. Part of the way they are able to do this is by seeking bids from competing insurers and amending and adjusting benefit structures. But under the grandfathering rules, employers are very limited in their ability to adjust current benefits without losing their grandfathered status. This also means they are limited in what they can do to help keep costs down.

The U.S. Chamber of Commerce, the largest U.S. business advocacy group, presented written comments on the grandfathering rules in August 2010, saying its first concern is with the restriction on cost-sharing. "By so severely restricting changes in cost-sharing, the regulations will effectively force plans to lose grandfathered status in order to remain solvent," the Chamber wrote.[12]

Employees pay the price of higher health costs

Many people argue that the ACA's restrictions are necessary to keep employers from cutting benefits or imposing higher and higher health costs onto their employees. But employees actually pay the price for higher health costs.

The cost of health coverage is part of employee compensation. A recent RAND study found that most of the pay increases that employees have received over the last ten years have been consumed by health costs.

Between 1999 and 2009, a median-income family of four that received health insurance through an employer saw their real annual earnings rise from $76,000 to $99,000 over the ten year period. But nearly all that gain was consumed by rising health care costs, according to the paper by David Auerbach and Arthur Kellermann of RAND. [13]

After taking into account the price increases for other goods and services, they said the typical family had just $95 a month more to devote to non-health spending in 2009 than they had a decade earlier. By contrast, the authors say that if the rate of health care cost growth had not exceeded general inflation, the family would have had $545 more per month in spendable income instead of $95 — a difference of $5,400 per year. Workers are paying the price for higher health costs.

Many companies have introduced plans that engage their employees as partners in managing health costs, giving them more control over health care and health spending decisions. These

companies have had success in holding down health cost increases. A 2011 survey for the National Business Group on Health on "purchasing value in health care" found that companies that offered account-based health plans, such as Health Savings Accounts or Health Reimbursement Arrangements, had coverage costs that were $900 lower than average for employee-only coverage and $2,885 lower for Preferred Provider and Point of Service (PPO/POS) plans.[14] "The cost of [account-based health plan] coverage is considerably more affordable than either PPO/POS plan or HMO plan coverage in 2011," the survey found. These premium savings benefit both employers and employees.

The number of people with HSA/HDHP (high-deductible health plan) coverage rose to more than 11.4 million in January 2011, up from 10 million in January 2010, 8 million in January 2009, and 6 million in January 2008.[15]

Of course consumer-directed plans are only one option of the wide array of policy choices offered in the private marketplace. But many employees and employers value this choice. Flexibility, rather than top-down rules, is essential for employers and employees to find ways to hold down health costs.

Relief from the grandfathering regulation

It is in the interest of both employers and employees to keep health costs down, and the grandfathering regulations issued by HHS restrict their ability to do that. Health costs are a jobs issue.

I understand that legislation is being drafted to reverse the interim final regulation issued by HHS on June 17, 2010. Reversing this regulation would give employers the flexibility they need to manage their health costs and find the balance between health costs, wages, and hiring new workers. The administration recognizes that companies need relief from burdensome and expensive regulations that impact their competitiveness and their ability to generate the revenues they need to hire more workers. Withdrawing the grandfathering regulation would be a good place to start.

Thank you for the opportunity to testify today, and I will be happy to answer your questions.

ENDNOTES

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Mr. PITTS. Ms. Trautwein, you are recognized for 5 minutes.

STATEMENT OF JANET TRAUTWEIN

Ms. TRAUTWEIN. Thank you, Chairman and Ranking Member Pallone. I appreciate this very much.

As you know, the leadership of this committee invited me here this past June to talk about the desperate economic situation that the ACA's medical loss ratio regulation has created for the half-million health insurance agents and brokers nationwide. Unfortunately, I do not have a positive update for the committee today. The economic outlook for many health insurance brokers and agents, and I would emphasize health insurance agents, which are different from general-purpose agents. The MLR specifically applies to those who work in the health insurance arena. The market continues to be bleak. As health insurance companies renew and revise their agent and broker contracts, it is clear that the financial situation for many of these people, many of whom are business owners themselves, is getting worse.

Clearly, this problem started when the MLR regulation was issued in December of 2010. It is very well documented that that is when the problem occurred. That regulation mandated that health insurance carriers, as you know, treat independent agent and broker compensation as a part of health plan administrative costs in spite of the fact that independent agents and brokers are not employed by health insurance carriers. They do run their own businesses, hire their own employees, pay all of their own office expenses including professional liability insurance. Each agent decides on their own which health insurance carriers he or she will represent and then they are retained by individual consumers and employers to assist them with their health insurance needs.

Issuance of the HHS regulation on MLR, which categorized agent commissions as an insurer administrative expense, triggered, as I said, an immediate response for many health insurance companies and immediate reduction in agent compensation.

In May 2011, a national actuarial study conducted by the NAIC taskforce—the professional—not the whole NAIC but the professional health insurers advisors taskforce that was assigned to address this problem regarding producer compensation said that in 2011, a significant number of companies have reduced commission levels, particularly in the individual market, and this was reinforced by the most recent report from the GAO private health insurance early experiences implementing new medical loss ratio requirements which states, "Almost all of the insurers we interviewed were reducing broker commissions and making adjustments to premiums in response to the MLR requirements." These insurers said that they decreased or planned to decrease commissions to brokers in an effort to increase their MLRs. As a result of these cuts, brokers serving individuals and the small business community, as has been said earlier, have seen their overall revenues slashed by 20 to 50 percent. This means that fewer of them are able to stay in business. It also means that those who are able to survive are being forced to make service cuts and are no longer able to provide the counseling and level of advocacy support to their clients that they have in the past.

Now, it may seem to you that what agents and brokers do is simple. You may think that all they do is fill out a form and sign people up for insurance, and some of you may even think it is as easy as buying an airline ticket, but there is so much more than that. They meet with each client and determine their specific needs covering everything from which doctors they use to their preferences for financial risk. They have candid conversations with people who are struggling to afford coverage and help them find ways to stay insured. With employers, they also discuss issues such as the savings that can be achieved through wellness and disease management programs and the characteristics of a particular company's workforce, discussing options for structuring their coverage.

This dire situation is why we are looking at all possible solutions, whether they are regulatory or legislative, to address the problem. This problem needs to be addressed both quickly and in a way that is politically viable, and there is a solution that we believe meets both of these requirements. We believe that if agent commissions, since they are not really an insurer expense, removed from what is currently defined as premium for MLR calculation purposes, either through a legislative act or regulatory action, that it would significantly improve the situation that exists today.

I am sure that you all are aware of H.R. 1206, which now has 120 bipartisan cosponsors, 24 members of this committee. It is authored by Mike Rogers and Congressman Barrow, and we definitely appreciate them having done this. We endorse this as well as do all other national agent professional associations as well as, I said, the NAIC broker taskforce, and I will stop there.

[The prepared statement of Ms. Trautwein follows:]

Testimony for the

United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Health Hearing

"Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations"

September 15, 2011

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September 15, 2011

Good morning. My name is Janet Trautwein, and I am the CEO of the National Association of Health Underwriters (NAHU). Thank you for inviting me here again today to talk about the regulatory impact that the Patient Protection and Affordable Care Act (PPACA) has had on NAHU members directly, as well as on their clients.

NAHU is the leading professional association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. The members of NAHU work on a daily basis to help individuals, families and employers of all sizes purchase health insurance coverage. They help their clients use their coverage effectively and make sure they get the most out of the policies they have purchased. Significantly, about three-quarters of NAHU members are principals in their own small businesses and employ multiple individuals from their communities.

The leadership of this committee invited me here this past June to talk about the desperate economic situation PPACA's medical loss ratio (MLR) regulation has created for the half-million health insurance agents and brokers nationwide. Unfortunately, I do not have a positive update for the committee today. The economic outlook for many health insurance agents and brokers across the country continues to be bleak. As health insurance companies renew and revise their agent and broker contracts for the coming year, it is clear that the financial situation for many of these business owners is getting worse.

The problem is clearly PPACA's MLR requirements, which mandate that health insurance carriers spend 85 percent of their premiums (large group) and 80 percent of their premiums (individual and small group) on direct medical care. The MLR interim final rule as designed by the Department of Health and Human Services requires health plans to treat independent agent and broker compensation as part of health plan administrative costs. This is despite the fact that independent agents and brokers aren't employed by health insurance carriers. They run their own businesses, hire their own employees and pay all of their own office expenses, such as professional liability insurance. Each agent decides which health insurance carriers he or she will represent. Agents and brokers are then hired by individual consumers and employers to serve as their agent/broker of record before all of the insurance carriers with which the agent is affiliated.

Health insurance carriers do collect and remit agent and broker fees to them, but they only do so as a consumer convenience and also to comply with overlapping webs of state-licensing, consumer-protection and premium tax laws. Not one penny of independent agent or broker compensation ever goes to a health insurer's bottom line. Instead it is a pass-through fee that goes directly from consumers to their health insurance agent.

The MLR provisions in PPACA were designed to ensure the appropriate use of premium revenue by the insurance companies. However, two recent nonpartisan analyses of the situation clearly show that one of the key ways health insurance companies have been attempting to comply with the MLR is by

cutting agent and broker fees even though they were never part of their revenue stream in the first place.

In May 2011, a national actuarial study conducted for the National Association of Insurance Commissioners' (NAIC) Professional Health Insurance Advisors (EX) Task Force regarding producer compensation in the PPACA MLR calculation found that "in 2011, a significant number of companies have reduced commission levels, particularly in the individual market."

A Government Accountability Office (GAO) report released in August 2011 titled Private *Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements* contained similar conclusions. It states: "Almost all of the insurers we interviewed were reducing brokers' commissions and making adjustments to premiums in response to the PPACA MLR requirements. These insurers said that they have decreased or plan to decrease commissions to brokers in an effort to increase their MLRs."

As a result of these cuts, brokers servicing the individual and small-business markets are seeing their overall business revenue slashed by 20 to 50 percent. This means fewer agents and brokers will be able to afford to stay in business. It also means that the agents who do survive will have to make service cuts and will no longer be able to provide the counseling and advocacy support to their clients at the same levels as they have in the past.

It may seem that what agents and brokers do is simple—they sell insurance. But there is much more to it than that. They meet with each client and determine their specific needs, covering everything from which doctors they use to preferences regarding financial risk. With employers, they also discuss issues such as the savings that can be achieved through wellness and disease-management programs and the characteristics of a company's particular workforce. Once they have a complete assessment, they help their client find the best plan at the best price.

Once the sale is over, the agent's job really kicks in. Agents are responsible for solving all the problems that consumers may have once coverage is in place. Many times, the role of the agent is invisible, particularly to the employees of a company. Typically when workers have issues with their health coverage, they contact their supervisor or the company's human resources department. But what many employees do not realize is that to solve their coverage problems, their employer will contact the health insurance agent. Many smaller companies do not even have an HR department for employees to contact so, as the Congressional Budget Office has noted, agents and brokers often "handle the responsibilities that larger firms generally delegate to their human resources departments – such as finding plans and negotiating premiums, providing information about the selected plans, and processing enrollees."

HHS officials have made repeated public statements, including to this committee, about the valuable role licensed agents and brokers play in the health care delivery system. HHS has even recently specifically sought out the expertise of agents to try and help make PPACA-related reforms work better. The federal government's Preexisting Condition Insurance Plan (PCIP) recently decided to use and traditionally compensate health insurance agents, in hopes of increasing its meager enrollment. In just one week, several thousand agents signed up

nationwide to assist health insurance consumers with serious medical conditions find coverage. Just this past week, Director Larsen sent a letter to both the NAHU membership and all health insurance agents and brokers working with the federal PCIP plan encouraging them reach out to their small-business owner clients and help them apply for PPACA health insurance tax credits if the businesses are eligible.

Consumer need for health insurance agent and broker services is at an all-time high due to the passage of PPACA. NAHU members are spending significant amounts of time educating their clients about the new law's provisions and helping them comply with its resulting regulations. Regardless of what the final outcome of PPACA may be, the need for licensed, trained professionals to help individuals, employers and employees with their health insurance needs will always be there. So we need to make sure this industry survives.

Earlier this year, President Obama announced a new executive order aimed at removing "regulatory burdens that have stifled innovation and have had a chilling effect on growth and jobs." It called for "a government-wide review of the rules already on the books to remove outdated regulations that stifle job creation and make our economy less competitive." In his State of the Union Address, the president promised that "when we find rules that put an unnecessary burden on businesses, we will fix them." In his speech to the joint session of Congress last week, the president said, "I agree that there are some rules and regulations that put an unnecessary burden on businesses at a time when they can least afford it. That's why I ordered a review of all government regulations. So far, we've identified over 500 reforms, which will save billions of dollars over the next few years. We should have no more regulation than the health, safety, and security of the American people require. Every rule should meet that common-sense test."

I am here to tell you today that the administration has missed few big regulations along the way. PPACA-related regulations have not been part of the administration's regulatory burden review process, yet they are costing American jobs and hindering American business owners every single day. In every state, as a direct result of the new law's MLR provisions, agency owners are reporting that they are reducing services to their clients, cutting benefits and eliminating jobs just to stay in business. In some instances, they are simply closing their doors.

NAHU recently surveyed its members and found that 21 percent of independent health insurance agency owners have been forced to downsize their businesses, including laying off employees. Twenty-six percent have also had to reduce the services they provide to their clients. Many agents are no longer able to provide basic services like travelling to clients' homes and offices to walk them through the application process. Employee hours spent solving problems that clients routinely encounter with their health insurance coverage, such as resolving billing and claims issues, have also been drastically cut. Five percent of respondents who were not principals in their agencies have already lost their jobs due to producer revenue reductions caused by the MLR regulation, and agency owners report that if their compensation continues to plummet more job loss will follow.

Some health insurance carriers have held off on making commission payment changes in 2011, with the hopes that the MLR requirements might be changed. But those health insurance carriers that did *not* make commission changes for 2011 almost universally report to our membership that, unless a change is made in the MLR rules very soon, they will be forced to reduce the amount of producer commissions for 2012 and beyond. Most insurance carriers renew their agent and broker contracts and adjust their commission rates in the fall of each year. So we know that, absent immediate congressional or federal regulatory action, further cuts are on the horizon in the near-term future.

So far, the data collected by both the GAO and the NAIC shows that the majority of carriers have imposed the commission reductions on newly placed business. But a number of carriers across the country have also modified commissions for existing health insurance contracts. Commission reductions on newly placed business disproportionately hurts younger agents and brokers who are just starting out in the industry, as well as those agents who are looking to grow their businesses and enroll previously uninsured clients, since all newly generated business warrants a first-year commission payment.

It's not like the typical health insurance agent or broker has a high income to start out with either. According to the Bureau of Labor Statistics, the average income for agents and brokers ranges from $45,000 to $62,000, with entry-level agents making less than $26,000 their first year. If current commission reduction trends continue, the average health insurance broker would make around $38,000 annually. In an economic climate where job opportunities are scarce, the MLR as currently structured is causing irrevocable harm to tens of thousands of small businesses and jeopardizing desperately needed American jobs.

This is why NAHU is seeking all possible solutions – be they regulatory or legislative – to this critical problem. We need to prevent additional job losses and economic disruption being caused by the MLR regulation, and we need this relief as soon as possible.

One way to do that would be H.R. 2077, which has been introduced by Representative Tom Price of Georgia and would completely repeal the PPACA MLR provisions and the resulting regulatory requirements. This solution has merit, as MLR regulation as it currently stands is causing disruption in all insurance markets. Its immediate impact has been diminishing access to health insurance agents, particularly in the individual and small-group markets. There will also be a long-term impact as, over time, the current MLR rules will reduce the number of insurers altogether, hindering competition and raising coverage prices for every purchasing sector.

I think it is critical for this committee to recognize that the solution to this urgent problem needs to both quick and bipartisan. I am here to save agent and broker jobs and preserve individual consumer and employer access to professional health insurance advocates. I am not here to score political points. There are too many American businesses at stake.

If independent health insurance producer commissions were removed from what is currently defined as premium for MLR calculation purposes, either through federal legislative or regulatory action, it would significantly improve the dire situation that exists today.

To do just that, Representatives Mike Rogers of Michigan and John Barrow of Georgia, both of whom serve on this committee, have introduced legislation, H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011. H.R. 1206 has 120 bipartisan cosponsors, including 24 members of this committee. NAHU fully endorses this legislation, as do all other national agent professional organizations, the National Conference of Insurance Legislators (NCOIL) and the NAIC's Professional Health Insurance Advisors (EX) Task Force, a group of insurance commissioners the NAIC established last year to specifically monitor the impact of PPACA on agents and brokers, especially during years leading up to 2014.

Removing agent and broker pass-through commissions from the MLR calculation would restore economic stability for licensed health insurance advisors nationally and it would benefit health insurance consumers and health insurance markets. Exempting the pass-through fees would preserve existing cost-saving practices by the producers in the current health insurance market, furthering the intent of the PPACA MLR provisions to reduce overall spending on administrative costs. At the same time, it would preserve important operational conveniences and consumer protections for small businesses and individuals. Finally, eliminating independent producer commissions from the MLR calculation will go a long way toward providing uniform and needed relief to all health insurance markets – and the consumers who reside within them – during the transitional period as PPACA requirements are fully implemented over the next three years.

In addition to eliminating independent producer commissions from the MLR calculation, H.R.1206 also acknowledges that additional adjustments to the MLR calculation may still be necessary for certain markets in particular states. Current MLR regulation allows states to apply for an "adjustment" of the MLR standard for their individual markets for up to three years if they can document disruption to that market as a result of the MLR rules. H.R.1206 would allow states to apply for an MLR waiver for their small-group health insurance markets as well. The reasoning behind this proposal is that these two markets are intrinsically linked, so a MLR adjustment for only one of them will lead to further state insurance market instability rather than help prevent it. A waiver for just the individual market in a state will create an uneven playing field and encourage adverse selection towards that market by small business owners. As has been proven time and time again with insurance market reform efforts in the states, creating adverse selection and uneven playing fields only leads to market disruption and higher prices for insurance consumers.

While H.R. 1206 will provide the needed MLR relief, we believe the fastest way to solve this problem rests with HHS. The secretary has a great deal of statutory authority over PPACA implementation and could effect a change in this area on an immediate basis. We have asked the secretary to amend the current interim final rule interpreting the MLR requirement to properly classify agent and broker commissions as pass-through amounts, and to exclude them from the overall MLR calculation. However, since HHS officials have indicated to our association that there may be statutory authority concerns with that approach, we have also told HHS that we would appreciate an immediate hold being placed on implementation and enforcement until these matters can be resolved by HHS and/or Congress. Similar holds on enforcement and implementation have been issued for many other provisions of PPACA that would have caused a detrimental impact on American businesses.

An optimal and expedited solution to the MLR calculation problem for health insurance agents and brokers and their clients is imperative. As I have documented, the financial impact on NAHU members, their employees and their clients has already been significant and will only continue to grow. In order to help preserve consumer access to independent agents and brokers and all of the important services they provide to their clients – both at the point of sale and throughout the life of the health insurance policy – a change to the MLR calculation is urgently in order. Without an immediate fix, the current law puts American consumers, businesses and families at risk; they will be left without advocates to assist with coverage or claims problems and without professional advisors to assist in the economical selection of benefits tailored to fit their needs.

Finally, while the focus of my remarks has obviously been PPACA's MLR requirements, other panelists have addressed the impact the new law's grandfathering provisions are having on employers and individual health insurance consumers everywhere. I would be remiss if I didn't briefly speak about them too. NAHU represents tens of thousands of people who not only make a living helping people and business owners with their health insurance coverage needs , but who also purchase small group health insurance coverage for their employees. Plus, I am the CEO of an organization that purchases small group health insurance coverage for its employees. So I know firsthand how the central promise of health reform, "If you like the coverage you have, you can keep it" isn't being upheld for most Americans. PPACA's interim final rule on grandfathered plans severely limits the ability of employers and individual health insurance consumers to keep their grandfathered status, even if they wish they could do so.

I greatly appreciate this opportunity to testify, and I would be glad to answer any questions you may have. My organization and I look forward to working with you, other members of Congress and the Obama Administration to come up with an expeditious solution that will preserve the valuable role independent health insurance agents and brokers play in our health care system and prevent additional economic harm to our industry.

Respectfully Submitted,

Janet Trautwein, Executive Vice President and CEO
National Association of Health Underwriters

Testimony Summary for Janet Trautwein, CEO of the National Association of Health Underwriters

NAHU is the leading professional association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. Our members work on a daily basis to help individuals, families and employers of all sizes buy health coverage. They help their clients use their coverage effectively and make sure they get the most out of the policies they have purchased. Significantly, about three quarters of NAHU members are principals in their own small businesses and employ multiple individuals from their communities.

PPACA's MLR requirements have created a desperate economic situation for the country's half-million health insurance agents and brokers. The MLR interim final rule as designed by the Department of Health and Human Services requires health plans to treat independent agent and broker compensation as part of health plan administrative costs, even though independent agents and brokers aren't employed by health insurance carriers. Health insurance carriers do collect and remit agent and broker fees to them, but they do so as a consumer convenience and also to comply with overlapping webs of state licensing, consumer protection and premium tax laws. Not one penny of independent agent or broker compensation ever goes to a health insurer's bottom line.

The MLR provisions in PPACA were designed to ensure the appropriate use of premium revenue by the insurance companies. However two recent nonpartisan analyses of the situation clearly show that one of the key ways health insurance companies have been attempting to comply with the MLR is by cutting agent and broker fees that were never part of their revenue stream in the first place.

As a result of these cuts, brokers servicing the individual and small-business markets are seeing their overall business revenue slashed by 20 to 50 percent. This means fewer agents and brokers will be able to afford to stay in business. It also means that the agents who do survive will have to make service cuts and will no longer be able to provide the counseling and advocacy services to their clients at the same levels as they have in the past.

NAHU is seeking all possible solutions – be they regulatory or legislative – to this critical problem. We need prevent additional job losses and economic disruption being caused by the MLR regulation, and we need relief as soon as possible. It is critical for this Committee to recognize that the solution to this urgent problem needs to both quick and politically viable.

If independent health insurance producer commissions were removed from what is currently defined as premium for MLR calculation purposes, either through federal legislative or regulatory action, it would significantly improve the dire situation that exists today.

To do just that, Representatives Mike Rogers of Michigan and John Barrow of Georgia, both of whom serve on this committee, have introduced legislation, H.R. 1206, the Access to Professional Health Insurance Advisors Act of 2011. H.R. 1206 has 120 bipartisan cosponsors, including 24 members of this committee. NAHU fully endorses this legislation, as do all other national agent professional organizations, the National Conference of Insurance Legislators (NCOIL) and the NAIC's Professional Health Insurance Advisors (EX) Task Force, a group the NAIC established last year to specifically monitor the impact of PPACA on agents and brokers, especially during years leading up to 2014.

We urge Congress and the Administration to work with us to come up with an expeditious solution to this serious economic situation for brokers in order the preserve the valuable role they serve in our health care system.

Mr. PITTS. The chair thanks the gentlelady.

We are going to recess at this point. We have got about 4 minutes left. I want to thank the witnesses for their patience. We have two votes. We will be right back to reconvene after the second vote. The subcommittee is now in recess.

[Recess.]

Mr. PITTS. The subcommittee will come to order. The chairman recognizes Ranking Member Emeritus Mr. Dingell for a unanimous consent request.

Mr. DINGELL. Mr. Chairman, I have a unanimous consent request that a letter signed by Charles M. Loveless, Director of Legislation for AFSCME, be inserted into the record, and also that a statement from Representative Tom Price of Georgia be inserted into the record at this point.

Mr. PITTS. Without objection, so ordered.

Mr. DINGELL. Thank you, Mr. Chairman.

[The information follows:]

Gerald W. McEntee
President
Lee A. Saunders
Secretary-Treasurer
Vice Presidents
Ken Allen
Portland, OR
Henry L. Bayer
Chicago, IL
George Boncoraglio
New York, NY
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Columbus, OH
Kathy J. Sackman
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South St. Paul, MN
Mary E. Sullivan
Albany, NY
Braulio Torres
San Juan, PR
David Warnick
Indianapolis, IN
Jeanette D. Wynn
Tallahassee, FL

September 14, 2011

Dear Representative:

On behalf of the 1.6 million members of the American Federation of State, County and Municipal Employees (AFSCME), I am writing to express our opposition to legislation that would roll back improvements under the Affordable Care Act (ACA) that the Energy and Commerce Health Subcommittee will discuss this Thursday.

H.R. 2077 would repeal the medical loss ratio (MLR) requirements of the ACA. The MLR provision ensures that consumers get their money's worth when they purchase health insurance. The ACA requires insurance companies to spend 80 to 85 percent of premium dollars on health care services, rather than spending it on exorbitant administrative overhead, executive salaries, marketing and profits that cheat consumers out of a fair value for their premium dollar. Significantly, a recent GAO report shows that the MLR requirements is putting downward pressure on insurance premiums, encouraging insurers to become more efficient and competitive.

The Subcommittee will also discuss a draft bill that would prohibit enforcement of the interim final regulations published regarding grandfathered plans. The regulations ensure that all plans comply with certain basic consumer protections. Specifically, plans may no longer apply lifetime coverage limits, impose recessions or maintain exclusions for pre-existing conditions for children (and for adults beginning in January 2014). All plans must also cover adult children up to age 26. Additional protections under the ACA will be phased in for plans that existed on March 23, 2010, as those plans take new shape with substantial changes in benefits or costs. These phased-in benefits include free preventive care, a prohibition on annual limits or a waiting period beyond 90 days (in 2014), premium rate review and, a prohibition on discriminatory premiums based on health status and out-of-pocket maximums (in 2014).

The draft bill to be discussed by the Subcommittee would nullify all of these protections for any plan that existed before the enactment of the ACA. This effectively denies the guarantee of these patient protections to 160 million people who have employer-sponsored coverage.

Both the grandfather regulations and the MLR provide much-needed protections for consumers. We strongly urge the Subcommittee not to advance these bills.

Sincerely,

Charles M. Loveless
Director of Legislation

CML: bcr

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Representative Tom Price, M.D. (GA-06)
Statement for the Record
Energy and Commerce Committee
Subcommittee on Health
"Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations"

Thanks so much to Chairman Pitts and the Subcommittee for holding this hearing today. At a time when regulations and misguided policies of the current Administration are stifling businesses and keeping unemployment figures steady at 9.1 percent, this hearing highlights specific actions that this Congress could take to ensure individuals would be able to keep their current health care coverage and foster job growth.

Throughout the health care debate, the American public heard repeatedly, "If you like your coverage, you can keep it." Yet many provisions in the *Patient Protection and Affordable Care Act (PPACA)* directly threaten this promise. One such provision requires insurers to meet an arbitrary medical loss ratio (MLR), which was defined by regulators and Washington bureaucrats. As a result of this provision, many small and medium-sized insurance companies are finding it extremely difficult to stay in business thereby limiting health coverage choices for consumers. Not only will consumers have to find a new health plan, but individuals will lose their jobs when insurance companies have to pull out of markets because of these provisions. H.R. 2077, the *MLR Repeal Act of 2011*, would ensure that individuals can keep their current plans and maintain adequate coverage options by repealing this onerous provision.

In theory, having insurers meet a medical loss ratio may sound like an admirable requirement. However, when applied, it actually creates perverse incentives. To calculate the MLR, the Department of Health and Human Services (HHS) determined which costs would be considered administrative rather than for clinical or quality improvement purposes. Once again we see Washington bureaucrats stepping in to the health care sector to define clinical care. This is very dangerous. Additionally, included in administrative costs are funds spent to limit fraud and abuse and implement the mandatory coding change from ICD-9 to ICD-10. This creates a clear disincentive for insurers to invest in fraud prevention. And consequently, it is wholly possible that insurers could be penalized for implementing changes they are required to make.

Along with many other waivers being offered from *PPACA*, HHS will grant waivers from the MLR requirements when they determine that a state has demonstrated that application of these requirements is likely to destabilize the market (again, the federal government picking winners and losers). The agency has already granted MLR waivers to Maine, New Hampshire, Nevada, Iowa, and Kentucky—states with a combined population of over 12 million people. Seven other states have outstanding requests for a waiver. The need to grant waivers clearly demonstrates that the MLR provision is misguided at best.

Individuals should not be forced to switch their health insurer, or have more limited health care choices, because of such a misguided public policy. Neither should Washington dictate private business decisions. This is not the type of reform Americans need or want, nor is it consistent with fundamental American free enterprise.

Again, I appreciate the Subcommittee's focus on this issue. Passage of H.R. 2077 is a needed step to reduce the regulatory stranglehold the government has on health care for states, businesses, and the American people.

Mr. PITTS. Thank you.

We will go back to the panel. Mr. Potter, you are recognized for 5 minutes for testimony summarization.

STATEMENT OF WENDELL BLAINE POTTER

Mr. POTTER. Mr. Chairman and members of the committee, thank you for this opportunity to be here today. My name is Wendell Potter. I am Senior Analyst at the Center for Public Integrity and former head of corporate communications at Cigna Corporation. The views that I express today are not necessarily those of either employer.

For 20 years, I worked as a senior executive at health insurance companies. During that time, I saw how these companies confused their customers and dumped the sick to satisfy their Wall Street investors. The top priority of for-profit companies is to drive up the value of their stock. The stock price of the big for-profit insurers fluctuates based on their quarterly reports. Investors and Wall Street analysts look for two key figures: earnings per share, which is common to all companies, and the medical loss ratio, or MLR, which is unique to the health insurance industry. As you know, the MLR is the ratio between what an insurer actually pays out in claims and what it has leftover to cover executive pay, underwriting, lobbying, sales, marketing, public relations, other administrative expenses and of course profits.

Within the executive offices, there is a single-minded focus on being able to show investors and analysts that the insurer made more money during the previous quarter than a year earlier and that the portion of each policyholder's premium devoted to covering medical expenses was less than it was a year earlier. Insurers almost always see sharp declines in their stock prices when they disclose that they spent more money on medical care than investors expected. I remember vividly when Aetna's stock price fell more than 20 percent on the day that it admitted that its first-quarter MLR had increased from 77.9 percent to 79.4 percent.

Studies done by the accounting firm PricewaterhouseCoopers have shown how successful insurers have been in meeting Wall Street's MLR expectations. One such study found that the average MLR in the insurance industry has fallen from approximately 95 percent in 1993 to around 80 percent today. That translates into a difference of several billion dollars in favor of insurance companies' shareholders and executives and at the expense of health care providers and their patients.

The provision of the Affordable Care Act that requires insurers to spend at least 80 percent of what we pay in premiums on our health care is one of the most important provisions of the law and one that must be preserved. Some have suggested that if the entire MLR provision is not repealed, Congress should at least exempt insurance agent and broker commissions from the calculation, and a bill introduced by Representative Rogers would take that a step further by excusing all sales commissions including payments to salaried sales staff from the formula. To make it even easier for insurers to meet the law's requirements by exempting broker commissions is precisely the wrong thing to do.

It is important to note that even before the passage of the Affordable Care Act, insurers were planning to take steps to reduce broker commissions anyway, which they viewed already as too high. A recent filing from the State of North Carolina revealed that Coventry had reduced its commissions on first-year policies from 27 percent to 14 percent and that Cigna had cut first-year commissions from 20 percent to 12 percent. My question to brokers is this: did you really deserve 27 percent of your client's premiums?

Another point: Insurers are not being forced by the MLR provision to reduce commissions. There are other levers on the administrative side or through reducing premiums. Basically, insurance companies have been choosing to reduce commissions to protect profits. I doubt you have heard of an insurers who have reduced the salaries of their CEOs and other top executives to meet the MLR requirements. You haven't, and you won't.

Another thing to keep in mind as you consider legislation to exempt commissions from the MLR equation is that even if it were to be enacted, it is not likely to be of much help to agents and brokers now or in the future. Insurers will not restore the commission reductions they have already made. Exempting commissions would only help insurers by making it easier for them to comply with the MLR provisions.

The proposed changes to the grandfathering provision are similarly misguided. By denying the Department of Health and Human Services the ability to enforce insurance reforms on current plans, the bill would take away important consumer protections including the prohibition on lifetime limits and a ban on rescissions, a practice that lets insurers take away your coverage midyear, usually after you have gotten sick. It would also prohibit enforcement of the rule that allows young people to stay on their parents' insurance plans until age 26. This week's census figures show that this provision has already helped half a million young people get insurance. Why would Congress take away their coverage? HHS carved out reasonable limits on what plans could be grandfathered. A plan can maintain its grandfathered status until it changes its benefits or raises its costs too much. This proposal would remove those limits so every plan is grandfathered forever. This means that people will be locked into the plans that don't have the protections they are entitled to under the ACA like preventive medicines without copayments.

A final point: If you pass the bill to repeal the grandfathering provision, you will be guaranteeing that millions of Americans will absolutely be facing the loss of the coverage they have. If my insurer is able to cut my benefits and hike my premiums and deductibles, actions that in the industry are referred to as "benefit buy-downs", that means that I will not have the same coverage I had or was happy with.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Potter follows:]

Testimony of

Wendell Potter

Philadelphia, PA

Before the House Committee on Energy and Commerce Subcommittee on Health

September 15, 2011

Mr. Chairman and Members of the Committee, thank you for the opportunity to be here today.

For 20 years, I worked as a senior executive at health insurance companies. During that time I saw how these companies confuse their customers and dump the sick to satisfy their Wall Street investors. Prior to the protections of the Affordable Care Act, Wall Street's dictates determined whether millions of American families would be offered coverage, whether they could keep it, and how much they would be charged for it.

For the last decade of my insurance career, I handled financial communications for one of the country's largest health insurance corporations. I worked closely with the CEO, the chief financial officer and the head of investor relations to be able to fulfill that responsibility.

The top priority of for-profit companies is to drive up the value of their stock. The stock price of the big for-profit insurers fluctuates based on their quarterly reports, which the CEO and other executives discuss every three months in conference calls with investors and analysts. On these calls, investors and Wall Street analysts look for two key figures: earnings per share, which is common to all companies, and the medical-loss ratio, or MLR, which is unique to the health insurance industry. As you know, the MLR is the ratio between what an insurer actually pays out in claims and

what it has left over to cover executive pay, underwriting, lobbying, sales, marketing, public relations, other administrative expenses, and, of course, profits.

Within the executive offices, there is a single-minded focus on being able to show investors and analysts that the insurer made more money during the previous quarter than a year earlier and that the portion of each policyholder's premium devoted to covering medical expenses was less than it was a year earlier.

To meet Wall Street's relentless profit and MLR expectations, insurers routinely dump policyholders who are less profitable or who get sick. This very committee found during a 2009 investigation that only three insurers had canceled the coverage of roughly 20,000 people over a five-year period, allowing those companies to avoid paying $300 million in claims. To avoid paying almost a third of a billion dollars in claims, many if not most of those 20,000 people had to be seriously ill when their policies were rescinded.

Insurers also dump small businesses whose employees' medical claims exceed what insurance company underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance company to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether—leaving all the company's workers and their families uninsured. This practice is known in the industry as "purging." The purging of less profitable accounts through unreasonable rate increases helps

explain why the number of small businesses offering coverage has fallen steadily over the past several years.

Studies done by the accounting firm PricewaterhouseCoopers, which audits the books of many insurers and has authored numerous reports for their trade association, have shown how successful the insurers' expense management, rescission and purging actions have been in meeting Wall Street's MLR expectations. One PricewaterhouseCoopers study found that the average MLR in the insurance industry has fallen from approximately 95 percent in 1993 to around 80 percent today. In another study, it found that the collective MLRs of the seven largest for-profit insurers fell from an average of 85.3 percent in 1998 to 81.6 percent in 2008. That translates into a difference of several billion dollars in favor of insurance company shareholders and executives and at the expense of health care providers and their patients.

Another firm that does a lot of consulting work for health insurers, McKinsey & Company, noted in a 2007 report that the United States spent $412 per capita on health care administration in 2003—nearly six times as much as other developed countries. McKinsey also found that 64 percent of the administrative costs incurred by private insurers in the U.S. is due to underwriting health risks and sales and marketing—costs that do not occur in most other developed countries. In other words, the term medical-loss ratio is largely unknown outside of the United States.

Part of my job when I worked in the insurance industry was to explain to the media every three months whether my company met Wall Street's profit expectations—and if it didn't, why not. I had to know what was influencing the MLR and what the company had done with the billions of dollars in premiums it received during the quarter from employers and individuals.

I came to know from personal experience that insurers almost always see sharp declines in their stock prices when they disclose that they spent more on medical care than investors expected. I'll never forget the day a few years ago when Aetna's stock price fell more than 20 percent on the day it admitted that its first quarter MLR had increased from 77.9% to 79.4%. Investors were so alarmed that they began selling shares of other insurers, too, believing that if the MLR was going up at Aetna, it was probably going up at its competitors as well.

When I handled financial communications for CIGNA, I knew as soon as I saw MLR numbers for a given quarter how busy my day would be when we announced quarterly earnings. If the company spent more on medical care than investors and analysts expected, my phone would be ringing all day long from financial reporters wanting to know why the MLR was going in the wrong direction—at least from Wall Street's perspective.

I might still be in my old job had I not come face to face with the real world consequences of that single-minded focus on pleasing Wall Street by constantly pushing the MLR downward.

In July of 2007, during a trip to East Tennessee to visit relatives, I read in the local paper about something called a 'health care expedition' that was being held a few miles across the state line at the Wise County, Virginia, Fairgrounds.

Thousands of people were expected to travel from as far away as Georgia and Ohio to this three-day event to get care from doctors and nurses and other caregivers who had volunteered their time.

Out of curiosity, I decided to go check it out. Nothing could have prepared me for what I saw when I arrived.

The parking lot was jam-packed. Many people were still in their cars and trucks, having slept in them all night. Others were lying on sleeping bags and inflated mattresses on the gravel.

When the fairground gates opened at 6 a.m., the place began to look like a refugee camp in a war zone. Enormous lines of people, many of them soaked from the rain that had been falling that morning, stretched out of view.

Some of those lines led to barns and animal stalls where doctors and nurses were treating patients. Many other people where being treated in open-sided tents. Dentists were pulling teeth and filling cavities, optometrists and ophthalmologists were checking eyes for glaucoma and cataracts, doctors and nurses were doing mammograms, and surgeons were cutting out skin cancers.

That day I realized that the folks in those lines were no different from me—they could have been my relatives or my parents' neighbors. I could tell from their faces that they were people with whom I shared cultural roots, but who hadn't had the good fortune to land a high-paying job as I had.

It was clear to me at that moment that my industry, with its obsession with the MLR and the bottom line, was one of the main reasons those folks at the fairgrounds had to go to such lengths to receive basic medical care.

Until that day, I had allowed myself to believe the insurance industry's characterization of them as deadbeats and shirkers. I could not have been more wrong. These people were not shirkers—our health care system had left them behind. They simply couldn't afford to get the care they needed.

Two-thirds of the 4,000 attendees at that health care expedition that weekend were employed. Most worked for small businesses that couldn't afford to provide

coverage for their employees. Undoubtedly, some of those small businesses had been purged by their insurers because an employee had gotten sick.

Many of those folks had tried to buy policies on their own, but like one-third of all people who try, they had been turned down because of pre-existing conditions. Others had had their policies rescinded when they most needed them.

So, a few months later, I quit my job. I know now I've found my real calling, which is to explain to people—including Members of Congress—just how broken our health care system really is and how vulnerable we all are, how close we all are to joining the ranks of the uninsured because of insurers' short-term profit goals.

The provision of the Affordable Care Act that requires insurers to spend at least 80 percent of what we pay in premiums on our health care is one of the most important provisions of the law and one that must be preserved. In my view, Congress was more than benevolent to the insurance companies by allowing them to include spending on activities to improve the quality of care along with medical claims in computing their MLRs. Insurers had never done that before the law was passed. In addition, Congress exempted all taxes from the MLR calculation—a huge artificial boost to insurers' MLRs.

Some have suggested that Congress should now exempt insurance agent and broker commissions from the calculation too. And the bill introduced by Representative

Rogers would take that a step further by excusing all sales commissions, including payments to salaried sales staff, from the formula. To make it even easier for insurers to meet the law's requirement by exempting broker commissioners is precisely the wrong thing to do. I have spoken with agents who have seen their commissions reduced by insurers, and I am sorry they now have to find other ways to earn the same income as before. Many of them have, indeed, provided a valuable service to individuals and small businesses. But it is important to keep in mind that by accepting commissions from the insurers, agents and brokers are in a very real sense working for the insurers more than for those individuals and small businesses. Yes, many of them have gone to bat for their customers when they've had a dispute with their insurers, but their business model is antiquated and often not in the best interest of consumers. I believe it is time for agents and brokers to develop new business models and, while they're at it, develop a new value proposition for the people they theoretically serve.

It is important to note that even before the passage of the Affordable Care Act, insurers had begun taking steps to reduce broker commissions, which they viewed as too high to start with. Insurers are not being forced by the MLR provision of the law to reduce commissions: there are other levers on the administrative side or through reducing premiums. Basically, insurers have been choosing to reduce commissions to protect profits. I doubt you have heard of any insurers that have reduced the salaries of their CEOs and other top executives to meet the MLR requirements. You haven't and you won't.

Another thing to keep in mind as you consider legislation to exempt commissions from the MLR equation is that even if it were to be enacted, it is not likely to be of much help to agents and brokers now or in the future. If you think insurers would restore the commissions they've already reduced, you don't understand how insurers, under constant pressure from Wall Street, really operate. Exempting commissions would really only help insurers by making it easier for them to comply with the MLR provisions.

The proposed changes to the grandfathering provision are similarly misguided. By denying the Department of Health and Humans Services the ability to enforce insurance reforms on current plans, the bill would take away important consumer protections, including the prohibition on lifetime limits and a ban on rescissions—a practice that lets insurers take away your coverage mid-year, usually after you've gotten sick. It would also prohibit enforcement of the rule that allows young people to stay on their parents' insurance plans until age 26. This week's Census figures show that this provision has already helped 500,000 young people get insurance. Why would Congress vote to take away their insurance?

HHS carved out reasonable limits on what plans could be grandfathered. A plan can maintain its grandfathered status until it changes its benefits or raises its cost too much. This proposal would remove those limits, so every plan is grandfathered, forever. This means that people will be locked into plans that don't have the

protections they are entitled to under the ACA, like preventive services without co-payments. Plans would also lose the guaranteed review of premium rates that increase by more than 10 percent, putting people once again at the mercy of health plans.

Repealing the grandfathering provision would be a gift to the insurance industry. As I learned during my years in that industry, another way insurers meet the profit expectations of their directors and investors is to constantly reduce the benefits in the policies they market and to shift increasing percentages of the cost of care from them to their policyholders.

If you ever listen to an insurance company's quarterly earnings call, you will hear executives and analysts use another obscure term is unique to the insurance industry: "benefit buydown." That euphemism describes the actions insurers and their employer customers take to cut benefits and shift additional out-of-pocket costs to consumers.

If Congress repeals the grandfathering provision of the law—which was intended to protect consumers from the effects of benefit buydowns—you will be guaranteeing that all Americans with private insurance will see continued reductions in benefits and cost shifting. While advocates of abolishing the grandfathering provision might claim that it is in the best interest of consumers, in reality it will make it easier for

insurers to meet their profit goals by enabling them to dump more and more of us into the ranks of the underinsured.

Thank you for giving me this opportunity to present my testimony.

Mr. PITTS. The chair thanks the gentleman and now recognizes Ms. Quincy for 5 minutes for her opening statement.

STATEMENT OF LYNN BATES QUINCY

Ms. QUINCY. Thank you for having me here today.

My name is Lynn Quincy, and I am the Senior Health Policy Analyst at Consumers Union, which is the independent nonprofit publisher of Consumer Reports magazine, and our mission is to provide consumers with unbiased information about good services, health and personal finance.

I am here to discuss the changes, the proposed changes to the grandfathered regulations and medical loss rules called for by the Patient Protection and Affordable Care Act, and I am here to ask the committee to take a holistic look at the impact of the proposed legislation and to holistically look at its impact on consumers.

The proposed legislation addressing grandfathered plans would undermine the Affordable Care Act's consumer protections in two ways. It broadens the definitions of plans that qualify as a grandfathered plan and it calls for a blanket exemption of these plans from all Affordable Care Act requirements. If enacted, this proposal would leave many consumers worse off. You have heard many examples today already about, for example, the impact on adult children up to age 26 or the current requirement that plans all present a uniform health insurance disclosure form to consumers so that they can better understand their health plan features. If enacted, this proposal would create a bifurcated market. In 2014, consumers wouldn't have the security of knowing that all their health insurance choices provide a minimum level of coverage and have understandable and uniform caps on out-of-pocket spending. Instead, anyone with access to a grandfathered plan would have to learn two insurance markets: the one featuring the new consumer protections and the one in which none of the Affordable Care Act provisions apply.

The proposal expands the definition of what constitutes a grandfathered plan, stripping away all requirements for maintaining reasonably similar cost-sharing levels, and let us be clear about what we are talking about here when we discuss an employer's ability to lower cost. What we are really referring to is employers' ability to shift costs onto employees, and believe me, that is not what consumers want. The things that are driving health care premium increases, you have to look in other areas besides these new provisions and the MLR, and there is nothing more serious that this committee should be doing. I just returned from Wyoming, where a broker described a 10-person dental office that just received a 56 percent premium increase, and he speculated that it was due to the fact that someone in that 10-person group had contracted Grave's disease. These are the problems that you need to be addressing.

We regularly hear from consumers about their health coverage, and I would like to assure this subcommittee that we have not heard a single consumer clamoring to keep their health plan as cost sharing rises over 18 percent a year, the approximate limit at which they might have to give up their grandfathering status.

We also oppose legislation that would repeal the medical loss ratio provisions. These provisions are working to improve value for

consumers as you have already heard today. Placing a floor under health insurers, MLR is not new. Roughly a third of States have enacted rules that require plans to spend a certain percentage of their premium dollar on medical care, and that provides us with significant credible experience about how MLR regulations affect consumer and brokers, and as you have already heard, there is early evidence that the federal rule is working to improve value to consumers to address those rising premiums that are of such great concern.

We note that that the evidence with respect to overall broker compensation is mixed. You have already heard about the NAIC study and the fact that they declined to support legislation that would carve brokers' commissions out of the MLR.

Today's MLR rules provide needed transparency. Steve Larsen talked about this. And this is really important. I think this would appeal to both sides of the aisle as we move forward. We need to understand what goes into those rising premiums so we can better understand how to clamp down on them to help consumers.

Finally, today's MLR rule is not a blunt instrument as the proposed legislation would be. It provides targeted, evidenced-based relief to States. They can apply for an adjustment, as we have all discussed, and some of the States that have applied for adjustments like Maine already have an oligopoly that has nothing to with the proposed MLR rule. There are structural problems in the insurance market, to be sure, but I am not really expecting the MLR rule to contribute greatly to those problems.

My written comments go into greater detail about the benefits of our grandfathered rules and MLR rules as they exist today.

Thank you for the opportunity to speak to you.

[The prepared statement of Ms. Quincy follows:]

Testimony of

Consumers Union of U.S., Inc.,

on the

Consumer Protections Embedded in the Grandfathering Regulations and Medical Loss Ratio Requirements of the Patient Protection and Affordable Care Act

before the

U.S. House of Representatives Committee on Energy and Commerce *Subcommittee on Health*

September 15, 2011

Introduction

Consumers Union, the independent, nonprofit publisher of *Consumer Reports*,[1] is pleased to describe the consumer protections embedded in the grandfathering regulations and medical loss ratio requirements of the Patient Protection and Affordable Care Act (ACA), and to comment on the proposed legislation which would repeal these protections.

[1] Consumers Union is a nonprofit organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance. Consumers Union's publications have approximately 8.3 million combined paid circulation and carry no advertising and receive no commercial support. Consumers Union's income is solely derived from the sale of Consumer Reports and ConsumerReports.org, its other publications and from noncommercial contributions, grants and fees. In addition product testing, Consumer Reports and ConsumerReports.org regularly carry articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions that affect consumer welfare.

Expanding Grandfathering Rules Restrain Consumer Protection

The proposed legislation would broaden the definition of what qualifies as a grandfathered plan and calls for a blanket exemption from all ACA requirements. If enacted, this proposal would reduce access to valuable new consumer protections.

The ACA includes popular, new consumer protections such as health insurance that does not discriminate on the basis of pre-existing conditions, ensures families can maintain coverage for their young adults, and places a needed threshold under the coverage purchased by individuals and small businesses – all protections that grandfathered plans would not have to provide if the proposal becomes law.

Consumer Benefits under the ACA Need to be Preserved

The ACA calls for several, critically important consumer protections in private health insurance. Already enacted protections prevent insurers from unjustly dropping coverage when you get sick. The ACA aims to lower health costs by allowing for annual checkups, cancer screenings and other preventive services at no out-of-pocket costs to the consumer. New rights to independent appeals give consumers a standard, reliable way to dispute coverage decisions. New health insurance disclosures coming online in 2012 will enable consumers to make a more informed choice among their health insurance options.

Patients facing a chronic illness have new protections that reduce annual benefit limits and eliminate lifetime limits. We've seen first hand the extraordinary relief this particular provision has provided to parents like Bill and Melinda Strong whose daughter Gwendolyn was diagnosed at birth with a rare-condition called Spinal Muscular Atrophy (SMA).[2] Almost completely paralyzed, Gwendolyn requires around the clock care, frequent hospital visits, and extensive medical equipment to survive. At age 3, Gwendolyn's care easily reaches into the hundreds of thousands each year, previously putting the Strong family at risk of reaching their lifetime limit. But with the implementation of these new consumer protections, the family now can focus their concerns solely on caring for Gwendolyn and improving her quality of life.

In 2014, consumer protections greatly expand. No one can be denied coverage, you can't be charged more if you have poor health, tax credit subsidies will help consumers afford coverage and new reporting requirements will make it easier for consumers to understand and select a health plan.

Role of Grandfathered Plans in Current Law

But not all consumers have access to these benefits. The ACA creates a way for a plan to maintain a "grandfathered status" and be exempt from several of the new requirements shown in Table 1.

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[2] *The Affordable Care Act: Gwendolyn's Story*, Consumers Union, http://youtu.be/n70H3AWrax4

Table 1: Patient Protections that Apply to Grandfathered Plans, Current Law

Provision	Effective Date	Applies to grandfathered group plans?	Applies to grandfathered individual market plans?
Young adults can stay on their parents' health plans until age 26	Health plan years starting on or after Sept. 23, 2010*	YES	YES
Prohibition of pre-existing condition exclusions for children under age 19	Health plan years starting on or after Sept. 23, 2010	YES	NO
Preventive services covered with no cost-sharing	Health plan years starting on or after Sept. 23, 2010	NO	NO
Restriction on annual limits in coverage	Health plan years starting on or after Sept. 23, 2010	YES	NO
Prohibition against unfair rescissions of coverage	Health plan years starting on or after Sept. 23, 2010	YES	YES
Limits on cost-sharing for out-of-network emergency services	Health plan years starting on or after Sept. 23, 2010	NO	NO
Right to internal and external appeals of insurer decisions	Health plan years starting on or after Sept. 23, 2010	NO	NO
Medical Loss Ratio Requirements	2011	YES	YES
Uniform explanation of coverage documents & standardized definitions for health insurance terms	By March 23, 2011	YES	YES
Prohibition of pre-existing condition exclusions for enrollees of all ages	2014	YES	NO
Prohibition of annual limits	2014	YES	NO

Mary E. from Leavenworth, Wash. wrote to us describing how these new benefits are impacting her family.

> *"I love the fact that our adult children can not only stay on our insurance until they are 26, but my daughter's annual exams are actually covered now. For children that are attending college, this is a big thing for our family. I just can't imagine what we would have done otherwise. The children can't begin to comprehend the savings this has incurred for us, but us parents realize what a benefit it is to our pocket book!"*

Mary further explains how she thought her plan was good until she went for an annual check-up. She wrote, "[t]he insurance only covered $100 and I had to pay the rest. I can't afford that so I only went to the doctor once every three years. Now that preventive care is actually covered, it makes it a lot easier to be able to afford to get checked annually as recommended by your doctor." This would not be the case if her plan was grandfathered.

The Proposed Legislation Would Broaden the Definition of a Grandfathered Plan

By broadening the definition of plans that can remain as grandfathered plans, many consumers would lose access to the new consumer protections.[3] The proposal strips all requirements for maintaining a grandfathered plan at a reasonably similar cost-sharing levels. The proposal would increase the number of consumers who can't access several of the ACA's popular provisions such as phased-out annual benefit limits and access to preventive care with no out-of-pocket cost sharing (Table 1).

Access to preventive care, such as cancer screenings, is important. Data on breast cancer compiled by the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute, shows that patients diagnosed while breast cancer remained localized had a 98.6 percent five-year survival rate.[4] Patients whose diagnosis came after the cancer had metastasized had a survival rate of just 23.4 percent. Attempts to loosen the definition of a "grandfathered plan" put additional patients at risk of late or missed diagnoses due to financial barriers to preventive care.

Also problematic is that consumers in grandfathered plans do not have federally guaranteed rights to standardized internal and external appeals, potentially leaving insurers, not doctors, to make treatment decisions without sufficient opportunity for outside review.

The Proposal Would Exempt Grandfathered Plans from ALL Protections in the ACA

The proposed legislation not only broadens the definition of grandfathered plan but also expands the list of consumer protections that would no longer apply. The proposal would prevent enforcement of "any requirement or regulation that imposes any standard or requirement set forth in the Patient Protection and Affordable Care Act...on a grandfathered health plan." **Under this proposal not only can a plan change, for example, from a $500 deductible to a $10,000 deductible without losing grandfathered status, but popular provisions currently in place and working for consumers will be stripped.** A recent census report shows that new rules allow dependents up to age 26 to remain on their parents' coverage have expanded access to health insurance for approximately 500,000 additional young adults.[5] These benefits, and several others, are simply gone under this proposal.

Current Law Defining Grandfathered Status Aligned with Consumer Preferences

We believe the regulations set forth by the Department of Health and Human Services (the Department) appropriately address this issue in the spirit of the ACA and in the

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[3] Interim Final Rule on Grandfathered Plans, June 17, 2010, available at http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf

[4] *National Cancer Institute*, http://seer.cancer.gov/statfacts/html/breast.html#survival

[5] *Department of Health & Human Services,* Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey, http://aspe.hhs.gov/health/reports/2011/CPSHealthIns2011/ib.shtml

interest of protecting consumers. These rules create a reasonable path to maintaining a "grandfathered status," helping consumers keep the plan they have and like, and allowing for exemptions from providing all of these new benefits.[6]

We constantly receive complaints of rising premiums, lost benefits, and drastic cost-sharing increases. **We've yet to hear from any of those same consumers arguing to keep a plan after coverage has been reduced or premiums increased.** Here are a few examples of the thousands of complaints we've received:

Sharon M. from Morganton, NC –

> *My insurance is thru my employer, but it none-the-less* [sic] *increased outrageously this year. A number of things doubled in cost: such as generic prescriptions and the deductible. Non-generic prescriptions cost 10 times as much as generic prescription. A doctor visit costs nearly twice as much and a specialist doctor costs greater than 300% more. I recently paid $50 to see a specialist and the insurance company only had to pay $19.03. Very lop-sided! The yearly co-insurance amount also increased significantly. I can't afford as good of health care as I was accustomed to."*

William E. from Double Oak, TX –

> *"My employer went from a PPO plan that it paid 100% premium to a high deductible HSA. This has forced us to delay in seeking medical attention except in extreme cases and the low contributions do not cover all of the out of pocket expenses for the year. More needs to be done to make insurance affordable to families and individuals. There is too much focus from congress on repealing the gains in health care reform. The focus needs to be made on making health care affordable and available."*

There is no evidence that shows consumers are clamoring to keep the plans they have when premiums are drastically increased or benefits substantially reduced. Current law is aligned with consumers' preferences. Table 2 lists the requirements that employers and plans must meet to avoid losing a grandfathered status under current law.

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[6] Op. Cit., Interim Final Rule on Grandfathered Plans

Table 2: Plan Changes Resulting in Loss of Grandfathered Status

Plan Component	Disqualifying Change
Copayment	The greater of an increase of more than $5 (adjusted for medical inflation since March 23, 2010) or an increase above medical inflation plus 15 percent.
Deductible	An increase above medical inflation (since March 23, 2010) plus 15 percent.
Out-of-pocket Limit	An increase above medical inflation (since March 23, 2010) plus 15 percent.
Co-insurance	Any increase in the co-insurance rate after March 23, 2010.
Annual Limit	Any decrease of an annual limit that was in place on March 23, 2010 or adoption of a new annual limit for plans that did not have one on March 23, 2010.
Employer Premium Contribution Rate	A decrease of more than 5 percentage points below the existing employer contribution rate as of March 23, 2010.
Benefits Package	The elimination of all or substantially all covered benefits to diagnose or treat a particular condition after March 23, 2010.

The rules create ample opportunity for employers to adjust cost-sharing to keep pace with the rising cost of health care. The rules allow a 15 percent increase above medical inflation for co-pays, deductibles, and out-of-pocket limits, creating generous flexibility for employers to maintain their grandfathered plans and avoid offering new benefits.

Given medical inflation of between 3 percent and 4 percent over the last three years, plans can increase cost-sharing by at least 18 percent without losing their grandfathered status.[7] Furthermore, rules allow plans to maintain annual limit provisions and employers can shift up to 5 percent more of the monthly premium onto employees.

Expanding Consumer Protections has had a Minimal Impact on Premiums

Federal agencies estimated that ending annual and lifetime limits will increase group premiums by about 1/2 of 1 percent and will increase non-group premiums by less than 1 percent.[8] Prohibiting pre-existing exclusions for children is estimated to have a negligible impact on group premiums and at most a 1 percent impact on non-group premiums.

A recent Anthem BCBS rate filing for individual market products in Connecticut shows that new protections from unjust rescissions have had no impact on premiums, ending lifetime limits have also benefited consumers without raising costs, and increasing coverage to young adults up to age 26 has resulted in just a .2 percent increase.[9]

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[7] Bureau of Labor & Statistics, *Consumer Price Index*, http://www.bls.gov/cpi/#tables

[8] Department of Treasury, Department of Labor, Department of Health and Human Services. "Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections." *Federal Register*, June 28, 2010. Available at: http://www.urban.org/uploadedpdf/412128-PPACA-impact.pdf

[9] Anthem Blue Cross Blue Shield of Connecticut, Individual Market Rate Filing, August 2011, http://www.catalog.state.ct.us/cid/portalApps/images/reports/005257351.pdf

Reject Proposals that Undermine Well-Balanced Grandfathering Rules & Reduce Consumer Protections

The proposed legislation not only erases a balanced approach to defining grandfathered plans, but reduces access to consumer protections that provide value for premiums and protect consumers from insurance industry abuses.

Consumers Need Medical Loss Ratio Provisions

Consumers Union strongly opposes any legislation that would repeal the Affordable Care Act's Medical Loss Ratio (MLR) provision. MLR is a measure of the amount of a premium dollar that goes to pay for health care as opposed to administrative expenses. A high medical loss ratio provides consumers with more value for their money. There is already evidence that the rule is working to improve value for consumers and little evidence to suggest it is having a negative impact on jobs.

MLR Rules Are Not New

The MLR requirements are not new. Approximately one-third of states have enacted similar provisions, providing us with significant experience with how MLR regulations affect consumers and brokers.

Consumers, Particularly in Non-group Market, Have Had Poor Return for Premium Dollar

To evaluate the impact of the ACA's MLR provisions, it is important to understand the problem policy makers were addressing in enacting the measure. While many plans had an MLR of 80 percent in the individual market and 85 percent in the large group market even before passage of the law, much variability existed in the marketplace. There have been instances of plans with loss ratios of as little as 46 percent, meaning those plan members only got back less than half of their premium dollar in the form of health care, an extremely poor return for their premium dollar.[10]

Current Law Provides Improve Transparency on Health Plan Value

In addition, MLR reporting requirements for plans will provide consumers with new information about how their dollars are being spent. Today, many consumers have no idea how well their dollar is being stretched because they don't know the proportion of their premium dollars that is returned to members in the form of medical care or quality improvement.

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[10] Minnesota Department of Commerce, Report of 2010 Loss Ratio Experience in the Individual and Small Employer Health Plan Markets (June, 2011), http://www.state.mn.us/mn/externalDocs/Commerce/Current_Loss_Ratio_Report_052104013421_LossRatioReport.pdf

As part of discharging its duties under the Affordable Care Act, the National Association of Insurance Commissioners (NAIC) now collects a new Supplemental Health Care Exhibit (SHCE) as part of its annual reporting requirement for health plans. The SHCE collects data about premiums and medical claims necessary to calculate the MLR. It will provide a wealth of information about how insurers spend consumer dollars, including the amount of premiums plans take in, the amount plans spend to improve health care quality, total incurred claims, and the amount spent on agent and broker commissions.[11] The ACA requires the Secretary of HHS to post information about insurers' MLR on the Internet.[12]

MLR Has Lowered Premium for Consumers

The current MLR rule has already caused insurers to scale back their premium rates. In just one example, Aetna lowered rates by as much as 19 percent for 15,000 Connecticut customers to bring premiums in line with the MLR rule.[13] The GAO reports that other insurers plan to either reduce premiums or fail to increase them.[14] Another Connecticut carrier acknowledged the MLR rule as a factor in lowering its rate increase request.[15]

MLR Has Had No Impact on Consumer Access to Brokers

The NAIC report found that consumers in states with state-enacted MLR requirements continued to have access to brokers.[16] It is important to note that under the ACA formula for MLR, it is easier for health plans to achieve 80 or 85 percent, compared to more traditional formulations.[17, 18]

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[11] National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, *Report on Options for Amending the Medical loss Ratio Formula to Address Concerns About Access to Agent and Broker Services* (June 19, 2011) p. 20.

[12] Public Health Services Act, § 2718(a)

[13] Matthew Sturdevant, *Aetna Seeking 10 Percent Price Decrease As Medical Spending Falls*, May 12, 2011

[14] U. S. Government Accountability Office, Private health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements, p. 18.

[15] *Anthem Proposes 12.9 percent rate increase*, The Connecticut Mirror (Sept. 2, 2011) http://www.ctmirror.org/story/13806/anthem-proposes-129-percent-rate-increase

[16] National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, *Report on Options for Amending the Medical loss Ration Formula to Address Concerns About Access to Agent and Broker Services* (June 19, 2011).

[17] U.S. Government Accountability Office, *Private Health Insurance: Early Experiences Implementing New Medical Loss Ratio Requirements* (July 2011) p. 5.

[18] Traditionally, the MLR was calculated by dividing the amount paid out in medical claims by premium revenue. The PPACA MLR allows insurers to count quality improvement as part of medical claims, raising the numerator relative to the old MLR formula. At the same time the PPACA formula lowers the denominator by allowing insurers to deduct state and federal taxes. Thus, an insurer's MLR will be higher under the PPACA MLR definition, making it easier to meet the 80 or 85 percent requirement than it would be under the traditional formula.

Targeted Relief is Available to States

The ACA allows the Secretary to adjust the MLR standard for a state if meeting the 80 percent Medical Loss Ratio standard would destabilize the individual market in that state.[19] HHS provides a mechanism for states to apply for adjustments, but they must provide evidence that it will destabilize their market.[20] More than a dozen states/territories have applied for adjustments and HHS has granted some and denied others, using a targeted, evidence-based process. Contrary to the criticisms that the adjustment process demonstrates the law does not work, this actually is evidence that the law is working *as intended.* Other flexibility in the law allows for "creditability" adjustments for smaller plans that often experience greater variability in their claims experience than larger plans, effectively lowering the threshold that they face.

Potential Rebates to Consumers

Plans will be required to rebate to consumers if they spend more on administrative expenses than is allowed under the rule. The NAIC modeled the impact of the MLR rule, had it been in effect for 2010, and found that consumers would have seen rebates of nearly $1 billion dollars in the individual market alone.

Table 3: NAIC Estimates of Rebates Paid to Consumers if the Current MLR Law Had Been in Effect in 2010

Market	Premiums Paid ($ millions)	Estimated Consumer Rebate ($ millions)
Individual	$25,311	$978
Small Group	$70,255	$447
Large Group	$154,959	$526
Total	**$250,525**	**$1,951**

We note that the purpose of the MLR is to make plans more efficient and to have them return an appropriate share of the premium to consumers in the form of medical care and quality improvement. Many analysts believe, and early evidence suggests, that plans will respond in this manner, as opposed to paying the estimated volume of rebates. Consumer benefit is even greater under this scenario, as it accrues to consumers earlier in the process.

MLR Impact on Brokers

We know that brokers and agents have been expressing concern about the impact of the MLR on their commissions. While we understand the fear brokers have about change the health reform law will have on their business it is important to note that evidence on the impact of the MLR on brokers' *overall compensation* is so far scant.

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[19] Public Health Services Act, §2718(a)(2)(c)

[20] The Center for Consumer Information and Insurance Oversight, http://cciio.cms.gov/programs/marketreforms/mlr/index.html, downloaded September 13, 2011.

The recent NAIC inquiry into the effect of the MLR on broker commissions was inconclusive; so much so, that NAIC declined to support legislation that would carve out brokers' commissions from the MLR. The NAIC found that while some insurers have reduced broker commissions particularly in the individual market, "a significant number of companies" did not reduce commissions in 2011.[21] It is also unclear how much the MLR is contributing to lower broker commissions. The NAIC found that some carriers have been shifting their compensation structures away from percentage commissions to other payment arrangements, which may have the impact of putting downward pressure on brokers' compensation.[22]

Structuring broker commissions as a percentage of premium--in an era of rapidly increasing premiums—appears to have provided brokers with higher commissions that bear no relationship to increase in their workload. As such, a shift to other payment arrangements may well represent a needed correction to fees that have accelerated unreasonably. The large expansion in private coverage expected in 2014 is likely to increase demand for brokers' services. Even today, brokers have new outlets for coverage due to the small business tax credit.

The MLR Should be Retained

Proposals to repeal or weaken the MLR rule should be rejected. These proposals would raise premiums for consumers. In 2014, that means increasing the need for tax-payer financed subsidies. The current law MLR provision is working and should be retained. The current MLR rule is providing a value for consumers in the form of lower premiums and more medical care for their premium dollar.

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[21] National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee, *Report on Options for Amending the Medical loss Ration Formula to Address Concerns About Access to Agent and Broker Services*, June 19, 2011, p. 3.
[22] *Ibid*, p. 6

Mr. PITTS. The chair thanks the gentlelady. Thanks to all the witnesses for their patience. We will now begin the questioning from the members, and I will begin by recognizing myself for 5 minutes for that purpose.

Ms. Trautwein, some argue that insurance agents add no value to the system are simply overhead in the system that can be eliminated at the stroke of a pen or regulation. Can you elaborate on the role agents play in our health care system?

Ms. TRAUTWEIN. Absolutely. Well, first of all, it is true that agents do help people secure health insurance coverage. They counsel their clients on the appropriate types of coverage, what is available in the market, what they can afford, both individuals and businesses. But where their jobs really kick in is after that coverage has been placed because if there is a claims issue, if there is a billing issue, if there is a question about a regulation, and I can tell you right now, our members are very busy advising businesses in that area, any of those things go through the broker. In fact, I saw a recent study from SHRM, which mainly serves larger businesses, that the primary place that they are getting their information about health reform comes from their broker. And so things like that, advice on compliance, on regulations, taking care of clients, and I mentioned this during the last hearing, but this issue of taking care of claims is significant. When I was a broker some 20 years ago, I never, ever had any of clients have the need to go to the appellate process through their insurer because we were able to address it quickly, and that is what our members and other brokers do every day.

Mr. PITTS. Thank you.

Ms. Turner, can you explain how the grandfathering rule diverts the resources of employers towards more expensive health coverage and away from capital investment, wage increases and job creation?

Ms. TURNER. Well, as I have mentioned in my testimony, if employers are not able to stay within the grandfathering provisions and they are required to provide a number of other consumer protection such as no out-of-pocket costs to employees for preventive care, for example, this is going to increase the cost of health insurance and so that is why I feel there is really sort of a catch-22 for employers, that they find that they need to make changes in order to keep their costs down, but if they make those changes, then they are subject to another list of rules through PPACA. And these do divert capital and I think it really is important, as Ms. Quincy was saying, we really do need to take a holistic look, that employers—and I have been a small business owner for 30 years or running small businesses for 30 years, you don't look at things in silos. You look at the bottom line, and if health care costs are rising, then you are going to have to figure out what can you do on the other side, and sometimes you don't hire that extra worker or you don't buy that new piece of equipment. So it really does impede employers' ability to make the right decisions for their business.

Mr. PITTS. Thank you.

Mr. Haislmaier, in December of 2009, the Congressional Budget Office released a paper stating that a legislative proposal to set an MLR of 90 percent would make health insurance an "essentially

governmental program" in combination with PPACA's other provisions. Do you believe that a slightly lower MLR of 85 percent like the one included in PPACA will give the federal government functional control of private health insurance in America?

Mr. HAISLMAIER. I don't know that the percentage makes as much difference as the structure of the regulatory design. As I pointed out in this regulation for minimum loss ratios but also coupled with the other regulations, the additional benefit requirements, the rate reviews, etc., do shift the industry to a regulated utility model. In fact, it is interesting that President Clinton's health advisor, Sara Rosenbaum, who, you know, is well known in this area, wrote a piece in defense of the individual mandate that essentially argued that well, yes, the individual mandate—she was—I am not, you know, talking about the legal question about the individual mandate but she basically made the point in that piece, I think it was for the Journal of the American Medical Association or New England Journal, that this design in PPACA turns insurers into a regulated public utility, and I agree with her on that. What didn't discuss is the economics of a regulated public utility and the economics are in that world, as a competitor, you either want to be, you know, too big to fail. You want to be one of the last two or three left that yes, you are going to be regulated but they can never put you out of business because they need you to be in business or otherwise people don't get the service. That is why people scream about, you know, power companies that we had this with the storms but they never actually drive them out of business. Well, once you get to that kind of a world, you don't care what the costs are, you just pass them through because your customers have no other choice, and that is the world we are headed to with these regulations. So yes, I see that happening.

Mr. PITTS. Thank you. My time is expired. The chair recognizes the Ranking Member Emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. First, I would like to compliment you, Ms. Quincy and Mr. Potter, for your very fine statements. Thank you.

This question is to Mr. Potter. The law requires health insurance companies to pay rebates if they spend fewer than 80 to 85 percent of their customers' dollars on health care and quality improvement activity. The Department of Health and Human Services estimates that the new minimum MLR law will result in consumer rebates to as many as 9 million people, up to 1.4 billion in the 2011 plan year and up to 1.49 billion in the 2011–2013 plan years. Agents and brokers are heavily lobbying for special exemption for being included into the medical loss ratio calculation. The fact is, some agents and brokers are really providing valuable and helpful services, and I have to agree with that statement. But they, like other costs within the insurance products, they should compete and keep costs competitively low as possible for consumers. At a time when everybody is being asked to tighten their belts and find and create efficiencies, asking for an exemption from these pressures, particularly at the expense of consumer pocketbooks, is not something that I think the consumers will take kindly to.

Mr. Potter, would you please talk to us about the dangers of exempting agent and broker commissions from the medical loss ratio

calculations and what types of commissions that they have been getting over the past years?

Mr. POTTER. Thank you, Congressman. Yes, if they are exempted, it will be, as I said in my testimony, really a gift to the insurance industry because it will give them just one more way that they can meet regulations that they could already be meeting if they were to reduce benefits, reduce premiums, or if they reduced spending in many other areas of spending. McKinsey and Company did a study a few years ago showing where most of these companies' administrative costs really are, and they are in underwriting, they are in sales and marketing and things of that nature. So my own salary, for example, was an administrative expense. In fact, I was talking to someone in France not long ago who said my job was unknown in the French system, and I can understand that.

But there are a lot of other places where cuts can be made, and yes, I agree with you, I think agents and brokers have indeed provided in many cases good value to the people they serve but they do get their income from insurers and they have been paid handsomely, and I think that they should be expected to give up some—you know, to sacrifice just as much as everybody else.

Mr. DINGELL. Thank you. I have a bunch of questions, and I apologize. I don't mean to curtail your testimony.

Ms. Quincy, Consumers Union expanding the consumer protections indicates that this has had a negligible impact on premiums. My colleagues on the Republican side claim that this is an enormous burden to health plans and employers and use that as a rationale for repealing key elements of the Patient's Bill of Rights for many people. First, and these are yes or no, if you can please, do you agree that the new consumer protections are imposing a huge burden on health plans and employers, or not?

Ms. QUINCY. I do not.

Mr. DINGELL. OK. Do you have any estimates or examples of how much these provisions would cost?

Ms. QUINCY. Yes. I would like to refer the committee to my written testimony, if I can find the page. We provided, I think, three or four sources that cited some actuarial estimates about what the cost of the various consumer protections are, and—I think have to go one page further to get there. Here we go.

So in the written testimony, I talk about the fact that federal agencies have estimated that ending annual lifetime limits will increase group premiums by about a half of 1 percent and will increase non-group premiums by less than 1 percent. Prohibiting preexisting exclusions for children is estimated to have a negligible impact on premiums. A recent Anthem Blue Cross Blue Shield filing for the individual market in Connecticut shows that the new protections from unjust rescissions have had no impact on premiums, and ending lifetime limits has also benefited consumers without raising costs, and for the sources for those statements, I refer you to the written testimony.

Mr. DINGELL. Thank you.

Now, Mr. Potter, very quickly, can you discuss insurance company practices with regard to individuals whose preexisting conditions prior to the passage of the Affordable Care Act and what can we expect since the passage of these new protections? In other

words, what it is going to do to costs, what is it going to do for consumers, what is it going to do to industry?

Mr. POTTER. Insurance companies for many years have refused to sell coverage to people with preexisting conditions, and it is something that continues to go on right now, except for children. That already has gone into effect. A Chattanooga newspaper recently disclosed that Blue Cross and Blue Shield Tennessee, a nonprofit, supposedly, refused to sell coverage to about one-third of applicants, largely because of preexisting conditions. It is the leading reason why we have now more than 50 million Americans without coverage, and it doesn't matter whether you are rich or poor.

Mr. DINGELL. You just don't get insurance if you have a preexisting condition.

Mr. POTTER. Exactly. If you have a preexisting condition, you are just out of luck, even if you were born with that preexisting condition.

Mr. DINGELL. Now, I guess my time is expired, Mr. Chairman. Thank you.

Mr. PITTS. The chair thanks the gentleman and recognizes the vice chairman, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

You know, I have done a lot of thinking this summer about the summer of 2009 when we all went home after this committee passed H.R. 3200, which was the House version of the health care bill. That version has died a natural death and Harry Reid's version is the one that was signed into law by the President. But the things I remember being asked at those town halls, and they were difficult and they were loud and they were long and they were hot, but those town halls, people said first off, don't do anything that is going to mess up the system that exists and works for arguably, 60, 65, 70 percent of us. We didn't do that. We screwed it up. Witness the large number of waivers that are in effect now and people concerned about issues like grandfathering. And the other thing they asked, and they were really clear on this, was can you do something to help us with cost because we are concerned about the cost of health insurance.

And then I looked around the country. The one place where really cost had been addressed in a very effective way was the State of Indiana and Governor Mitch Daniels with his Healthy Indiana plan, and for the life of me, I don't know why we did not subpoena him and bring him to this committee and chain him to the chair until he spilled the beans as to how he was able to hold health care costs for his State employees down by 11 percent over the previous 2 years.

So Ms. Turner, you are familiar with Governor Daniels' plan. Can you very briefly encapsulate what is embodied in that?

Ms. TURNER. Well, Governor Daniels and particularly the Healthy Indiana plan, but he also has incentivized State employees to enroll in consumer-directed plans, and what he has recognized is that if you engage consumers as partners and really giving them more information so they have the ability to make decisions and to use better information to make better decisions, that they really will become partners in helping to manage costs, and we have seen it across the board.

I have a section in my testimony when I talk about a new study by the National Business Group on Health and it found that companies that offered account-based health plans, whether health savings accounts or health reimbursement arrangements, had costs that were $900 lower on average for individuals and $2,885 lower for families. So the reason that the number of employees that have joined these plans is rising is because they really do help to hold down costs and employees become partners. They are more likely actually to use preventive services when they have a health savings account than they are in regular insurance because, as one said, I realized that if I take better care of myself, I will save money in the long run. So they provide the right kind of incentives and transparency and give employees an incentive to be partners in managing costs.

Mr. BURGESS. Now, as I understand for Governor Daniels' plan for State employees, he actually funds the health savings account that is associated with that high-deductible plan. Is that understanding basically correct?

Ms. TURNER. Yes, and they put money into the health savings account and with the Medicaid expansion, their Healthy Indiana plan, both the State and the individuals share in funding that account so they really do have a stake.

Mr. BURGESS. And of course, the phrase I have heard associated with that is something magic happens when people spend their own money for health care, even if it wasn't their own money in the first place.

But perhaps Mr. Haislmaier and Ms. Turner, you can talk about how the MLR regs affect consumer-directed health plans and perhaps the one place we should have gone that we didn't go in the health care law. What is the future ahead for consumer-directed health care under the MLR?

Mr. HAISLMAIER. Well, this is one of the areas where as your colleague, Representative Cassidy, pointed out, there are some problems with the way the statute was drafted because it didn't take into account the fact that if you have a consumer-directed plan where of the total spending that the individual is doing, more of it is going directly from the individual to the provider and less through the insurer, then the insurer for that portion that they are handling is going to have, by necessity, higher administrative costs and are going to be penalized for that product design. So it is correct that it will favor product designs that are more comprehensive, meaning that more of the total spending goes through the insurer's hands.

There are other places that practitioners in this area have encountered. I remember this from a former colleague who was a Democratic insurance commissioner and saying that one of the problems that they ran into is they are running into things like when you have overseas employees and you provide them medical care, if you want to send somebody to be an oil worker in Nigeria or something, you know, you are not only going to have to pay them well but you are going to have to make sure—they are going to be worried about, well, hey, you are sending me off to work on an oil platform in some Third World country, what happens if something happens to me medically. Well, these are not adminis-

tratively cheap plans to run because you are going to have to airlift them out of there, you are going to have to do this all other stuff. So under the MLR, those plans are disadvantaged. The other thing—I mean, you just keep compounding this. This fellow was pointing out to me, he is in insurance law practice no, was another client where it was a church that had missionaries who aren't employees but they are providing them with health benefits, so how does that get handled. So you have got a lot of problems in this.

You know, I could just make one point because I think it is really important to understand that disclosing, as I said in the testimony, this information is fine, OK. If you want to put this information out, States already have the data to do that, and I think States should put it out and let the consumer say, you know, this is one more piece of comparative information. It is only when you set a standard that says well, you have to do this, you have to do this minimum, that you create these problems.

So I would present to you a hypothetical, and let us just think about this, if you will indulge me. We have two—let us take two insurance plans, two situations. We will call them A and B, OK? Under both scenarios, the plans cover the same benefits, OK, so there is not a difference in lesser benefits or more benefits. Under both scenarios, you are going to pay about a thousand bucks for out-of-pocket deductible and copays. Plan A charges $5,000 and has an 80 percent medical loss ratio, meaning $1,000 is retained and $4,000 goes to paying claims. Plan B charges $4,000 and has a 75 percent ratio, meaning they keep $1,000 and $3,000 goes to claims. Which is the better buy? Do you buy the plan with the higher loss ratio but $1,000 lower premium or do you buy the plan with the lower loss—I am sorry—the better loss ratio under this scenario but is $5,000 more expensive? You see, those are the kinds of decisions a consumer has to make. As a piece of information, that is fine, but when you say everybody has to fit into this box, you have a problem.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. The chair thanks the gentleman and recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minutes of questioning.

Mr. CASSIDY. Mr. Potter, if I have been smiling at you the whole time, it is nothing inappropriate. I am reading Harry Potter to my 10-year-old right now, so we spent 15 minutes on the phone last night. She would be disappointed you don't have a scar on your head.

You know, I read your testimony. It is very compelling. But you could want to remove power from insurance companies and not necessarily be for the ACA. That is a fair statement. And one of the reasons why I like consumer-driven health care is because it truly moves the locus of power from a bureaucrat, whether it is Washington, D.C., or elsewhere, to the consumer. You are the numbers guy. You are the fellow who used to help an insurance company look at things. Looking at your testimony—and your testimony was almost an insurance company as an organic organism which is going to move to maximize profits. Let us take Mr. Haislmaier's assertion. This MLR seems to reward companies that sell higher-priced policies because your 15 percent of a higher-

priced policy is a greater absolute amount than 15 percent of a lower-priced policy, and again, the consumer-driven health care plan, you don't start paying claims until someone is paid their HSA and their out of pocket and then you move into it. So just your thoughts on that. I mean, again, looking at your testimony, it seems that—I would draw from that that they would react in such a way as to preserve their profit margin, which means that they would be prejudiced towards a higher-priced policy.

Mr. POTTER. You have to consider the cost of insurance, including the cost of what you have to pay out of pocket. If you just keep premiums in isolation, then it skews what is really the obligation of the person who has that policy. Another point too is that——

Mr. CASSIDY. No, but I don't follow how that answers my question, and no offense, but I don't see—again, my assertation is that if you artificially restrict MLR and not account for the absolute, as Mr. Haislmaier's example, we have a cheaper policy, $4,000, but if it is a thousand bucks for administrative costs, that is 25 percent MLR. We are prejudiced against that policy towards one which is $5,000 and now meets this artificial MLR requirement. Would you disagree with the example he just gave?

Mr. POTTER. I would.

Mr. CASSIDY. I don't follow why.

Mr. POTTER. Because again, you have to consider the value that the person has in the policy. If you are paying a certain premium, yes, there is no doubt, the account-based plans typically have a lower premium but there is great cost shifting from the employee or the insurer to the——

Mr. CASSIDY. Now, there is a Kaiser Family Foundation study either there or CRS or GAO, I forget which, which shows that those who have consumer-driven health care plans with an HSA have $500 extra out of pocket relative to a traditional policy, but because their premiums are 25 to 30 percent cheaper, net they are $2,000 ahead. So they also found that those patients with HSA and a high deductible accessed preventive services as frequently as do those who have a traditional policy. They also found that 50 percent of those in this particular survey—I am remembering, so I may have it a little wrong—were previously uninsured, costs lower by 25 to 30 percent. Previously uninsured people now have the ability to purchase insurance and they are accessing preventive services as frequently as those who have traditional policies. That sounds like a good value to me.

Mr. POTTER. It is for some people but some of the other studies you might have seen too show that many people who are in these kinds of accounts don't have the money to meet that deductible. A lot of employers are benevolent and they do provide some money to pay that deductible. People who are in the individual market like my son don't have that ability. He had to buy—he was forced to buy a high-deductible plan——

Mr. CASSIDY. How old is your son?

Mr. POTTER. He is 28.

Mr. CASSIDY. Now, reasonably speaking, a 28-year-old without a chronic medical condition made a wise financial decision, correct?

Mr. POTTER. Here is what happened. He was told that he would have to be moved out of his plan, which had a $500 deductible, to

one that had a $5,000 deductible or his premium would go up 67 percent, and my son has asthma and so yes, he is going to be paying quite a bit out of his own pocket. He doesn't have a very——

Mr. CASSIDY. But what was his savings on his insurance policy? Because net, if he paying $3,000 less——

Mr. POTTER. Two dollars and 12 cents a month was his savings, but he is facing a deductible that is 10 times as much.

Mr. CASSIDY. No, I am sorry. That is $2,000 relative to his previous savings but it is more than $2.20 to what his premium would be. I guess that is my point.

Mr. POTTER. The math is that by moving out of the plan that he was in to the one that he moved into, yes, his premiums were about the same, actually maybe $2 less, but his deductible, his total out-of-pocket expenses over the year is considerably more.

Mr. CASSIDY. I guess I am a little confused, because if he had stayed in his previous policy, his premiums would have been substantially more.

Mr. POTTER. That was not available to him. He was forced out of that plan, just as I was a few years ago, Congressman. I worked at Cigna for quite a few years, and I had a plan that I liked. It was a PPO. Cigna decided, didn't ask me, Cigna decided that it would move me and every other employee out of the PPO or the HMOs into an account-based plan. For me and for the CEO and for the executive board of GE, that is perfectly fine, but most of the employees of Cigna make far, far less than——

Mr. CASSIDY. We are almost out of time and we are about to start getting the clunk on us, but let me just respond again. The Kaiser Family Foundation study suggested that most people with HSAs have modest incomes, $75,000 or less, and that their out-of-pocket, their global costs decrease over the year by a couple thousand dollars, and again, they are accessing preventive services as well. I would be interested if you have data which shows—and this will have to be an off-the-record answer—that shows there is any difference in incomes, because people point to the anecdotes but I don't find that there is any data on difference in outcomes.

Mr. POTTER. Yes, you are right. We could take a look at that more closely, but I think people who are healthier do gravitate toward these plans.

Mr. CASSIDY. I think the data shows that even people now who are not as healthy or doing as well——

Mr. POTTER. Because they are being forced into these plans against their own——

Mr. CASSIDY. No, but I am talking about outcomes and their pocketbook.

Anyway, I think we are out of time. Thank you.

Mr. BURGESS. [Presiding] The gentleman's time has expired. The chair recognizes the Chairman Emeritus for a follow-up.

Mr. DINGELL. You are most kind, Mr. Chairman. Thank you.

This goes to Mr. Potter and Ms. Quincy. Our colleagues on the other side of the aisle are portraying the discussion draft as a means for Americans who like their health coverage to keep it. In fact, the legislation is much broader. The real intention appears to be to eliminate the insurance reforms enacted by the Affordable Care Act and to put insurance companies, not patients, back into

control. Would it be accurate to say that this legislation is another way to repeal health reform, and am I correct in my first assumption? Yes or no.

Mr. POTTER. Yes.

Mr. DINGELL. Ms. Quincy?

Ms. QUINCY. It would greatly undermine the various provisions of the Affordable Care Act that are expected to work together.

Mr. DINGELL. Good. Now, does the legislation that we are discussing here allow patients to keep their insurance if they like it, as claimed by my Republican colleagues, or are the insurers really in charge of being allowed to cut benefits, increase cost sharing and make other changes? Which is the case?

Ms. QUINCY. If the discussion draft were enacted, it would permit tremendous latitude with respect to self-insured employer plans and insurers to make changes in benefits, some of which would certainly include cost shifting to employees.

Mr. DINGELL. Mr. Potter?

Mr. POTTER. Absolutely. As I said in my testimony, if you pass the repeal, the grandfathering, you can absolutely guarantee that people who have coverage now, their coverage will change significantly in the near future, if not the long term.

Mr. DINGELL. Now, as I understand this, what we are essentially doing is setting up two categories of insurance carriers. The first category would be those who are grandfathered. The grandfathered plans would be able to do most anything they want and achieve strong competitive advantage over the latecomers, who would not have that privilege. Am I correct?

Mr. POTTER. Yes.

Mr. DINGELL. Is that right, Ms. Quincy?

Ms. QUINCY. Yes.

Mr. DINGELL. And that would lead then to very significant advantages to the first category and a strong discouragement to the second category going into this business. Is that right?

Ms. QUINCY. Well, my greatest fear would be the segmentation of risks since this hugely different—since two different insurance markets exist side by side. I think that is the greatest danger.

Mr. DINGELL. And you would tend to see all the bad business being shoved into the second category that weren't grandfathered. Is that right?

Ms. QUINCY. Yes.

Mr. POTTER. Yes. You are correct.

Mr. DINGELL. Now, if you have got a plan that is grandfathered, it would then be able to charge lower prices for its product and give less benefits at the same time. Isn't that right?

Ms. QUINCY. Yes.

Mr. POTTER. Yes.

Mr. DINGELL. Let us raise one of the more problematic issues with this legislation. Consumers in grandfathered health plans including those that have raised premiums, cut benefits or increased cost sharing would not have any federally guaranteed rights to internal and external appeals. Is that right?

Ms. QUINCY. Yes.

Mr. POTTER. That is correct.

Mr. DINGELL. So they could kick them all around the block and they couldn't complain. All right. This creates an environment then where insurers, not health professionals, will be making treatment decisions without opportunity for outside review bottomed only on the situation where some green eye-shaded actuary in an insurance company would be defining what treatments the guy could get. Is that right?

Ms. QUINCY. Particularly in self-insured plans.

Mr. DINGELL. OK. Now, my Republicans have said all along that the Affordable Care Act is turning the doctor-patient relationship into a patient-government relationship. First of all, is that true? Yes or no.

Ms. QUINCY. I am sorry. The question, does that interfere with that doctor-patient relationship when you can't have——

Mr. DINGELL. Yes. Does this bill interfere with the doctor-patient relationship? I am talking about the Affordable Care Act. Does it interfere with the doctor-patient relationship?

Ms. QUINCY. I think that you could say that, because around 50 percent of——

Mr. DINGELL. All it really does, Ms. Quincy, is to define the rights of the patient and within that new definitions the patients and the doctors decide what they want to do, and one of the noteworthy things is that the medical profession supported this particular thing after years of having complained about the need to protect us against interference in that relationship. Is that right?

Mr. POTTER. Yes, Congressman.

Mr. DINGELL. I am going to ask unanimous consent to ask one more question, Mr. Chairman.

Mr. BURGESS. Seeing no objection, the gentleman is given an additional minute, but I caution you about statements about the AMA. I am a member. I yield to the gentleman.

Mr. DINGELL. I am not a member, but I am a good friend of the AMA, and all I am doing is defining what it is they had to say and do.

Mr. BURGESS. I appreciate you doing that. We are going to have an opportunity to talk about that a great deal more in the future.

Mr. DINGELL. And I say this with great respect for my friend from Texas.

Now, what I want to know is, is it important that we give guaranteed internal and external appeals rights to the patients who would have benefits under the plan and were being treated in a way they didn't like by the insurance company?

Ms. QUINCY. It is critically important. A GAO report shows that roughly 50 percent of coverage decisions that are disputed using the appeals process are reversed, so that means a mistake was made by the insurance company. So it is a critically important right.

Mr. DINGELL. Mr. Potter?

Mr. POTTER. It is, and it is an essential benefit of the Patient's Bill of Rights that Congress considered many years ago, and it is about time the Congress enacted it.

Mr. DINGELL. Mr. Chairman, I thank you for your kindness.

Mr. BURGESS. I thank the chairman emeritus for his walk down memory line. I need to remind the chairman emeritus that it was

an amendment that he and I put into H.R. 3200 that would enshrine the rights of internal and external review. The Speaker of the House stripped that provision out of the bill that went from this committee on July 30th to the House Floor to vote on November 9, 2009. The Senate did provide some coverage but it was pretty watered down and nowhere near as expansive as the brilliant amendment offered by the chairman emeritus and the vice chair, and it was a shame because Texas has led the way on this.

Mr. DINGELL. If the gentleman would yield?

Mr. BURGESS. Yes, I would be happy to yield.

Mr. DINGELL. My good friend is just indicating how well we have worked together.

Mr. BURGESS. There you go.

Mr. DINGELL. And the fine consequences of that kind of effort. I am here to say, I am anxious to work with the gentleman if he will stop pushing this kind of nonsense legislation. If we work together, we can come up with something much better.

Mr. BURGESS. It was our opponents on the Senate that prevented us carrying the day on that as well as the Speaker's office and the White House probably had some interference, but nevertheless, we are where we are.

Let me just ask you, Mr. Potter. I think you testified or provided in your written testimony that Congress has exempted all taxes from the MLR calculation. Is that correct?

Mr. POTTER. I don't think it is in my written testimony, but there is much that has been exempted in the MLR calculation. That is correct.

Mr. BURGESS. But by regulation, working the MLR regulation at HHS, they decided to sort of pick and choose which taxes are exempt from the calculation. Do you feel that that is inconsistent with the intent of the law?

Mr. POTTER. I think that the statute was pretty clear that certain taxes are exempt from the equation. I can't tell you which ones in particular would qualify for that. That was the intent of Congress, as I understand it.

Mr. BURGESS. I don't have the page number, but in your testimony, the statement is, "In addition, Congress exempted all taxes from the MLR calculation, a huge artificial boost to insurers' MLRs."

Mr. POTTER. Exempting taxes is a boost to MLRs.

Mr. BURGESS. Well, again, the impression given that all taxes, but HHS did not see it that way.

Ms. Trautwein, let me just ask you, one of the things that concerns a lot of us, and there are obviously a lot of things that concern us in the Affordable Care Act, but the cost is a big one, and we had estimates of costs all over the place but I think no one now believes those figures that were originally delivered to us by the CBO and even the Chief Actuary for CMS has said the cost is going to be some $450 billion over 10 years higher than what was advertised in March of 2010, and in fact, those numbers are probably higher still, and the difficulty is, of course, the CBO having to estimate how many people would leave their employer-sponsored insurance or how many employers would drop employer-sponsored insurance and push their employees into the exchange.

So do you think that the number of people ending up in the exchange will be greater than currently estimated? Has your organization done any looking at this?

Ms. TRAUTWEIN. Well, thank you very much for this question. I am very glad you asked that. This is actually one of our primary concerns, not so much whether they end up in the exchange or somewhere else. We are very worried about what we are seeing in terms of some employer decision-making process. So if we calculated the cost of this legislation being whatever the final number was modified three times over by CBO or whomever, if that is all based on some assumptions that frankly we are very worried are not correct. What we are seeing is many employers saying look, the burden is too heavy, and I have talked to them personally. This is not anecdotal. Now, if too many of them do this, of course, all the estimates that we made relative to the cost of providing subsidies for a group of people that did not have employer-sponsored coverage is going to mushroom dramatically. And so what we are thinking is that many of them are not going to be providing coverage far more than were estimated to be dropped in the additional calculations, and this is based on massive input from our members and their clients.

Mr. BURGESS. I want to thank everyone for attending. That appears to be the conclusion of all the questions, and I want to thank the witnesses for participating in today's hearing. I thank them for their indulgence while the floor did votes.

I remind the members that they have 10 business days to submit questions for the record, and I ask the witnesses to respond promptly to these questions. Members should submit their questions by the close of business on September 29th.

The subcommittee hearing stands adjourned.

[Whereupon, at 2:21 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of the Honorable Joe Barton
Chairman Emeritus, Committee on Energy and Commerce
Subcommittee on Health
Hearing
"Cutting the Red Tape: Saving Jobs from PPACA's Harmful Regulations"
September 15, 2011

Thank you, Chairman Pitts for holding this hearing today on 'Cutting the Red Tape from the Affordable Care Acts Harmful Regulations'. I strongly support H.R. 2077 and the Discussion Draft that prevents the enforcement of this Administration's grandfathered plan regulations, which stifles the opportunity for individuals to maintain their current health coverage.

I recall President Obama stating on many occasions, that if individuals liked the insurance plan they had, they could keep it. Section 1251 of PPACA sets forth the grandfathering conditions for an individual or group's health plan if effective before March 23, 2010. Yet on June 17th 2010, additional encumbrances were added by the Departments of Health and Human Services, Labor and the Treasury. They issued an interim final rule imposing so many additional restrictions on the existing health plans to protect their grandfathered status that the additional costs will roll over to the employer and to the employee.

"In everything one thing is impossible: rationality". A quote by Friedrich Neitzsche that I believe the President must live by. Why would you make the promise to be able to maintain and keep your insurance plan and then make it virtually impossible to do so?

Under Section 1311 in the act states that employees with incomes at 100% to 400% of the federal poverty level are eligible for taxpayer funded subsidies in the form of a tax credit to help pay for their premiums. Eligibility is only possible if an exchange is established by the state. In those states that chose not to set up an exchange, the employee is eligible for the federal exchange. However, the Act makes

no mention of tax credit availability for federal exchanges. This is a technical error in the law. So in some states, employees who are already at the poverty level and are being forced to buy health insurance will not receive the tax credits that others do in other states.

Section 1001 requires health plans to spend a high percentage of their revenues on reimbursements for clinical services and activities to improve health care. This means there is less money for the health plans to do audits and review on fraudulent payments for services. To me this means that there will be more fraudulent claims paid, and no one to audit them.

Employers are going to cut back on employees as their costs continue to rise, and the burdens on their business keep going up from our federal regulations. Instead of spending time in production of what their main line of business is, they will be spending more time in administration of that business, costing them time and money. We have a struggling economy that is trying even with this Administration's downgrade trying to get back up on its feet, and this is what we offer up: More red tape? There are way too many job killing and negative consumer consequences from the errors in this Administration's health care plan. Employers will be faced with so many new tasks to maintain their current employee's records with regards to all of these new imposed rules having to do with grandfathered plans and federal exchanges they will have no choice but to cut back on employees.

Again you have my strong support for H.R. 2077 and the Discussion Draft to prevent enforcement of excessive regulations to grandfathered health plans that will preserve their freedom of choice. This is a 'rational' decision and an easy one. With this, I yield back.

Steve Larsen's Additional Written QFRs
Energy & Commerce Subcommittee on Health
"Cutting the Red Tape: Saving Jobs From PPACA's Harmful Regulations"

September 15, 2011

The Honorable Joseph R. Pitts

1. **During your testimony, you suggested that insurers could be "exploiting the Medical Loss Ratio (MLR) provision" to lower agent and broker commissions, but stated you were "not sure there in any clear data" to support that claim. Testimony given at our September 15th hearing given by representatives of broker community points directly at the MLR interim final rule as the cause of massive income and job loss in the agent community, rather than any exploitive action taken by health plans. Can you point us to any data in support of the\theory you offered in your testimony?**

   Answer: Between April and June of 2011, the NAIC Health Care Reform Actuarial Working Group of the Health Actuarial (B) Task Force collected and analyzed commissions data from a variety of sources.[1] These data show that, while a number of issuers reduced commission levels in 2011, a significant number of issuers kept commission levels unchanged, and some issuers have even increased commissions subsequent to the implementation of the MLR provisions.[2] These data also suggest that commission reductions were not limited to 2011, but had also occurred prior to the implementation of the MLR provisions. Data collected by the NAIC indicate that the industry has moved toward restructured commission schedules to replace arrangements based on percentage of premium with arrangements based on flat dollar amounts per employee or per member, and/or tiered arrangements based on volume of business generated by a producer.

   In sum, the data collected by the NAIC suggests that commission adjustments have occurred prior to the passage of the Affordable Care Act (ACA) and issuers may have had business considerations to reduce commission rates other than the MLR requirements.

2. **In response to questions regarding the logistics of assuring proper payment of MLR rebates from insurers to employees with employer-sponsored insurance, you testified that the Center for Consumer Information and Insurance Oversight (CCIIO) is considering modifying the MLR rule to ensure a more efficient rebate process. Can you provide the committee with a list of options CCIIO is considering towards this end?**

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[1] Data available at http://www.naic.org/committees_b_hcra_wg.htm

[2] *See, e.g.*, National Health Underwriters Associations, "De-identified Report, Agent Revenue Reduction," *Survey Attachment in Ltr to Eric King, NAIC* (May 10, 2011), available electronically at: http://www.naic.org/documents/committees_b_ha_tf_110512_mlr_data_submission_attachment.xls

Answer: As we are evaluating comments on the interim final rule, we are looking at this issue carefully. We expect more information on rebates will be available in the final rule when it is published sometime in December.

3. **In testimony before the committee on March 25th, you mentioned that patients in non-grandfathered plans now have greater freedom to choose their own doctor. Mr. Shimkus asked you if section 1311(h) of PPACA authorizes HHS to issue regulations that would prohibit qualified health plans from contracting with certain health care providers. Section 1311(h) clearly states the Secretary has that authority. Has CCIIO made any decisions regarding issuing quality requirements under this provision for providers?**

   Answer: To enhance patient safety, beginning January 1, 2015, section 1311(h) of the Affordable Care Act directs that qualified health plans may contract with health care providers that implement mechanisms to improve health care quality. CMS has not made any decision regarding the quality requirements under section 1311(h) but welcomes dialogue with stakeholders to discuss issues or concerns.

4. **If a health plan concurrently reviews drug utilization to avoid potential adverse drug reactions, does the MLR rule classify that expense as administrative?**

   Answer: The MLR Interim Final Rule (IFR), Section 158.150(b)(2)(iii)(A)(4) includes "Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions" as an example of an activity that improves health care quality. Retrospective and concurrent utilization reviews are excluded from activities that improve health care quality and are an administrative expense provided in Section 158.150(c)(7). These classifications were recommended by the NAIC in its recommendations to the Secretary regarding MLR, as provided in Section 2718 of the Public Health Service Act, and adopted by the Secretary. The NAIC MLR model regulation was adopted by the unanimous approval of the States' insurance commissioners, following an extended and open process in which issuers, providers, consumers, and other interested stakeholders participated.

5. **Please update the Committee regarding the timing of proposed and final regulations related to essential health benefits.**

   Answer: CMS understands the importance and interest in the proposed and final regulations related to essential health benefits. We are working diligently to develop a proposed rule and issue guidance to interested stakeholders in a timely fashion.

6. **Please update the Committee regarding the timing of final regulations regarding American Health Benefits Exchanges.**
   Answer: CMS has issued three Notices of Proposed Rule Making: "Establishment of Exchanges and Qualified Health Plans" 76 Fed. Reg. 41866 (July 15, 2011), "Standards Related to Reinsurance, Risks Corridors and Risk Adjustment" 76 Fed. Reg. 41930 (July 15, 2011), and "Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers" 76 Fed. Reg. 51202 (August 17, 2011) to guide the

development and operation of Affordable Insurance Exchanges. CMS is in the process of reviewing comments and anticipates releasing these final rules in 2012 and understands the need to provide States with answers to questions as they develop their Exchange infrastructure.

7. **Please provide the Committee with a detailed list of all contracts entered into by HHS related to the creation, development, planning, staffing, or any other activity related to federally facilitated exchanges administered by the Secretary under authority granted to HHS by Section 1321(c) of PPACA. The response should include the dollar amount and summary of the scope of work associated with each contract.**

Answer: HHS and CMS have obligated approximately $72 million in FY 2010 and FY 2011 from the Health Insurance Reform Implementation Fund and HHS General Departmental Management in support of Exchanges. Only about half of that amount is related specifically to the Federally-Facilitated Exchange, as many contracts fund work that will both inform implementation of the Federally-Facilitated Exchange as well as carry out the Secretary's responsibilities on behalf of all Exchanges. The $72 million does not include amounts spent solely on oversight and support of State-operated Exchanges.

The following is a list of contractors working on planning or implementation activities regarding the Federal-Facilitated Exchange and the work CMS must do on behalf of all Exchanges.

Description	Contractor	Total Obligations
Provide detailed research and analysis and recommendations regarding the design and development of the appeals process for both Exchanges. Provide support, research analytics, and technical assistance to aid CMS CCIIO and/or States in the development and implementation of Eligibility and Enrollment functions and strategies.	Booz Allen Hamilton	$2,583,935
Provide expertise and analysis to support the development of reinsurance formula and calculation of State allocation; development for out-of-pocket limits for cost-sharing reductions and development of standard populations for use in actuarial value.	Acumen, LLC	$1,698,054

Research and Development for Production of a Federally-Certified Risk Adjustment Model	Research Triangle Institute	$2,427,414
IT Requirements Management and Analysis Task Order to provide professional requirements engineering, requirements training, and related information about IT for CMS	Genova Technologies	$2,828,148
Exchange IT Support Contract	Quality Software Services	$1,664,520
Cloud Computing Services Contract	Terremark Federal Group, Inc	$3,951,975
Analytic services in response to Request for Comment and NPRM	The George Washington University	$695,007
Exchange Consultant Contract	Wakely Consulting Group	$432,093
Building and supporting the information technology systems of the Federally-facilitated Exchange.	CGI Federal	$55,744,082
Total		**$72,025,228**

8. **Please provide the Committee with an updated list of outlays from the $1 billion implementation fund provided in Section 1005 of HCERA. How much of the $1 billion has been spent to date?**

   Answer: We recognize that the Committee is interested in understanding these figures and will provide them to the Committee under separate cover.

9. **Does HHS have legal authority to apply PPACA regulations to plans that are written by foreign insurers? If no, is it your understanding that Congress intended for PPACA to put American insurers at a competitive disadvantage against non-American companies in the global marketplace?**

   Answer: Title I of the Affordable Care Act applies to policies and plans sold by health insurance issuers licensed by a State. It applies to policies and plans sold by a health insurance insurer domiciled overseas that is licensed to sell products in a State, but it does not apply to a foreign health insurance issuer selling a policy or plan issued in a foreign

country. Similarly, the Affordable Care Act does not apply to a policy or plan issued overseas by a health insurance issuer or the subsidiary or affiliate of a health insurance issuer domiciled in the U.S.

CMS has taken account of the special circumstances of expatriate policies that cover U.S. employees working abroad. In consideration, the MLR IFR provides for national aggregation and a 2.0 multiplier for 2011 to the incurred claims for those plans to account for the greater administrative costs and volatility of experience in these plans.

10. Is it also your understanding that PPACA intended to require employers who send American workers overseas to purchase two health plans for those workers to satisfy the requirements of PPACA?

Answer: It is our understanding that the Affordable Care Act does not require employers who send American workers overseas to purchase two health plans in order to satisfy the requirements of the Affordable Care Act.

11. Does the Administration support changes to the law to maintain global competitiveness of U.S.-based multinational employers and health plans serving globally mobile workforces?

Answer: Assuming this question refers to expatriate plans, CMS does not believe that the Affordable Care Act will materially affect U.S. issuers' ability to compete with foreign issuers, in part because U.S. employers want to provide their employees who are working abroad and their dependents with comprehensive health insurance that meets the unique needs of expatriates and provides benefits that are at a minimum comparable to the coverage of their U.S.-based employees.

CMS does recognize that expatriate policies have significantly different and additional administrative costs than do policies that provide primarily domestic coverage. These administrative costs are not likely to change or decrease as a result of new options for coverage that will become available in 2014. In addition, the experience of expatriate policies is subject to more variability than other types of policies, since they primarily cover care in all parts of the world in a wide variety of health care systems. The MLR IFR allows expatriate plans to adjust the MLR calculation to take into account their higher administrative costs.

Health Reform Implementation Fund Expenditures

As of September 30, 2011, the following amounts have been spent from the Health Reform Implementation Fund:

Health Reform Implementation Fund - Obligations and Outlays as of September 30th, 2011

FY 2011

Organization	Through September 30th, 2011 Obligations	Outlays	
Internal Revenue Service	$188,861,953	$112,093,091	
Office of Personnel Management	$1,855,701	$435,770	
Department of Labor	$1,496,410	$1,424,449	
Department of Health and Human Services	$242,617,622	$116,469,245	
Administration on Aging	*$3,947,967*	*$3,559,789*	*(Non-Add)*
Centers for Medicare and Medicaid Services	*$208,761,833*	*$92,885,031*	*(Non-Add)*
Health Resources and Services Administration	*$1,584,000*	*$1,466,685*	*(Non-Add)*
Indian Health Service	*$750,000*	*$750,000*	*(Non-Add)*
Office of the Secretary	*$27,573,822*	*$17,807,740*	*(Non-Add)*
Total Health Reform Implementation Fund	$434,831,685	$230,422,554	